

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 15G377	X2) MULTIPLE CONSTRUCTION A. BUILDING 00 B. WING _____	X3) DATE SURVEY COMPLETED 02/08/2013
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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 52549 MYRTLE ST SOUTH BEND, IN 46637
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W0000	<p>This visit was for the investigation of Complaint #IN00122911.</p> <p>Complaint #IN00122911: SUBSTANTIATED, Federal and state deficiencies related to the allegations are cited at W102, W104, W120, W122, W149, W154, W156, W159, W189, W216, W240, W318, W331 and W9999.</p> <p>Dates of survey: January 23, 24, 25, 28 and February 8, 2013</p> <p>Facility number: 000891 Provider number: 15G377 AIM number: 100244320</p> <p>Surveyor: Christine Colon, Medical Surveyor III/QMRP</p> <p>The following deficiencies also reflect state findings in accordance with 460 IAC 9. Quality Review completed 2/18/13 by Ruth Shackelford, Medical Surveyor III.</p>	W0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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W0102	<p>483.410 GOVERNING BODY AND MANAGEMENT The facility must ensure that specific governing body and management requirements are met.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to meet the Condition of Participation: Governing Body. The governing body failed to exercise operating direction over the facility to ensure the outside day program met the health needs for client A, the facility implemented their policy and procedures to prevent neglect of client A and to ensure the health needs of client A were met.</p> <p>Findings include:</p> <ol style="list-style-type: none"> Please refer to W120. The governing body failed to ensure the contracted day program services met the health needs of each client by not ensuring the staff were properly trained in transferring client A in and out of his wheelchair. Please refer to W122. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Client Protections. The governing body neglected to implement their neglect policy and neglected to protect 1 of 3 sampled clients (client A), from a fall which resulted in the death of client A. Please refer to W318. The governing body failed to exercise general policy and operating direction over the facility in regards to meeting the Condition of Participation: Health Care Services. The governing body failed for 1 of 3 sampled clients (client A), to ensure nursing services provided staff training on lifting, obtained Occupational/Physical Therapy assessments for 	W0102	LOGAN Community, Inc will require a written Lift/Transfers Risk Plan be developed for all clients who require a mechanical lift for transfers when being provided daily hygiene care. The guardian and a Residential Provider management staff will be asked to physically view the mechanical lift in effort to prevent any misrepresentations or misunderstandings regarding the mechanical lift that will be utilized for transfers. The Lift/Transfers Risk Plan will be written by the Residential Provider. The Life/Transfers Risk Plan components will include, but not be limited to: client identifying information, diagnosis, pertinent health history, lift type to be utilized, general procedures and steps, client specific information regarding lift techniques and the author of the Lift/Transfers Risk Plan. After written and appropriate approvals are received by the way of signatures on the risk plan from the guardian, residential and day provider, staff will be receiving training to implement the Lift/Transfers Risk Plan. Logan will ensure that Logan staff receive training on all Lift/Transfers Risk Plan from the Residential Provider. Logan will	03/15/2013
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	<p>the use of a lift and assessed and treated the client for documented skin breakdown.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-1(a)</p>		<p>ensure that Logan staff assigned to work with the individual who requires the Lift/Transfers Risk Plan are available and receives training on the plan. The training will take place at the location where the mechanical lift will be utilized and with the client present for comprehension and demonstration purposes. All training will be documented. Documentation will include the date of training, agenda, and the name and title of trainer. Logan will work cooperatively with the Residential Provider training staff to develop this written documentation. Documentation will be kept on Logan property and available to the Residential Provider, as requested. Training on the Lift/Transfers Risk Plan will be provided on an annual basis, unless there is a change or revision to the plan based on the client's individual needs or status. Revisions will be the responsibility of the Residential Provider. Logan will ensure appropriate Logan staff are available and receive the annual training and/or training on any revisions to the Lift/Transfers Risk Plan. Annual training and/or training revisions will be provided by the Residential Provider and will be documented.</p>		

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W0104	<p>483.410(a)(1) GOVERNING BODY</p> <p>The governing body must exercise general policy, budget, and operating direction over the facility.</p> <p>Based on record review and interview for 1 of 3 sampled clients (client A), the governing body failed to exercise general policy and operating direction over the facility to prevent neglect of client A and neglected to conduct a thorough investigation of an incident which resulted in death. The governing body failed to exercise general policy and operating direction over the facility to ensure the facility's nursing services met the health care needs of client A, and to ensure nursing services trained facility staff to meet the health care needs of the client.</p> <p>Findings include:</p> <p>Please refer to W149. The governing body neglected for 1 of 3 sampled clients (client A) to implement written policy and procedures to prevent neglect of a client who required complete assistance with transferring in and out of his wheelchair. The governing body neglected to conduct a thorough investigation for an incident which resulted in client A's death. The governing body neglected to put in place measures to prevent injury. The governing</p>	W0104	<p>The facility will ensure thorough and accurate investigations will occur immediately. Logan will be responsible to report to the agency Nurse any injuries that occur at Day Program. The agency Nurse and the Logan Nurse will work collaboratively to ensure all necessary information is thoroughly documented (in writing) and proper follow-up occurs. Corvilla nursing services will ensure group home staff and day program staff are trained on the use of lift for transferring clients in and out of wheelchair. Corvilla nursing services will ensure all group home staff and all day program staff are trained on using lift before staff use lift and yearly, at month of annual. The Day Program staff will be responsible to notify agency Nurse of any new adaptive equipment for Corvilla residents, based upon appropriate assessments and has been agreed upon by the resident's IDT prior to implementation of the equipment. This will be reviewed annually. Day Program nurses will be trained on faxing all written documentation of any accidents/injury by 3-15-13. All group homes and day program staff will be trained annually at the month of the client's annual</p>	03/15/2013	

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	<p>body neglected to ensure nursing services met the health care needs of client A and to ensure staff were adequately trained to provide assistance with transferring client A in and out of his wheelchair.</p> <p>Please refer to W331. The governing body failed for 1 of 3 sampled clients (client A) by not ensuring they received nursing services by not assessing the client for the use of a Hoyer lift and Sure Hands lift while transferring the client in and out of his wheelchair, failed to ensure group home staff and day program staff were trained on the use of lifts and failed to assess client A for documented skin breakdown.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-1(a)</p>		meeting.		

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W0120	<p>483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client. Based on record review and interview for 1 of 3 sampled clients (client A), the facility failed to ensure outside day program services met the needs of each client by not ensuring the day program provided sufficient care for client A.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Name of day program]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and</p>	W0120	<p>LOGAN Community, Inc will require a written Lift/Transfers Risk Plan be developed for all clients who require a mechanical lift for transfers when being provided daily hygiene care. The guardian and a Residential Provider management staff will be asked to physically view the mechanical lift in effort to prevent any misrepresentations or misunderstandings regarding the mechanical lift that will be utilized for transfers. The Lift/Transfers Risk Plan will be written by the Residential Provider. The Life/Transfers Risk Plan components will include, but not be limited to: client identifying information, diagnosis, pertinent health history, lift type to be utilized, general procedures and steps, client specific information regarding lift techniques and the author of the Lift/Transfers Risk Plan. After written and appropriate approvals are received by the way of signatures on the risk plan from the guardian, residential and day provider, staff will be receiving training to implement the Lift/Transfers Risk Plan. Logan will ensure that Logan staff receive training on all Lift/Transfers Risk Plan from the Residential Provider. Logan will</p>	03/15/2013			

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	<p>fidgiting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount</p>		<p>ensure that Logan staff assigned tow ork with the individual who requires the Lift/Transfers Risk Plan are available and receives training on the plan. The training will take place at the location where the mechanical lift will be utilized and with the cleint present for comprehension and demonstration purposes. All training will be documented. Documentation will include the date of training, agenda, and the name and title of trainer. Logan will work cooperatively with the Residential Provider training staff to develop this written documentation. Documentation will be kept on Logan property and available to the Residential Provider, as requested. Training on the Lift/Transfers Risk Plan will be provided on an annual basis, unless there is a change or revision tot he plan based on the client's individual needs or status. Revisions will be the responsibility of the Residential Provider. Logan will ensure appropriate Logan staff are available and receive the annual training and/or training on any revisions to the Lift/Transfers Risk Plan. Annual training and/or training revisions will be provided by the Residential Provider and will be documented.</p>	

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	<p>of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the client's Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan.</p>			

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	<p>Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he</p>				

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	<p>responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been</p>						

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	<p>hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of client A's record did not indicate an assessment of the use of a lift to transfer client A in and out of his wheelchair. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a lift to transfer client A in and out of his wheelchair.</p>						

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	<p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'."</p> <p>A review of the contracted day program records was conducted on 1/25/13 at 3:15 P.M.. Review of the records indicated an incident report involving client A dated 1/16/13, which indicated: "[Client A] needed to be changed, took to restroom. [Client A] has to be lifted with lift. 'Secured' him to lift, removed chair when lift got close to changing table, [client A]'s upper body slipped from arm rests and fell-slipped approximately 2-2 1/2 feet head first to floor, striking head on table leg and lift leg-lost consciousness approximately 1 minute, back of head and bleeding freely, called code 1 for nurse...."</p> <p>A review of a written statement dated 1/17/13 indicated: "...[Client A] appeared to not be feeling well yesterday about noon-time....[Client A] complained of not feeling well...Approximately 1 pm, [client A] was bundled to go home, staff noticed he had wet himself and needed to be changed and requested I (staff #19) take him to bathroom...I took [client A] to</p>						

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	<p>bathroom, [staff #20] already there with lift in position to receive [client A]. I (staff #19) guided his chair into position, locked the wheels and [staff #20] went to his left side. I to the right, to secure [client A]'s arms and legs into the lift, making sure his arms were positioned snugly and then placed his legs in brackets correctly so they (brackets) were level and touching each other between his legs. When he was secured in position, I moved to back of his chair, removed his oxygen and prepared to remove his chair as [staff #20] began to raise [client A] up to move him to the changing table. At her signal and with [client A]'s agreement, I removed the chair. [Staff #20] guided the lift over to the changing table (about 3 feet away) when lift was within inches of table [client A] began to slip out of arm supports, like he lost his upper body strength, and slipped-fell about 2 2 1/2 feet, head first to the floor. His legs then also slipped free of the supports. The back of his head struck the changing table leg and possible lift leg and there was some blood under his head on the floor...."</p> <p>Interview with the Quality Assurance Director (QAD) of Day Services, was completed on 1/25/13 at 3:30 P.M.. The QAD indicated the day program staff had been using a "Sure Hands" lift to transfer</p>						

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	<p>client A to and from his wheelchair for about 3 months. When asked if client A had a lift risk plan in place to give guidance to day program staff on how client A was to be transferred to and from his wheelchair, the QAD stated "No." When asked if the day program had an order/assessment for the use of the "Sure Hands" lift to transfer client A to and from his wheelchair, the QAD stated "No." When asked if day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "Staff were trained 3 years ago by a representative when the lift was first purchased. Every time the lift is used there is always a lead staff present." When asked if a lead staff was present on the date of the incident, the QAD stated "Yes, one of the staff present during the incident was a lead staff." When asked if any documentation was available for review to indicate day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "I don't have any written documentation to show the staff have been trained." When asked if the facility knew the day program used the "Sure Hands' lift to transfer client A in and out of his wheelchair, the QAD stated "Yes, we discussed it with the [nurse name] and [QMRP name]."</p> <p>This federal tag relates to #IN00122911.</p>			

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	9-3-1(a)				

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W0122	<p>483.420 CLIENT PROTECTIONS The facility must ensure that specific client protections requirements are met. Based on record review and interview, the Condition of Participation, Client Protections, is not met as the facility failed to have written documentation to indicate a thorough investigation of an allegation of neglect was completed for 1 of 1 incident of a fall which resulted in death involving 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>1. Please refer to W149. The facility failed to implement their abuse/neglect policy by not completing a thorough investigation for 1 of 1 incident reviewed of an allegation of staff neglect which resulted in death involving 1 of 3 sampled clients (client A), to prevent neglect of a client who required complete assistance with transferring in and out of his wheelchair. The facility neglected to ensure nursing services met the health care needs of client A and to ensure staff were adequately trained to provide assistance with transferring client A in and out of his wheelchair.</p> <p>2. Please refer to W154. The facility failed for 1 of 1 incident of a fall which resulted in death involving 1 of 3 sampled</p>	W0122	To ensure that the facility does not fail to adhere and to implement appropriately its Abuse and Neglect Policy in future, the corporate staff (Nurse, QMRP, and Residential Supervisor) have been retrained on the policy. Thereby, ensuring alleged incidents of abuse, neglect and/or mistreatment are investigated immediately and reported to the Executive Director. Also, to ensure proper transferring of a client in and out of his/her wheelchair occurs, staff will be trained on proper transferring techniques and needed Risk Management Plan(s) immediately. Thereafter, staff will be trained/retrained annually. Also, Lift/Transfer Risk Management Plans will be put into place for all clients who require a mechanical lift for transferring to meet their personal hygiene care needs	03/15/2013			

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	<p>clients (client A), to provide evidence a thorough investigation was completed.</p> <p>3. Please refer to W156 as the facility failed to report the results of 1 of 1 incident of a fall which resulted in death while at the contracted day service, involving 1 of 3 sampled clients (client A), to the administrator within five business days.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-2(a)</p>				

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W0149	<p>483.420(d)(1) STAFF TREATMENT OF CLIENTS The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect or abuse of the client. Based on record review and interview for 1 of 3 sampled clients (A), the facility neglected to implement written policy and procedures to prevent neglect of a client who required complete assistance with transferring in and out of his wheelchair. The facility neglected to conduct a thorough investigation for an incident which resulted in client A's death. The facility neglected to put in place measures to prevent injury. The facility neglected to ensure nursing services met the health care needs of client A and to ensure staff were adequately trained to provide assistance with transferring client A in and out of his wheelchair.</p> <p>Findings include:</p> <p>1. A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation</p>	W0149	To ensure that the facility does not fail to adhere and to implement appropriately its Abuse and Neglect Policy in future, the corporate staff (Nurse, QMRP, and Residential Supervisor) have been retrained on the policy. Thereby, ensuring alleged incidents of abuse, neglect and/or mistreatment are investigated immediately and reported to the Executive Director. Also, to ensure proper transferring of a client in and out of his/her wheelchair occurs, staff will be trained on proper transferring techniques and needed Risk Management Plan(s) immediately. Thereafter, staff will be trained/retrained annually. Also, Lift/Transfer Risk Management Plans will be put into place for all clients who require a mechanical lift for transferring to meet their personal hygiene care needs. The Nurse and QMRP will be responsible for monitoring on a monthly basis, the Residential and Day Provider staff's ability to provide services necessary to avoid physical harm to the residents of Corvilla.	03/15/2013			

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	<p>Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the</p>			

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	front of the lift. A code was called and [day program] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the client's Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he				

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	<p>would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were</p>						

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	<p>perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of client A's record did not indicate an assessment for the use of a lift to transfer client A in and out of his wheelchair. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a lift to transfer client A in and out of his wheelchair. Further review of the record failed to indicate any lift plans to give staff guidance and when and how to assist client A with transferring in and out of his wheelchair.</p>						

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	A review of the facility's "Personnel Policy and Procedure: Abuse or Neglect" no date noted was conducted at the facility's administrative office on 1/25/13 at 1:45 P.M.. Review of the facility's policy indicated: "All incidents of unusual occurrences will be documented and reported within 24 hours to the QMRP. Any incident of unusual occurrence that has the potential of causing significant harm or injury or that requires medical follow-up will be reported to the Executive Director and appropriate State agencies within 24 hours. An investigation of these occurrences will take place and the results will be reported within 5 working days....Purpose: This policy has been established to provide guidelines for staff by which incidents of unusual occurrences will be documented and reported. The policy will also ensure the Executive Director and appropriate State agencies will be notified and that, when necessary, an investigation will take place in a timely manner and appropriate staff and agencies will be notified of the results...Procedure: Incidents of unusual occurrences will include but are not limited to: suspected sexual, physical or verbal abuse or exploitation, neglect, elopement, property destruction, self injurious behavior, injuries of unknown origin, death, residential problems."			

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	<p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons</p>			
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	<p>are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'." When asked if there was an assessment completed to indicate how client A was to be transferred in and out of his wheelchair, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place." When asked if there was documentation</p>						

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	<p>available for review to indicate she had conducted a thorough investigation of the incident, the QMRP indicated she did not have written documentation to indicate she conducted an investigation because the incident occurred at the day program.</p> <p>A review of the contracted day program records was conducted on 1/25/13 at 3:15 P.M.. Review of the records indicated an incident report involving client A dated 1/16/13, which indicated: "[Client A] needed to be changed, took to restroom. [Client A] has to be lifted with lift. 'Secured' him to lift, removed chair when lift got close to changing table, [client A]'s upper body slipped from arm rests and fell-slipped approximately 2-2 1/2 feet head first to floor, striking head on table leg and lift leg-lost consciousness approximately 1 minute, back of head and bleeding freely, called code 1 for nurse...."</p> <p>A review of a written statement dated 1/17/13 indicated: "...[Client A] appeared to not be feeling well yesterday about noon-time....[Client A] complained of not feeling well...Approximately 1 pm, [client A] was bundled to go home, staff noticed he had wet himself and needed to be changed and requested I (staff #19) take him to bathroom...I took [client A] to bathroom, [staff #20] already there with</p>						

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	<p>lift in position to receive [client A]. I (staff #19) guided his chair into position, locked the wheels and [staff #20] went to his left side. I to the right, to secure [client A]'s arms and legs into the lift, making sure his arms were positioned snugly and then placed his legs in brackets correctly so they (brackets) were level and touching each other between his legs. When he was secured in position, I moved to back of his chair, removed his oxygen and prepared to remove his chair as [staff #20] began to raise [client A] up to move him to the changing table. At her signal and with [client A]'s agreement, I removed the chair. [Staff #20] guided the lift over to the changing table (about 3 feet away) when lift was within inches of table [client A] began to slip out of arm supports, like he lost his upper body strength, and slipped-fell about 2 2 1/2 feet, head first to the floor. His legs then also slipped free of the supports. The back of his head struck the changing table leg and possible lift leg and there was some blood under his head on the floor...."</p> <p>Interview with the Quality Assurance Director (QAD) of Day Services, was completed on 1/25/13 at 3:30 P.M.. The QAD indicated the day program staff had been using a "Sure Hands" lift to transfer client A to and from his wheelchair for</p>						

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	<p>about 3 months. When asked if client A had a lift risk plan in place to give guidance to day program staff on how client A was to be transferred to and from his wheelchair, the QAD stated "No." When asked if the day program had an order/assessment for the use of the "Sure Hands" lift to transfer client A to and from his wheelchair, the QAD stated "No." When asked if day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "Staff were trained 3 years ago by a representative when the lift was first purchased. Every time the lift is used there is always a lead staff present." When asked if a lead staff was present on the date of the incident, the QAD stated "Yes, one of the staff present during the incident was a lead staff." When asked if any documentation was available for review to indicate day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "I don't have any written documentation to show the staff have been trained."</p> <p>2. A review of client A's day program record was conducted on 1/25/13 at 3:15 P.M.. Review of the record indicated the following nursing notations:</p> <p>"11/7/12 at 4:00 P.M., skin integrity: While toileting [client A], the staff noticed some skin irritation that they</p>			

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	<p>wanted me (nurse) to take a look at. In the assessed inner leg crease and including 1/3 of the supra-pubic area was very moist, white tissue, as if the tissue were (sic) overly saturated with moisture. The leg crease area was more red in color and irritated. Along the upper thigh and abdomen area were areas in all stages of blistering and scabbed over (from when blister breaks open) which have occurred as a result of skin contact with the plastic part of the client's depends. Program Coordinator (PC) from day program and [Group home nurse name] were both notified of my assessment. [Group home nurse name] said that she would follow up and check into it."</p> <p>"11/21/12 at 1:30 P.M., skin integrity: Called to senior's restroom to assess client skin. Staff noticed some abnormal irritation. Assessed the client skin integrity around the peritoneal area. The inner thigh leg crease was deep red and very moist. In some areas very exposed and raw. There were also several areas on the client's scrotal sac, which was also a deep red, that had peeled away, leaving a little blood present. The skin around the penis was white in color, as in overly saturated with excessive moisture. Information passed on to client's PC at day program."</p>						

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	<p>"11/26/12 at 2:00 P.M.: Called to assess the skin on the client's buttocks. Staff was concerned when they noticed a few open areas. Assessed the client's buttocks. On the right buttock were 2 small open areas approximately the size of a nickel. Very superficial. A very thin layer of skin was peeled away from the surface, exposing a moist tissue...The (sic) was also a significant amount of skin discoloration on both buttocks. Unable to determine if this was a new occurrence, perhaps caused by skin peeling, or a status that has been present for some time...notified PC from day program and PC contacted and updated [QMRP name] via email."</p> <p>An interview with the facility's nurse was conducted on 1/28/13 at 11:00 A.M.. When asked how often nursing assessments were completed, the nurse stated "Monthly." When asked if concerns were noted in the nursing assessments, the nurse stated "Yes, all concerns are written in the assessments." When asked if there was any documentation to indicate client A's noted skin break down was assessed, the nurse indicated it would be documented in his record.</p> <p>A review of client A's record was conducted on 1/28/13 at 1:00 P.M..</p>			

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	<p>Review of client A's monthly nursing assessments dated 10/12, 11/12 and 12/12 failed to indicate the agency nurse assessed client A for skin breakdown. Further review of client A's record failed to address any skin breakdown for client A for the noted incidents.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-2(a)</p>			

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W0154	<p>483.420(d)(3) STAFF TREATMENT OF CLIENTS The facility must have evidence that all alleged violations are thoroughly investigated.</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident which resulted in death, involving 1 of 3 sampled clients (client A), to provide evidence a thorough investigation was completed.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was</p>	W0154	In accordance with all DDRS policies and procedures including policy BQUIS 460 0316 043 Mandatory Components of an Investigation, Logan Community Resources, Inc. will continue to investigate incidents that occur on Logan property. The Director of Quality Assurance will conduct the investigation and will share the results and report with the Residential Provider. When an incident occurs on Logan property, Logan will work cooperatively with the Residential Provider so that the Residential Provider may complete an investigation as is required by DDRS policies and procedures. Logan Community Resources, Inc. will continue the practice of providing detailed information to the Residential Provider, who is responsible for BDDS reportable follow-up, for use in completing the required follow-up. This information will be provided electronically and in a timely manner to the Residential Provider in order to allow for the Residential Provider to submit the information within the designated timeframes.	03/15/2013			

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	<p>observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of</p>			

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	<p>his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the client's Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC)</p>			
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	<p>was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked</p>			

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	<p>that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating</p>				

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	<p>proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. When asked if there was documentation available for review to indicate she had conducted a thorough investigation of the incident, the QMRP indicated she did not have written documentation to indicate she conducted an investigation because</p>						

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	<p>the incident occurred at the day program. The QMRP further indicated the contracted day program was going to conduct an investigation. When asked if she had the investigation from the contracted day program, the QMRP stated "No."</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-2(a)</p>			

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W0159	<p>483.430(a) QUALIFIED MENTAL RETARDATION PROFESSIONAL Each client's active treatment program must be integrated, coordinated and monitored by a qualified mental retardation professional.</p> <p>Based on interview and record review, the Qualified Mental Retardation Professional (QMRP) failed to develop and ensure measures were put in place for client A's identified transferring needs and to ensure a form of communication between the contracted day program and the facility was developed/implemented for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for</p>	W0159	To ensure that there are no other deficiencies of this nature in the future; the QMRP and Nurse will be responsible for developing and training Lift/Transfer Plans for all residents that require the use of a mechanical lift. The QMRP will implement the Plan with the approval of the IDT and guardian. The QMRP will be responsible for monitoring the plan both in the home and Day Program. Quarterly the QMRP will also be responsible for communicating with the Day Program to ensure that the Plan is continuing to meet the needs of the client. Pertainin to communication between Logan Community Resources, Inc. and Corvilla: Per the Day Program Services Agreement between Logan Community Resources and Corvilla, Logan and Corvilla will continue to maintain open communication regarding individuals' needs, services and progress. In an effort to ensure that communication is provided and received by the Residential Provider, Logan will implement the following: All verbal communication with the Residential Provider by the way of a phone call will be followed up with written communication by the	03/15/2013

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	pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the		way of electronic mail and in some instances a fax (once the Residential Provider fax number is confirmed). Proof of delivery and receipt of all communication will be required. For electronic mail a delivery receipt will be obtained and a read receipt will be requested. For a fax, a fax receipt will be obtained. 1) If a logan Day Program Nurse speaks with the Residential Provider Nurse or other Residential Provider staff, the Logan Day Program Nurse will follow up the verbal conversation with a written case note by the way of electronic mail to the Residential Provider QMRP and the Residential Provider Executive Director. The Logan Day Program Nurse will also send a copy of this electronic mail to the Residential Provider Nurse by way of fax (as electronic mail is not an option to the Residential Provider Nurse). Once the Residential Provider fax number is confirmed all faxes will be sent to the Residential Provider Nurse and a fax receipt obtained indicating that the fax transmittal was successful. 2) If the Logan Program Coordinators, Adult Day Services Manager or the Day Services Director verbal communicate by the way of a phone call with the Residential Provider Nurse or other Residential Provider staff, they will also follow up the conversation with a written note sent by the way of electronic mail		

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	nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the clients Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital		to the Residential Provider QMRP and Residential Provider Executive Director. If it involves a medical/health issue, a copy of this electronic mail will be faxed to the Residential Provider Nurse and a fax receipt obtained indicating that the fax transmittal was successful.		

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	<p>[client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic</p>						

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	<p>deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift.</p>						

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	<p>The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of client A's record did not indicate an assessment for the use of a lift to transfer client A in and out of his</p>				

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	<p>wheelchair. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a lift to transfer client A in and out of his wheelchair. Further review of the record failed to indicate any lift plans to give staff guidance and when and how to assist client A with transferring in and out of his wheelchair.</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'." When asked if there was an assessment completed to indicate how client A was to be transferred in and out of his wheelchair, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair while at the group home, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place." When asked how the contracted day program and the facility communicated, the QMRP stated "By telephone."</p> <p>A review of the contracted day program records was conducted on 1/25/13 at 3:15</p>						

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	<p>P.M.. Review of the records indicated an incident report involving client A dated 1/16/13, which indicated: "[Client A] needed to be changed, took to restroom. [Client A] has to be lifted with lift. 'Secured' him to lift, removed chair when lift got close to changing table, [client A]'s upper body slipped from arm rests and fell-slipped approximately 2-2 1/2 feet head first to floor, striking head on table leg and lift leg-lost consciousness approximately 1 minute, back of head and bleeding freely, called code 1 for nurse...."</p> <p>A review of a written statement dated 1/17/13 indicated: "...[Client A] appeared to not be feeling well yesterday about noon-time....[Client A] complained of not feeling well...Approximately 1 pm, [client A] was bundled to go home, staff noticed he had wet himself and needed to be changed and requested I (staff #19) take him to bathroom...I took [client A] to bathroom, [staff #20] already there with lift in position to receive [client A] I (staff #19) guided his chair into position, locked the wheels and [staff #20] went to his left side. I to the right, to secure [client A]'s arms and legs into the lift, making sure his arms were positioned snugly and then placed his legs in brackets correctly so they (brackets) were level and touching each other between his</p>						

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	<p>legs. When he was secured in position, I moved to back of his chair, removed his oxygen and prepared to remove his chair as [staff #20] began to raise [client A] up to move him to the changing table. At her signal and with [client A]'s agreement, I removed the chair. [Staff #20] guided the lift over to the changing table (about 3 feet away) when lift was within inches of table [client A] began to slip out of arm supports, like he lost his upper body strength, and slipped-fell about 2 2 1/2 feet, head first to the floor. His legs then also slipped free of the supports. The back of his head struck the changing table leg and possible lift leg and there was some blood under his head on the floor..."</p> <p>Interview with the Quality Assurance Director (QAD) of Day Services, was completed on 1/25/13 at 3:30 P.M.. The QAD indicated the day program staff had been using a "Sure Hands" lift to transfer client A to and from his wheelchair for about 3 months. When asked if client A had a lift risk plan in place to give guidance to day program staff on how client A was to be transferred to and from his wheelchair, the QAD stated "No." When asked if the day program had an order/assessment for the use of the "Sure Hands" lift to transfer client A to and from his wheelchair, the QAD stated "No." When asked if day program staff</p>			

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	<p>were trained on the use of the "Sure Hands" lift, the QAD stated "Staff were trained 3 years ago by a representative when the lift was first purchased. Every time the lift is used there is always a lead staff present." When asked if a lead staff was present on the date of the incident, the QAD stated "Yes, one of the staff present during the incident was a lead staff." When asked if any documentation was available for review to indicate day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "I don't have any written documentation to show the staff have been trained." When asked if the facility knew the day program used the "Sure Hands' lift to transfer client A in and out of his wheelchair, the QAD stated "Yes, we discussed it with the [nurse name] and [QMRP name]."</p> <p>A review of client A's day program record was conducted on 1/25/13 at 3:15 P.M.. Review of the record indicated the following nursing notations:</p> <p>"11/7/12 at 4:00 P.M., skin integrity: While toileting client A, the staff noticed some skin irritation that they wanted me (nurse) to take a look at. In the assessed inner leg crease and including 1/3 of the supra-pubic area was very moist, white tissue, as if the tissue were (sic) overly saturated with moisture. The leg crease</p>			

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	<p>area was more red in color and irritated. Along the upper thigh and abdomen area were areas in all stages of blistering and scabbed over (from when blister breaks open) which have occurred as a result of skin contact with he plastic part of the client's depends. Program Coordinator (PC) from day program and [Group home nurse name] were both notified of my assessment. [Group home nurse name] said that she would follow up and check into it."</p> <p>"11/21/12 at 1:30 P.M., skin integrity: Called to senior's restroom to assess client skin. Staff noticed some abnormal irritation. Assessed the client skin integrity around the peritoneal area. The inner thigh leg crease was deep red and very moist. In some areas very exposed and raw. There were also several areas on the client's scrotal sac, which was also a deep red, that had peeled away, leaving a little blood present. The skin around the penis was white in color, as in overly saturated with excessive moisture. Information passed on to client's PC at day program."</p> <p>"11/26/12 at 2:00 P.M.: Called to assess the skin on the client's buttocks. Staff was concerned when they noticed a few open areas. Assessed the client's buttocks. On the right buttock were 2</p>			

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	<p>small open areas approximately the size of a nickel. Very superficial. A very thin layer of skin was peeled away from the surface, exposing a moist tissue...The (sic) was also a significant amount of skin discoloration on both buttocks. Unable to determine if this was a new occurrence, perhaps caused by skin peeling, or a status that has been present for some time...notified PC from day program and PC contacted and updated [QMRP name] via email."</p> <p>An interview with the contracted day program nurse was conducted on 1/25/13 at 4:30 P.M.. When asked how often the facility's nurse and QMRP visited the contracted day program, the nurse indicated the facility nurse and QMRP never visited the day program. When asked if the facility was aware the day program was using the "Sure Hands" lift to transfer client A in and out of his wheelchair, the nurse stated "Yes, they knew we were using the lift for about 3 months when his health started to decline."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a</p>			

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	<p>'Hoyer lift.'" When asked if there was an assessment completed to indicate how client A was to be transferred in and out of his wheelchair, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place." When asked if there was documentation available for review to indicate she had conducted a thorough investigation of the incident, the QMRP indicated she did not have written documentation to indicate she conducted an investigation because the incident occurred at the day program. When asked if she had the investigation from the contracted day program, the QMRP stated "No."</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-3(a)</p>						

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W0189	<p>483.430(e)(1) STAFF TRAINING PROGRAM The facility must provide each employee with initial and continuing training that enables the employee to perform his or her duties effectively, efficiently, and competently.</p> <p>Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) to provide day program staff with training on transfer methods.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and</p>	W0189	<p>Logan will ensure that Logan staff receive training on all Lift/Transfers Risk Plan from the Residential Provider. Logan will ensure that Logan staff assigned to work with the individual who requires the Lift/Transfers Risk Plan are available and receives training on the plan. The training will take place at the location where the mechanical lift will be utilized and with the client present for comprehension and demonstration purposes. All training will be documented. Documentation will include the date of training, agenda, and the name and title of trainer. Logan will work cooperatively with the Residential Provider training staff to develop this written documentation. Documentation will be kept on Logan property and available to the Residential Provider, as requested. Training on the Lift/Transfers Risk Plan will be provided on an annual basis, unless there is a change or revision to the plan based on the client's individual needs or status. Revisions will be the responsibility of the Residential Provider. Logan will ensure appropriate Logan staff are available and receive the annual training and/or training on</p>	03/15/2013			

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	<p>fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount</p>		<p>any revisions to the Lift/Transfers Risk Plan. Annual training and/or training revisions will be provided by the Residential Provider and will be documented.</p>	

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	<p>of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the client's Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan.</p>			

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	<p>Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he</p>				

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NAME OF PROVIDER OR SUPPLIER CORVILLA INC	STREET ADDRESS, CITY, STATE, ZIP CODE 52549 MYRTLE ST SOUTH BEND, IN 46637
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	<p>responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of client A's record did not indicate an assessment for the use of a lift to transfer client A in and out of his wheelchair. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a lift to transfer client A in and out of his wheelchair. Further review of the record failed to indicate any lift plans to give staff guidance and when and how to assist client A with transferring in and out of his wheelchair.</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This</p>			

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	<p>training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and</p>			

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	<p>effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'." When asked if there was an assessment completed to indicate how client A was to be transferred in and out of his wheelchair, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place." When asked if there was documentation available for review to indicate all staff who worked with client A received client specific training on how to transfer client A in and out of his wheelchair, the QMRP indicated she did not have written documentation available to indicate staff were trained on the use of a Hoyer lift or Sure Hands lift to transfer client A in and out of his wheelchair.</p> <p>A request for group home and day</p>						

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	<p>program staff training on the use of Hoyer lift and Sure Hands lift training was made on 1/25/13 at 3:00 P.M.. No documentation was submitted for review to indicate group home and day program staff were trained on using a Hoyer lift or Sure Hands lift to assist client A in being transferred in and out of his wheelchair.</p> <p>A review of the contracted day program records was conducted on 1/25/13 at 3:15 P.M.. Review of the records indicated an incident report involving client A dated 1/16/13, which indicated: "[Client A] needed to be changed, took to restroom. [Client A] has to be lifted with lift. 'Secured' him to lift, removed chair when lift got close to changing table, [client A]'s upper body slipped from arm rests and fell-slipped approximately 2-2 1/2 feet head first to floor, striking head on table leg and lift leg-lost consciousness approximately 1 minute, back of head and bleeding freely, called code 1 for nurse..."</p> <p>A review of a written statement dated 1/17/13 indicated: "...[Client A] appeared to not be feeling well yesterday about noon-time....[Client A] complained of not feeling well...Approximately 1 pm, [client A] was bundled to go home, staff noticed he had wet himself and needed to be changed and requested I (staff #19) take him to bathroom...I took [client A] to</p>						

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	<p>bathroom, [staff #20] already there with lift in position to receive [client A]. I (staff #19) guided his chair into position, locked the wheels and [staff #20] went to his left side. I to the right, to secure [client A]'s arms and legs into the lift, making sure his arms were positioned snugly and then placed his legs in brackets correctly so they (brackets) were level and touching each other between his legs. When he was secured in position, I moved to back of his chair, removed his oxygen and prepared to remove his chair as [staff #20] began to raise [client A] up to move him to the changing table. At her signal and with [client A]'s agreement, I removed the chair. [Staff #20] guided the lift over to the changing table (about 3 feet away) when lift was within inches of table [client A] began to slip out of arm supports, like he lost his upper body strength, and slipped-fell about 2 2 1/2 feet, head first to the floor. His legs then also slipped free of the supports. The back of his head struck the changing table leg and possible lift leg and there was some blood under his head on the floor..."</p> <p>Interview with the Quality Assurance Director (QAD) of Day Services, was completed on 1/25/13 at 3:30 P.M.. The QAD indicated the day program staff had been using a "Sure Hands" lift to transfer client A to and from his wheelchair for</p>			

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	<p>about 3 months. When asked if client A had a lift risk plan in place to give guidance to day program staff on how client A was to be transferred to and from his wheelchair, the QAD stated "No." When asked if the day program had an order/assessment for the use of the "Sure Hands" lift to transfer client A to and from his wheelchair, the QAD stated "No." When asked if day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "Staff were trained 3 years ago by a representative when the lift was first purchased. Every time the lift is used there is always a lead staff present." When asked if a lead staff was present on the date of the incident, the QAD stated "Yes, one of the staff present during the incident was a lead staff." When asked if any documentation was available for review to indicate day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "I don't have any written documentation to show the staff have been trained."</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-3(a)</p>				

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W0218	<p>483.440(c)(3)(v) INDIVIDUAL PROGRAM PLAN The comprehensive functional assessment must include sensorimotor development.</p> <p>Based on interview and record review, the facility failed to assess the need of a mechanical lift for 1 of 3 sampled clients (client A) who used a wheelchair for mobility and who required significant assistance to transfer with the use of a mechanical lift at all transfer times.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was</p>	W0218	<p>Each client's file has been reviewed and no similar deficiency has been found. To ensure each client receives needed sensory motor assessments in a timely manner, the QMRP and Nurse will be responsible for obtaining the proper professional to conduct the assessment. The QMRP and the Nurse will also be responsible for securing the proper professional to train the appropriate staff on the use of a mechanical lift. The QMRP and the Nurse will also be responsible for developing and implementing a Lift/Transfer Risk Plan that all appropriate staff will be trained on as well. The QMRP and the Nurse will be responsible for monitoring monthly to ensure the Plan is being implemented correctly.</p>	03/15/2013

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	<p>observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of</p>			

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	<p>his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the clients Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC)</p>			

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	<p>was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked</p>			

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	<p>that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. The review did not indicate a physical therapy evaluation (PT) or occupational therapy evaluation (OT) to determine how and when a mechanical lift should be used for client A.</p> <p>An interview with the QMRP was conducted on 1/25/13 at 2:51 P.M.. The QMRP indicated there were no PT or OT assessments for the use of a Hoyer lift or Sure Hands lift at the group home and day program for review.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-4(a)</p>						

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W0240	<p>483.440(c)(6)(i) INDIVIDUAL PROGRAM PLAN The individual program plan must describe relevant interventions to support the individual toward independence.</p> <p>Based on record review and interview, the facility failed to develop specific guidelines related to how 1 of 3 sampled clients (client A), was to be transferred in and out of his wheelchair with the use of a Hoyer lift or Sure Hands lift.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and</p>	W0240	To ensure a client has interventions to support him/her towards independence when he/she needs assistance to transfer in and out of a wheelchair, the QMRP and Nurse will be responsible for developing a Lift/Transfer Risk Plan. The QMRP and the Nurse will implement the Plan with the approval of the IDT and the guardian. Both the QMRP and the Nurse will be responsible for monitoring monthly to the ensure the client's safety needs are being met.	03/15/2013	

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	<p>of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the clients Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan.</p>			

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	<p>Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he</p>				

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	<p>responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a Hoyer lift or Sure hands lift to transfer client A in and out of his wheelchair. Further review of the record failed to indicate any lift plans to give group home and day program staff guidance and when and how to assist client A with transferring in and out of his wheelchair.</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at</p>						

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	<p>3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name]</p>			

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	<p>cannot locate the written documentation to support this statement."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'." When asked how staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place." When asked if client A's ISP gave written instruction to staff for the use of a lift for client A, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift."</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-4(a)</p>				

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W0318	<p>483.460 HEALTH CARE SERVICES The facility must ensure that specific health care services requirements are met. Based on record review and interview, the Condition of Participation: Health Care Services, is not met as the facility failed to provide adequate nursing services for 1 of 3 sampled clients (client A).</p> <p>Findings include:</p> <p>Please refer to W331. The facility failed for 1 of 3 sampled clients (client A) by not ensuring nursing services assessed the client for the use of a Hoyer lift and Sure Hands lift while transferring the client in and out of his wheelchair, failed to ensure group home staff and day program staff were trained on the use of lifts and failed to assess client A for documented skin breakdown.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-6(a)</p>	W0318	<p>Corvilla clients will receive adequate nursing services in accordance with their needs.</p> <p>Corvilla will ensure nursing services access clients for use of lift while transferring the client in and out of wheelchair.</p> <p>Corvilla nursing services will ensure group home staff and day program staff are trained on the use Qf lift for transferring clients in and out of wheelchair.</p> <p>Corvilla nursing services will ensure all group home staff and all day program staff are trained on using lift before staff use lift and yearly at month of annual.</p> <p>See policy — Clients using mechanical lift for</p>	03/15/2013	

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			<p>transfers.</p> <p>Corvilla nursing services will assess and document</p> <p>all reports of skin breakdown by day program.</p> <p>Day program nurse will report in writing any</p> <p>accident or injury of Corvilla clients by faxing agency</p> <p>nurse at Corvilla office the day accident/injury is noted.</p> <p>The Corvilla nurse will document assessment on</p> <p>that note and report will be monitored and signed off by</p> <p>agency Director, QMRP, and Nurse Consultant These</p> <p>notes will be filled along with inhouse accident/injury</p> <p>reports.</p> <p>All Corvilla staff and day program staff will be</p> <p>trained on lift when a lift is used for transfers.</p> <p>Day program nurses will be trained on faxing a</p> <p>written documentation of all accidents/injurys by 3-4-</p>		

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			<p>13.</p> <p>Policy-Clients using mechanical lift for transfers.</p> <p>Nursing services will ensure all group home and day program staff are trained on mechanical lift before any staff use lift. All group home and day program staff will be retrained yearly at month of clients annual meeting.</p>	

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W0331	<p>483.460(c) NURSING SERVICES</p> <p>The facility must provide clients with nursing services in accordance with their needs. Based on record review and interview, the facility failed for 1 of 3 sampled clients (client A) by not ensuring nursing services assessed the client for the use of a Hoyer lift and Sure Hands lift while transferring the client in and out of his wheelchair, failed to ensure group home staff and day program staff were trained on the use of lifts and failed to assess client A for documented skin breakdown.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L</p>	W0331	<p>Corvilla clients will receive adequate nursing services in accordance with their needs. Corvilla will ensure nursing services access clients for use of lift while transferring the client in and out of wheelchair. Corvilla nursing services will ensure group home staff and day program staff are trained on the use of lift for transferring clients in and out of wheelchair. Corvilla nursing services will ensure all group home staff and all day program staff are trained on using lift before staff use lift and yearly at month of annual. See policy — Clients using mechanical lift for transfers. Corvilla nursing services will assess and document all reports of skin breakdown by day program. Day program nurse will report in writing any accident or injury of Corvilla clients by faxing agency nurse at Corvilla office the day accident/injury is noted. The Corvilla nurse will document assessment on that note and report will be monitored and signed off by agency Director, QMRP, and Nurse Consultant These notes will be filled along with inhouse accident/injury reports. All Corvilla staff and day program staff will be trained on lift when a lift is used for transfers. Day program nurses</p>	03/15/2013			

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	(liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an		will be trained on faxing a written documentation of all accidents/injurs by 3-4- 13. Policy-Clients using mechanical lift for transfers. Nursing services will ensure all group home and day program staff are trained on mechanical lift before any staff use lift. All group home and day program staff will be retrained yearly at month of clients annual meeting.	

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	open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the clients Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his						

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	<p>oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to</p>				

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	<p>treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>A review of client A's record was conducted on 1/25/13 at 2:17 P.M.. Review of client A's record failed to indicate an assessment for the use of a lift to transfer client A in and out of his wheelchair. Review of his Individual Support Plan (ISP) dated 1/3/13 did not indicate the use of a lift to transfer client A in and out of his wheelchair. Further review of the record failed to indicate any lift plans to give staff guidance and when and how to assist client A with transferring in and out of his wheelchair.</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile</p>						

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	<p>Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5</p>						

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	<p>years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>An interview with the Qualified Mental Retardation Professional (QMRP) was conducted on 1/25/13 at 2:51 P.M.. The QMRP stated "We did not know they (day program) were using a 'Sure Hands' lift for [client A]. They told us they had a 'Hoyer lift'." When asked if there was an assessment completed to indicate how client A was to be transferred in and out of his wheelchair, the QMRP stated "No." When asked how group home staff transferred client A in and out of his wheelchair, the QMRP stated "Staff used a Hoyer Lift." When asked if there was a plan in place to give guidance when and how group home and day program staff were to transfer client A in and out of his wheelchair, the QMRP stated "No, there wasn't a plan in place."</p> <p>A review of the contracted day program records was conducted on 1/25/13 at 3:15 P.M.. Review of the records indicated an incident report involving client A dated 1/16/13, which indicated: "[Client A] needed to be changed, took to restroom. [Client A] has to be lifted with lift.</p>			

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	<p>'Secured' him to lift, removed chair when lift got close to changing table, [client A]'s upper body slipped from arm rests and fell-slipped approximately 2-2 1/2 feet head first to floor, striking head on table leg and lift leg-lost conscious approximately 1 minute, back of head and bleeding freely, called code 1 for nurse...."</p> <p>A review of a written statement dated 1/17/13 indicated: "...[Client A] appeared to not be feeling well yesterday about noon-time....[Client A] complained of not feeling well...Approximately 1 pm, [client A] was bundled to go home, staff noticed he had wet himself and needed to be changed and requested I (staff #19) take him to bathroom...I took [client A] to bathroom, [staff #20] already there with lift in position to receive [client A] I (staff #19) guided his chair into position, locked the wheels and [staff #20] went to his left side. I to the right, to secure [client A]'s arms and legs into the lift, making sure his arms were positioned snugly and then placed his legs in brackets correctly so they (brackets) were level and touching each other between his legs. When he was secured in position, I moved to back of his chair, removed his oxygen and prepared to remove his chair as [staff #20] began to raise [client A] up to move him to the changing table. At her</p>				

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	<p>signal and with [client A]'s agreement, I removed the chair. [Staff #20] guided the lift over to the changing table (about 3 feet away) when lift was within inches of table [client A] began to slip out of arm supports, like he lost his upper body strength, and slipped-fell about 2 2 1/2 feet, head first to the floor. His legs then also slipped free of the supports. The back of his head struck the changing table leg and possible lift leg and there was some blood under his head on the floor...."</p> <p>Interview with the Quality Assurance Director (QAD) of Day Services, was completed on 1/25/13 at 3:30 P.M.. The QAD indicated the day program staff had been using a "Sure Hands" lift to transfer client A to and from his wheelchair for about 3 months. When asked if client A had a lift risk plan in place to give guidance to day program staff on how client A was to be transferred to and from his wheelchair, the QAD stated "No." When asked if the day program had an order/assessment for the use of the "Sure Hands" lift to transfer client A to and from his wheelchair, the QAD stated "No." When asked if day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "Staff were trained 3 years ago by a representative when the lift was first purchased. Every</p>						

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	<p>time the lift is used there is always a lead staff present." When asked if a lead staff was present on the date of the incident, the QAD stated "Yes, one of the staff present during the incident was a lead staff." When asked if any documentation was available for review to indicate day program staff were trained on the use of the "Sure Hands" lift, the QAD stated "I don't have any written documentation to show the staff have been trained." When asked if the facility knew the day program used the "Sure Hands' lift to transfer client A in and out of his wheelchair, the QAD stated "Yes, we discussed it with the [nurse name] and [QMRP name]."</p> <p>A review of client A's day program record was conducted on 1/25/13 at 3:15 P.M.. Review of the record indicated the following nursing notations:</p> <p>"11/7/12 at 4:00 P.M., skin integrity: While toileting client A, the staff noticed some skin irritation that they wanted me (nurse) to take a look at. In the assessed inner leg crease and including 1/3 of the supra-pubic area was very moist, white tissue, as if the tissue were (sic) overly saturated with moisture. The leg crease area was more red in color and irritated. Along the upper thigh and abdomen area were areas in all stages of blistering and scabbed over (from when blister breaks</p>						

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	<p>open) which have occurred as a result of skin contact with he plastic part of the client's depends. Program Coordinator (PC) from day program and [Group home nurse name] were both notified of my assessment. [Group home nurse name] said that she would follow up and check into it."</p> <p>"11/21/12 at 1:30 P.M., skin integrity: Called to senior's restroom to assess client skin. Staff noticed some abnormal irritation. Assessed the client skin integrity around the peritoneal area. The inner thigh leg crease was deep red and very moist. In some areas very exposed and raw. There were also several areas on the client's scrotal sac, which was also a deep red, that had peeled away, leaving a little blood present. The skin around the penis was white in color, as in overly saturated with excessive moisture. Information passed on to client's PC at day program."</p> <p>"11/26/12 at 2:00 P.M.: Called to assess the skin on the client's buttocks. Staff was concerned when they noticed a few open areas. Assessed the client's buttocks. On the right buttock were 2 small open areas approximately the size of a nickel. Very superficial. A very thin layer of skin was peeled away from the surface, exposing a moist tissue...The</p>			

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	<p>(sic) was also a significant amount of skin discoloration on both buttocks. Unable to determine if this was a new occurrence, perhaps caused by skin peeling, or a status that has been present for some time...notified PC from day program and PC contacted and updated [QMRP name] via email."</p> <p>An interview with the facility's nurse was conducted on 1/28/13 at 11:00 A.M.. When asked how often nursing assessments were completed, the nurse stated "Monthly." When asked if concerns were noted in the nursing assessments, the nurse stated "Yes, all concerns are written in the assessments." When asked if there was any documentation to indicate client A's noted skin break down was assessed, the nurse indicated it would be documented in his record. When asked if she conducted any training to day program staff on how to transfer client A in and out of his wheelchair using a lift and how to monitor for skin breakdown, the nurse stated "No." When asked if she had documentation to indicate when she went to the contracted day program to monitor and check on client A, the nurse indicated she did not.</p> <p>A review of client A's record was conducted on 1/28/13 at 1:00 P.M..</p>			

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	<p>Review of client A's monthly nursing assessments dated 10/12, 11/12 and 12/12 did not indicate the agency nurse assessed client A for skin breakdown. Further review of client A's record did not mention skin breakdown for client A for the noted incidents.</p> <p>This federal tag relates to complaint #IN00122911.</p> <p>9-3-6(a)</p>				

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W9999	<p>State Findings:</p> <p>460 IAC 9-3-1(b) The following Community Residential Facilities for Persons with Developmental Disabilities rule was not met:</p> <p>The residential provider shall report the following circumstances to the division by telephone no later than the first business day followed by written summaries as requested by the division.</p> <p>This state rule is not met as evidence by:</p> <p>Based on record review and interview, the facility failed for 1 of 1 incident of a fall which resulted in death of 1 of 3 sampled clients (client A), to report a Bureau of Developmental Disabilities Services (BDDS) follow up report in a timely manner.</p> <p>Findings include:</p> <p>A review of the facility's Bureau of Developmental Disabilities Services reports (BDDS) was conducted on 1/23/13 at 3:25 P.M.. Review of the reports indicated:</p> <p>The 1/17/13 BDDS report, for an incident</p>	W9999	<p>It is this Agency practice to follow the regulations of BDDS/BQIS in reporting incidents in a timely manner. Per the Incident Management/Reporting Policy; an Incident Follow-up Report is required to be submitted within seven (7) days from the date of the email and every seven (7) days thereafter until the incident is resolved to the satisfaction of all entities. The e-mail for the incident in question was sent on January 18, 2013 at 3:41:19 PM. The Follow-Up Report was submitted by the Residential Provider's QMRP to BQIS on January 25, 2013 at 12:44:18 PM and was received. This Agency will continue to make all possible efforts to adhere to BDDS/BQIS rules and regulations.</p> <p>INVESTIGATION REPORT Date: January 21, 2013 Victim: - Client A Date of Incident: January 16, 2013 Location: ADS Seniors' Large Bathroom at LOGAN Industries Lead Investigator: Cindy ZoOk, Director of Quality Assurance Reason for Investigation: On 1/16/2013, at approximately 12:45 pin, Client A was prepared to be picked up by his residential provider. During the time he was waiting, his Seniors Habilitation Instructor, Mindy Burns, observed that he was wet and needed to be changed. The two staff; Jennifer Sweeney and Peggy Casner</p>	03/15/2013			

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	<p>on 1/16/13 at 12:45 P.M., at the contracted workshop indicated: "[Client A] is a 60 year old male who presents with MRDD (Mental Retardation Developmental Disability), Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalus who attends the Seniors Day Program at [Day program name]. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L (liters)/minute. On 1/16/13 at approximately 11:15 A.M., [client A] was observed having labored breathing and fidgeting in his chair as if he were (sic) uncomfortable. [Day Program name] nurse was called to check him out. In listening to his chest she heard 'rails' and contacted [client A]'s provider Corvilla. She relayed her findings to Corvilla [nurse name] and the decision was made to pick [client A] up early from Day Program. At approximately 12:45 P.M., staff took [client A] to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with [client A] as his independence has declined recently. [Client A] was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, [client A]'s upper body</p>		<p>were assigned to complete this task. During the transfer of Client A from his wheel chair by the way of the Sure Hands lift, to the changing table, he fell hitting the back of his head on the lift leg. This resulted in an injury that required medical care. 911 was called and he was transported to the closest hospital. LOGAN was notified the following morning that Client A had passed on during the early morning hours. This investigation is to provide a detailed account of the incident from LOGAN staff, to substantiate/Am-substantiate abuse/neglect and to identify any appropriate corrective and preventative actions. • Name and Title of all involved parties: Jennifer Sweeney, Program Assistant Peggy Curler, Program Assistant/Float- Kathy Honer, RN, BSN, LOGAN Industries Nurse Patti Miller, Day Services Director Ann Goens, Seniors Program Coordinator Mindy. Burns, Habilitation Instructor-Seniors 2 Chandra Rogers, Habilitation Instructor-Seniors 1 Statement of January 16, 2013 event: Seniors classroom staff observed and reported that Tim was not feeling well earlier in the day on 1/16/13. Classroom staff; Mindy Burns, Habilitation Instructor and Jennifer Sweeney, Program Assistant reported that Client A felt warm to the touch and reported not feeling well. Mindy</p>				

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	slipped from the armrests. Staff were not able to stop him from falling. [Client A] fell approximately 2-2 1/2 feet to the floor, hitting the back of his head on the front of the lift. A code was called and [Day program name] medical and Administrative staff arrived. Staff reported that [client A] was unresponsive for approximately 1 minute. When the nurse arrived, [client A] was lying on his back trying to elevate his head. He had an open wound that was shaped like a 'Y' approximately 1 inch long on the back of his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. [Client A]'s guardian, [guardian name] was contacted. The provider, Corvilla was also notified and they stated that [client A] was to be taken to [hospital #1 name]. The nurse continued to support [client A]'s head and keep him calm. She positioned the client's Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it triangular in shape and approximately 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was		reported notifying the LOGAN Industries Nurse, Kathy Honer. Kathy Honer came down to the classroom and checked Client A's temperature. She reported Client A's fever of 97.9 (ax). She reported observing frothy bubbles on the edge of his lips. She noted; as did other staff working with Client A on this .day, that he stated he did not feel well. With a stethoscope, Kathy listened to Client A's chest. Kathy reported hearing "vales" when listening to his lungs. After her assessment of Client A, at approximately 12:22 pm, Kathy called the Corvilla nurse, Julie King, RN and they decided it was best for Client A to go home and residential staff would be picking him up. After notifying the Corvilla nurse, Kathy reported that she increased Client A's O2 flow up from 2L to 3L and then to 4L. After approximately 10 minutes, Kathy decreased the O2 flow back to 3L. At approximately 12:45 pm, Client A was dressed in his outerwear (coat, hat) in preparation for being picked up by his residential provider staff. - At approximately 12:50 pm, Mindy Burns noticed that Client A's clothing was wet-he had soiled hirnself and needed to be changed. Mindy notified Jennifer Sweeney, and told her that Cient A needed to be changed. Mindy reported she told Jennifer to get someone to help her. Chandra Rogers, Habilitation Instructor, was present in the				

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	<p>alert but speech was garbled. She was unable to determine the (sic) [client A]'s orientation at this time. After assessing [client A], the paramedics advised that he would be best served by going to [hospital #2 name] since it was closer. Provider and Guardian were notified of the change. Program Coordinator (PC) did accompany [client A] to the hospital. At the hospital [client A] continued to be disoriented and pulled out his IV (intravenous) and his oxygen. His speech continued to be garbled. He did not recognize who I (PC) was. [Client A] was taken for a CT scan. Corvilla House Manager arrived approximately 45 minutes later. [Client A] did not appear to recognize her. [Client A]'s sister arrived a short time later, Corvilla nurse arrived. I (PC) left at this time."</p> <p>Facility reported BDDS report submitted dated 1/17/13 indicated: "While two Day Program staff were transferring [client A] from his wheelchair to a changing table they dropped him. In the fall he hit his head on one of the legs of the changing table. The connection with the table leg caused a laceration (sic) head with a lot of bleeding. The day program Nurse called a (sic) reported said injury to Corvilla's Nurse and they agreed that [client A] should be immediately transported by ambulance to the hospital. When Corvilla</p>		<p>classroom and she initiated the call to Peggy Casner, Program Assistant/Float and designated lead operator of the Sure Hands lift. This lift is utilized to transfer Client A from his wheelchair to the table where staff can assist him and change his clothing. Jennifer assisted Client A out of his outerwear since he was dressed and ready for pick up by his residential provider staff. She wheeled him to the designated Seniors bathroom. Jennifer reported that Peggy was waiting for her with the lift ready in the designated Seniors bathroom. Both Peggy and Jennifer were in the Seniors bathroom with Client A and prepared to transfer him from his wheelchair to the changing table. Peggy and Jennifer positioned the wheelchair with Client A in it, up to the Sure Hands lift. They placed his arms over the designated arm lifts and placed his legs in the designated leg apparatus. During this time they reported that Client A was Communicative and cognitive of the procedure and understood they were going to change him out of his wet clothes. As the designated Program Assistant float and therefore the trained operator of the Sure Hands I lift, Peggy operated the lift. Once Client was determined to be secured in the lift, Jennifer moved to the back of Client A's wheelchair in preparation to pull</p>	

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	<p>staff and [client A]'s family arrived at the hospital [client A] did not seem to know them and he seemed to be disoriented too. Various Neurological test (sic) were perform (sic) and the Neurologist reported [client A] was hemorrhaging on the brain and there was also severe swelling. The Doctor suggested surgery however his sister said she did not want any 'heroic deeds' done. Corvilla's Nurse did get the Sister to agree to allow the Doctors to treat [client A]'s zooming blood pressure and any possible pain. She also asked that they give him 24 hours to see if he responded to more conventional treatment. The Doctors agreed to the treatment plan but they wanted us to know there was not much hope. [Client A]'s Sister received a call from the hospital at approximately 12:15 A.M. today telling her [client A] had passed, she (sic) any return calle (sic) Corvilla staff."</p> <p>On 1/25/13 at 1:20 P.M., the Qualified Mental Retardation Professional (QMRP) submitted a BDDS "Incident Follow-Up Report" dated 1/25/13 which indicated: "The following information was provided by [Day program name] to Corvilla: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This</p>		<p>the chair back and way as Client A was lifted with the Sure Hands device. Jennifer reported removing his 02 tubing from his nose (as the 02 tubing is not long enough to remain in place during the time Client A is transferred and changed. It is put back into place once he is returned to his wheelchair). After in the lift, but before starting any of the lifting procedure, Peggy reported asking Client A if he was ready to go. Client A's typical response is "up, up and away". and was similar to this on this day. As Peggy operated the lift and Client A began to rise up out of his wheelchair, Jennifer pulled his wheelchair back and away. Peggy guided the lift, with Client A in it, over to the changing table, -estimated to be approximately 3 feet away. After Jennifer had pulled the wheelchair back and -away she came around to the right side of Client A. Peggy was still behind the lift operating it. When Client A was approximately a few inches from the table, Jennifer noticed-that Client A was slipping out of the arm rests/side grips.-Jennifer verbalized quite loudly (per Peggy) "he's . slipping". Peggy reported that she noticed that Client A's face was quite red. Both women tried to get to Client A and provide support. Due to the position of where they were each relative to the Sure-Hands lift, the changing table and Client A;</p>				

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	<p>training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands Lift. The following day each staff was supervised again in its use with the individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient [Day program name] staff. Additionally, a select group of staff have been identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as 'lead operators'. It is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. [Day program name] has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although staff who operate the Sure Hands lift have received training to efficiently and</p>		<p>neither could get to him fast enough and provide the needed physical assistance to prevent Client A from slipping and falling out of the lift. Per their report, Client A fell approximately 2-2 1/2 feet to the floor hitting-his head on the right table leg and possibly the right lift leg. Per staff report, within a "split second", Jennifer called a Code 1 using the phone paging system (located right outside the door of the bathroom) and also called specifically for Kathy the nurse. Peggy remained at Client A's side and Jennifer returned to his side after placing the calls. Jennifer reported that Client A was unresponsive at this point. She reported that she checked Client A's mouth to see if his tongue was blocking his airway. It was not and Client A was breathing on his own. Peggy reported he was making gurgling sounds and saliva was coming out of his mouth. Jennifer reported checking his pupils and she felt they were okay. She described them as not dilated or fixed. Jennifer reported Client A was not responsive to verbal cues (being asked "are you okay") at this time. Jennifer reported that she told Peggy not to move Client A and noticed he was bleeding from the back of his head. Jennifer and Peggy reported that very quickly Nurse Kathy arrived on the scene almost immediately after the Code 1 was called. Kathy reported that she</p>		

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	<p>effectively use it, [Day program name] cannot locate the written documentation to support this statement."</p> <p>A review of the Bureau of Developmental Disabilities Services (BDDS) reporting policy effective March 1, 2011 was conducted on 1/25/13 at 7:00 P.M.. The policy indicated: "It is the policy of the Bureau of Quality Improvement Services (BQIS) to utilize an incident reporting and management system as an integral tool in ensuring the health and welfare of the individuals receiving services administered by BDDS.</p> <p>Reportable Incident Follow-Up</p> <ol style="list-style-type: none"> 1. An incident may be closed by BQIS upon receipt and processing. 2. If an incident is not closed upon BQIS ' receipt and processing, BQIS shall forward an email notification to the person responsible for incident follow-up reporting. 3. The person responsible for incident follow-up reporting shall: <ol style="list-style-type: none"> a. submit an electronic incident follow-up report within 7 days of the date of the incident initial report; b. continue to submit incident follow-up reports on an every 7 day schedule, until such time as the incident is resolved to the satisfaction of all entities;" <p>An interview with the Qualified Mental Retardation Professional (QMRP) was</p>		<p>got the call/heard the page at approximately 12:55 pm. Kathy reported that when she arrived Client A was lying on his back with his head resting on the right leg of the Sue Hands lift. Kathy reported that Client A, at this point was trying to lift his head up. She noted that she observed blood dripping from the back of his head. She reported applying pressure from where the blood was dripping. At this point, she reported that Client A began "thrashing his arms" and "trying to lift his head". Ann Goens, Seniors Program Coordinator arrived at the scene at approximately or very close to the time Nurse Kathy arrived. Patti, Miller, Day Services Director, arrived on the scene at approximately the same time that Ann arrived at the scene. When Patti arrived, Kathy indicated that Client A needed to go to the hospital and Patti responded by having 911 called. Ann Georgia, Administrative Assistant, was covering at the front desk and placed the call to 911 between 1:05 pm and 1:10 pm. Patti left the room and went to the front of the LI building to direct the paramedics once they arrived on the scene. While waiting for the paramedics to arrive, Kathy reported that she continued to support Client A's head and tried to encourage him to remain calm. She instructed Jennifer and Peggy to reposition the 02 for</p>				

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	<p>conducted on 2/8/13 at 3:10 P.M.. The QMRP indicated no BDDS follow up report was submitted within 7 days.</p> <p>9-3-1(b)</p>		<p>Client A. Kathy reported that she was able to assess the wound on the back of Client A's head. She described it as triangular in shape approximately 1" on all sides. She estimated the center to be approximately the size of a pea. She reported the bleeding subsided and swelling was noted under the skin approximately the size of a Ping Pong ball. At this point she described Client A as being alert, but his speech was garbled. Once the paramedics arrived, between 1:15 pm and 1:20 pm, Patti escorted them back to the bathroom and shared with them that Corvilla (client A's residential provider) had been notified and they had requested that Client A be transported to SJRMC. Upon assessment, the paramedics • suspected that Client A experienced a head injury. They felt he would best be served at Memorial Hospital. Memorial is the closer hospital to LOGAN Industries and the paramedics felt the timing of needed care was critical. The change in destination was communicated to Corvilla and the guardian by Patti and-Ann respectively. Per report, the paramedics secured and lifted client A from the floor on a flat board. His head was immobilized. He was transported by ambulance to Memorial Hospital ER at approximately 1:30 pm. Ann Goens followed the</p>		

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			<p>paramedics to the hospital and stayed with Client A for roughly 45 minutes:until the residential home manager arrived. The guardian arrived shortly after that. Ann continued to remain at the hospital with the guardian until the residential provider's nurse arrived approximately 45 minutes later. Client A's guardian called Ann Goens the next morning around 6:50 am and informed her that he passed away in the hospital at 1:30 am on 1/17/13. Patti Miller, Day Services Director, was contacted by Nancy Pemberton the Deputy Coroner of St. Joseph County. Nancy reviewed the basic circumstances of the fall and was given information about the type of lift in use at the time. The Deputy Coroner reported that Client A suffered a subdural hematoma and a subarachnoid hematoma and was not a good candidate for surgery given his overall fragile state. In addition, the guardian had asked that no heroic measures be taken. Therefore, Client A's death was a direct result of the fall. An autopsy was not performed. Written Account of the Incident by the following LOGAN Staff: Jennifer Sweeney, Program Assistant Peggy Cotter, Program Assistant Kathy Honer, LOGAN Industries Nurse Ann Goens, Seniors Program Coordinator Documents Reviewed and Attached: • BADS Reportable Incident Reports</p>		

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			<p>submitted by LOGAN Community Resources on 1/17/2013 • Incident Follow-up Report answers to the queStions posed by Renee.Depew@fssain.gov on 1/18/13 from incident reports of 1/17/2013. • LOGAN' s Internal Incident Reports completed by Peggy Casner and Jennifer Sweeney • Written statements as outlined above. Each of the individuals above was also interviewed in person by Cindy Zook, Director of Quality Assurance on 1/17/2013</p> <p>Additional Information acquired in course of the Investigation: Peggy arid Jennifer did note that they had some concerns about the-Sure Hands device and utilizing it with Client A. In the past, Peggy noted that she bad mentioned her concerns about Client A's face turning red when in the lift and her concerns about the lift several times before Christmas. Jennifer also noted she had shared concerns with Client A's decline in strength in December and January. They reported that they had expressed these concerns to Ann and felt that Ann had taken these concerns seriously and was making effort into looking into their concerns regarding the operation of the Sure Hands as well as if their were other options for lifting and transfer devices, such as a sling lift. Ann noted in her written report timeline that Peggy had approached her on the</p>		

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			<p>morning of 1/16/13 and reported that she was concerned that Client A appeared weak and might have difficulty using the lift. At that point, Ann tried to contact Anedria Gibson of Corvilla, but she was unavailable. She also started to research additional accessories/adaptive equipment that could be used with the Sure Hands lift. Although Peggy had noted concern previously in the day to Ann, she and Jennifer did not anticipate that Tim was in danger or compromised to the point of falling on the day and at the time of the incident. Peggy and Jennifer had used the Sure Hands lift for the past three months successfully with Tim to transfer him from his chair to table when he needed to be changed from wet clothing to dry clothing. On 1/16/13, they were focused on changing him into clean/dry clothing in preparation for his transfer home. There was not another device available for staff to use instead of the Sure Hands device. Staff did not consider using a 3 person lift as they did not feel the procedure to be particularly safe or more effective. Because of where staff are positioned when using the Sure Hands device-one behind the device to operate the lift part, and one staff moving the wheelchair out of the way, it is difficult to be in close body proximity of the person on/in the lift. And, it appears to be</p>		

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			<p>reasonable to expect the Sure Hands device to independently operate successfully with out the hands on physical assistance of staff when an individual is in the lift. That is the major reason the device was purchased and is used. Although all staff who operate the Sure Hands Lift have received training to efficiently and effectively use it, LOGAN could not locate the written documentation of the training. • Conclusions: 1. No violation of rights is evident. 2. Abuse/Neglect was unsubstantiated. 3. Agency Policy and procedures were not followed in regard to documentation of training. 4. Federal and state regulations were not followed as it pertains to documentation of training. 5. To the best of LOGAN's knowledge the Sure Hands Lift was fully operational. It was determined to be an effective device that had been consistently used with Tim in the past to transfer him from his wheelchair to the changing table Corrective Action 1. The two staff involved using the lift were suspended during the investigation. Abuse/Neglect was unsubstantiated. As a result, they were reinstated to their positions and duties. 2. LOGAN Staff will be disciplined for not ensuring that training was being documented as required. 3. The Sure Hands Mobile Lift will no longer be utilized until the Sure</p>		

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			<p>Hands Representative provides confirmation that the lift is fully operational and safe. LOGAN will confirm with the rep that all required equipment is in place and 5 LOGAN will make sure all required equipment is accessible to staff each time the lift is used.</p> <p>4. Contact the Sure Hands Representative</p> <p>a. Provide additional hands on training to staff on operation of the lift. Increase the number of "approved staff" that operate the Sure Hands lift. Include staff in the actual training in the lift by having them sit in a wheelchair and be lifted up by the Sure Hands lift. Involve the current client who uses the lift so the Sure hands Representative can get an accurate idea of how the lift is being used.</p> <p>b. Document the training which will include the dated training agenda, staff signatures, and the name and title of the trainer.</p> <p>c. Look at additional accessory options for the Sure Hands Lift to determine if these options are beneficial and meet the needs of the individual who uses the lift.</p> <p>5. For the remaining client who currently uses the Sure Hands lift, a Lift Risk Plan will be developed and implemented. There will always be two staff. present when using the lift and one of the staff will be the designated "lead operator".</p> <p>6. For anyone that utilizes a lift (Sure Hands or Hoyer) obtain guardian and Residential</p>		

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			<p>provider written approval for the utilization of the lift for the designated client. Signing off on the Lift Transfer Plan will constitute this approval. 7. For the client(s) that utilize the Sure Hands lift, upper body strength is required. If there is deterioration in health, stamina, and upper body strength, the team must make a determination if the Sure Hands lift can continue to be utilized. This may mean that the Sure Hands lift can not be used while the needs of the individual are being reviewed and a decision made. Teams may need to consult with the company representative and/or other professionals in order to make the determination. Once made the decision will be documented by implementation of the appropriate Lift Transfer Plan. 8. Develop and implement Lift Risk Plans for all current and future clients who will require physical assistance, either mechanically or by staff, for lifting/transferring when toileting/changing clothing. 9. Develop a more formal program to monitor the use of all mechanical lifts used with clients, to include a minimum of monthly observation of the lift in use by supervisory or nursing personnel. This would include an annual evaluation of all lifts utilized on LOGAN premises by company representatives to ensure they are working</p>		

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			<p>properly. Request the representatives provide written documentation that the evaluation was completed and lifts are fully functional. At this time, include annual training with supporting documentation for all staff that utilizes the lifts. During the annual training, consider an observation by the lift company representative of LOGAN client(s) that utilize the lift in order to determine if the specific lift used continues to be appropriate for the client. i 0. Identify if there are other mechanical lifts available for use at LOGAN, such as a Royer Lift. Determine their safety and functionality. Determine the suitability of these models for individuals who require lifts. 11. Provide training to staff in regard to proper lifting teelmiques, when not using mechanical devises. Document the training which will include the dated training agenda, staff signatures, and the name and title of the trainer. 12. Develop and implement 02 risk plans for all clients that require oxygen by mechanical devices.</p> <p>From: Renee.Depew@fssa.in.gov [mailto:Renee.Depew@fssa.in.gov] Sent: Friday, January 18, 2013 3:41 PM To: jlucky@CORVILLA.ORG Cc: BDDSIincidentReports@fssa.in.gov Subject: INCIDENT FOLLOW-UP REPORT REQUIRED =====</p>		

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			<p>Additional information and/or modifications made by DEPEWR on Friday, 01/18/2013 03:41:19 PM Please include the following in follow-up: Please submit training records for all staff who were trained to use this "sure hands device", including the dated training agenda, staff signatures, and also the name/title of the trainer who provided the training. These can be sent to BQISRM@fssa.in.gov. How/when/where was this training conducted? Did this take place in a classroom, or was this hands-on with the lift/device? Had staff demonstrated the ability to use the lift/device properly at the time they were trained? Also, please include how often a professional staff/medical staff had conducted monitoring of staff's use of this device, and what did this monitoring include? How was monitoring documented, and when was the last time this routine monitoring occurred? Thank You.</p> <p>=====</p> <p>An Incident Initial Report was received by BQIS on 1/17/2013 1:30:10 PM for the individual identified below. This report has been processed and entered into the database. If you have not received a copy of this Incident Initial Report from the reporting entity identified below, please contact them directly. This e-mail is your notification that this incident is NOT CLOSED and</p>		

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			<p>that you are designated as the person responsible for follow-up. If you are not the correct person to submit the follow-up report, please contact so the information in the database can be corrected. Per the Incident Management/Reporting Policy, an Incident Follow-up Report is required to be submitted within 7 days from the date of this e-mail and every 7 days thereafter until the incident is resolved to the satisfaction of all entities. Incident Follow-up Reports should be submitted via the web at https://ddrsprovider.fssa.in.gov/IFUR/. In an emergency situation, a report can be e-mailed to BDDSIincidentReports@fssa.in.gov or faxed to 260-482-3507. Thank you for your prompt attention to this e-mail and your continuing efforts to ensure the health and welfare of the people we support. Questions related to incident management can be e-mailed to BDDSIincidentReports@fssa.in.gov. Name: Client A Customer ID: 15972 Provider(at time of incident): CORVILLA, INC. Funding Source: SGL Customer Address: 52549 MYRTLE ST City: SOUTH BEND State: IN Zip: 46637 County: ST. JOSEPH Incident # : 501720 Date and Time of Incident: 1/16/2013 12:45:00 PM Date Of Knowledge: 1/16/2013 Reporting Entity : LOGAN COMMUNITY RESOURCES, INC. Reporting</p>	

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			<p>Person : Ann Goens Reporting Person Telephone: (574) 289-0385 Reporting Person Email: goensa@logancenter.org</p> <p>Narrative: Client A is a 60 yr. old male who presents with MRDD, Seizure Disorder, Hemi paresis, Hypertension and Hydrocephalous who attends the Seniors Day Program at Logan Industries. He has had some recent hospitalizations for pneumonia, chest pains and shortness of breath and is on oxygen 2L/min. On 1/16/13 at approximately 11:15 am, Tim was observed having labored breathing and fidgeting in his chair as if he were uncomfortable. Logan Industries nurse was called to check him out. In listening to his chest she heard "rails" and contacted Tim's provider Corvilla. She relayed her findings to Corvilla Nurse Julie and the decision was made to pick Tim up early from Day Program. At approximately 12:45 pm, Staff took Tim to the restroom to take care of his personal care and change him before going home. All staff have been trained to use the sure hands device and have used successfully in the past. We have been using the lift for several months with Tim as his independence has declined recently. Tim was secured in the lift and gave the go ahead to staff to lift him. As they reached the bed, Tim's upper body slipped</p>		

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			from the armrests. Staff were not able to stop him from falling. Tim fell approximately 2-2 ½ feet to the floor, hitting the back of his head on the foot of the lift. A code was called and Logan medical and Administrative staff arrived. Staff reported that Tim was unresponsive for approximately 1 minute. When the nurse arrived, Tim was lying on his back trying to elevate his head. He had an open wound that was shaped like a "Y" approximately 1 inch long on the back of his head. There was a significant amount of blood on the floor and coming from the wound. The nurse applied pressure. 911 was called. Tim's Guardian, Mary Jo Hall was contacted. The provider, Corvilla was also notified and they stated that Tim was to be taken to St. Joe Medical. LI nurse Kathy continued to support Tim's head and keep him calm. She positioned the clients Oxygen at 3L/min. His Bi-ox was 84-85% and pulse at 110-120. His skin color was pink, warm and dry. His breathing was non labored and rhythmic. She assessed the wound and found it to be triangular in shape and approx. 1 inch on all sides. The center was approximately the size of a pea. The bleeding had stopped but swelling was noted under the skin, approximately the size of a ping pong ball. The client was alert but speech was garbled. She was unable to determine the	

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
			<p>Tim's orientation at this time. After assessing Tim, the paramedics advised that he would be best served by going to Memorial Hospital since it was closer, and timing was critical. Tim was placed on a flat board with head immobilized and transported to Memorial Hospital. Provider and Guardian were notified of the change. Program Coordinator, Ann Goens did accompany Tim to the hospital. At the hospital Tim continued to be disoriented and pulled out his IV and his oxygen. His speech continued to be garbled. He did not recognize who I was. Tim was taken for a CT scan. Corvilla House Manager arrived approx. 45 minutes later. Tim did not appear to recognize her. Tim's sister arrived and a short time later Corvilla nurse Julie arrived. I left at this time. Plan to Resolve: Staff were suspended pending investigation. Investigation was initiated late in the day on 1/16/2013 and continued on 1/17/2013. The investigation determined that the fall was accidental and neglect was unsubstantiated. Staff were reinstated. Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privilege information. Any unauthorized review, use, disclosure, or distribution is prohibited. If you are not the</p>		

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			intended recipient(s), please contact the sender by reply e-mail and destroy all copies of the original message. Indiana Division of Disability and Rehabilitative Services Follow-Up#: 307256 INCIDENT FOLLOW-UP REPORT - Confidential REV 08-01-2010 For Lice in Reporting Circumstances In 460 IAC 6-9-5, 431 IAG 1.1-3-1 (b) and/or DDRS Policy and Procedures INCIDENT FOLLOW-UP REPORT - Confidential Consumer Information CONSUMER NAME: Timothy Whitacre SSN: ***-**-5960 Incident Number: 501720 Incident Date: 1/16/2013 NARRATIVE - DETAILS Describe investigation into the incident and/or all other follow-up actions taken. The following information was provided by LOGAN to Corvine: After acquiring the Sure Hands Mobile Lift System, the Sure Hands representative provided training to all staff who would be using the lift. This training was conducted on June 8, 2009 at 3:30 pm in the environment in which the device was going to be used (i.e. the bathroom where individuals would be placed on the toilet or changing table). The training included the lift and transfer of a colleague. At the completion of this training staff demonstrated proficiency to utilize and operate the Sure Hands lift. The following day each staff was supervised		

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			again in its use with the Individual clients who required the lift in the bathroom, again demonstrating proficiency. As additional staff have been hired they have received the same training from previously trained and proficient LOGAN staff. Additionally, a select group of staff have been Identified who have proficient skill and experience using the Sure Hands lift; these staff are referred to as lead operators°. it is the common procedure when using the lift that two staff persons are always present, one being a lead operator. In that sense then a lead operator is always monitoring the staff use of the device. As there is always a lead operator present, we do not routinely document the monitoring. LOGAN has utilized and operated the Sure Hands lift device successfully for 3.5 years without incident. Although all staff who operate the Sure Hands Lift have received training to efficiently and effectively use it, LOGAN cannot locate the written documentation to support this statement. Describe systemic actions being taken to assume health and safety issues. The following Information was provided by LOGAN to Corvine: Moving forward, staff training at LOGAN for the use of the Sure Hands lift will be documented and include the dated training agenda, staff signatures, the name and title of the trainer. In response to	

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			<p>this incident, a representative from Sure Hands will be returning to LOGAN in the near future to provide hands on training to the staff who use the lift. This training will be property documented as indicated above. LOGAN Is also developing a more formai program to monitor the use of the lift, to Include a minimum of monthly observation of it In use by supervisory or nursing personnel. LOGAN will also be following up with the Sure Hands representative to discern the types of individuals and their needs that are best suited to this model of the Sure Hands Lift versus one with a sling. The acquisition of another lift system may be required. At the present time the Sure Hands lift works well for the one individual with whom it is currently used. Report Generated Date & Time:1/25/2013 12:44:18 PM Agency Submitting Report; Date Report Submitted: 1125/2013 CORVILLA, INC. Telephone Number of Person Submitting Report: Email Address of Person Submitting Report: (574) 289-9779 agibson@corvina.org Action Taken by Provider; Staff suspension Staff termination due to ANE Staff termination (for other reasons) Disciplinary action Probation Staff removed from home Staff moved to another home Staff training Revised agency policy Staff returned to work Follow behavioral support</p>		

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			plan (BSP) IAddressed all issues ' Changed schedule (consumer, transportation, etc) Turned Investigation over to the authorities / police involvement IOther changes made I Not applicable INo action taken 'Staff resigned Was the allegation of ANE Substantiated/Not Substantiated? Staff Suspended: Name of Person Submitting Report: Title of Person Submitting Report: Anedria Gibson QMRP Report Generated Date & Time:1/25/2013 12:44:18 PM		