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	MHL092-928	A. BUILDING: _____ B. WING _____	04/12/2019

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V 000	INITIAL COMMENTS An annual and complaint survey was completed 4/12/19. The complaint (Intake # NC00149523) was not substantiated. Deficiencies were cited. This facility is licensed for the following service category: 10A NCAC 27G .5400 Day Activity.	V 000		
V 110	27G .0204 Training/Supervision Paraprofessionals 10A NCAC 27G .0204 COMPETENCIES AND SUPERVISION OF PARAPROFESSIONALS (a) There shall be no privileging requirements for paraprofessionals. (b) Paraprofessionals shall be supervised by an associate professional or by a qualified professional as specified in Rule .0104 of this Subchapter. (c) Paraprofessionals shall demonstrate knowledge, skills and abilities required by the population served. (d) At such time as a competency-based employment system is established by rulemaking, then qualified professionals and associate professionals shall demonstrate competence. (e) Competence shall be demonstrated by exhibiting core skills including: (1) technical knowledge; (2) cultural awareness; (3) analytical skills; (4) decision-making; (5) interpersonal skills; (6) communication skills; and (7) clinical skills. (f) The governing body for each facility shall develop and implement policies and procedures for the initiation of the individualized supervision plan upon hiring each paraprofessional.	V 110		

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V 110	Continued From page 1 This Rule is not met as evidenced by: Based on observation, record review and interviews, 3 of 6 audited staff (#9, #23, #28) failed to demonstrate competence in knowledge and skills to meet the needs of the population served. The findings are: Observation on 3/19/19 at approximately 1:30 PM of wheelchair vans on site revealed: - two vans equipped to transport individuals in wheelchairs; one gray and one white - the gray van had 6 tie down straps secured to the floor of the van and 2 additional tie downs stored at the front on the van - the white van had 6 tie down straps secured to the floor of the van and 2 additional tie down stored in a basket at the front of the van - the Program Director (PD) demonstrated how the tie downs are secured to the floor of the van and how they are tightened to prevent loosening during transport During an interview on 3/19/19, the PD reported: - only 1 wheelchair client is transported on a van at a time - all facility designated drivers are trained in how to use the tie down devices; 4 tie downs are required to secure 1 wheelchair - staff that transport clients in their personal vehicles may not have training on how to use tie downs - ultimately, the driver is responsible for assuring wheelchairs are properly secured prior to transporting	V 110		

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V 110	Continued From page 2 Review on 3/18/19 of the Lindley Driver/ Monitor Training Packet signed by staff #28 on 3/8/19 revealed: - "I, [staff name printed], verify that I have received the in person training for all Lindley College drivers. As a part of those trainings, I understand that it is imperative I adhere to policies and procedures listed below. - "Before departure on any outing where I am transporting consumers, I am responsible that all individuals have been properly secured in seatbelts and/or wheelchair tie downs (4 minimum)...." Review on 3/18/19 and 3/19/19 of staff #28's record revealed: - a Hab Tech job description signed 1/9/19 and a Route Driver job description signed 3/8/19 - a Driving Safety certificate dated 8/19/14; an on line training - a Driver Training dated 3/3/19 - a Lindley Initial Transportation Training dated 3/8/19 Review on 3/19/19 of staff #9's record revealed: - a Hab Tech job description - a Driving Safety certificate dated 9/13/17 Review on 3/15/19 and 3/19/19 of staff #23's record revealed: - a Hab Tech job description signed 6/6/18 - an on-line Defensive Driving: The Basics certificate dated 10/1/18 Review on 3/15/19 of an Incident Response Improvement System (IRIS) report for an incident of 2/14/19 revealed: - Diagnoses including Moderate Mental Retardation, Quadriplegia Cerebral Palsy, Dysphasia and Wheelchair dependency	V 110		

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V 110	Continued From page 3	V 110		

- the following documentation in the Incidents Comment section of the report, "[Client #4] was being transported in [facility] van to community activity. Her wheelchair moved during the transport causing her to fall over which resulted in a scratch on the right hand against the van wall and a bruise on her forehead against the van floor."

Review on 3/21/19 of emergency department discharge instructions dated 2/13/19 from a local hospital revealed:
- the reason for client #4's visit to the emergency room was a fall
- the diagnosis was "hematoma of scalp, initial encounter"

Review on 3/26/19 of client #4's medical record information received from the local hospital for a visit on 2/13/19 revealed:
- client #4 was admitted to the emergency department at 5:47 PM
- the chief complaint was "pt (patient) reports being transported in a wheelchair van and wheelchair tipped over, pt reports hitting head and causing abrasion to R (right) hand
- medications prescribed were Naproxen as needed for pain and Ondansetron as needed for nausea
- results of a CT (computed tomography) Head included: 1. no acute intracranial abnormality 2. Small midline frontal scalp hematoma. No underlying calvarial (skull) fracture 3. There is likely thinning of the mid and posterior corpus callosum with mild parenchymal volume loss (atrophy) of the bilateral parietal lobes, RIGHT greater than LEFT
- Progress note at 10:41 PM revealed: CT head without evidence of intracranial hemorrhage, skull fracture. We will discharge patient home as

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V 110	Continued From page 4 previously discussed with Naproxen, Ondansetron, topical bacitracin Review on 3/26/19 of client #4's medical record information received form the local hospital for a visit on 2/17/19 revealed: - client #4 was admitted to the emergency department at 10:53 AM - the chief complaint was vomiting; client #4 also complained of sore throat and cough - Clinical impression: Non-intractable vomiting with nausea, unspecified vomiting type (primary encounter diagnosis), Dehydration Review on 4/10/19 of neurology office visit documentation for client #4 dated 3/7/19 revealed: - client #4 was referred to neurology by her primary care physician for "post-concussive headaches and vomiting, history of cerebral palsy" - client #4's mother reported within a couple of days of the initial head injury that resulted from her wheelchair tipping over in a van and sustaining a scalp hematoma, client #4 had persistent problems with nausea and vomiting - client #4's mother further reported client #4 had dizziness and headaches which now happened less frequently [previous CT scan was reviewed] - neurologist's impression was it was unclear if the nausea, vomiting and headaches "represent a postconcussive migraine phenomenon although I suspect this to be the case given the episodic nature of the symptoms" During an interview on 3/19/19, staff #9 reported she was present on the day of client #4's incident in the van. Staff #9 reported: - she had not had safe driving training	V 110		

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V 110	Continued From page 5 - she and staff #23 buckled client #4's wheelchair and another client's wheelchair in but there were only 3 tie downs per wheelchair when there were supposed to be 4 tie downs for each for each wheelchair - she was not sure how long the van had only 3 tie downs per wheelchair; she had not been in that van for awhile - staff #9 and staff #23 had the wheelchair clients' wheelchairs secured before the driver, staff #28, got on the van - staff #28 did ask if everyone was secured - when the van pulled off and began to circle the roundabout, they were not going fast - client #4's wheelchair fell over - staff #9, staff #23 and staff #28 picked the wheelchair up; client #4 had a knot on her head the size of a ping pong ball - the other client's chair did not turn over because it was a heavier chair and was more sturdy than client #4's chair - staff #28 pulled the van back into the driveway and got an ice pack for for client #4 - staff #23 called client #4's mother and told her what happened - client #4 still wanted to continue on the outing; it was not until they were returning from the outing that client #4 complained of her head hurting During an interview on 3/20/19, staff #23 reported: - staff #23 had not had Safe Driving training; staff #9 showed her how to fasten the tie downs - on the day of client #4 fell, she and staff #9 strapped client #4 into the van - they told the driver, staff #28, there were only 3 tie downs per wheelchair - 2 additional tie downs were on the van but they were not fastened to the floor; the tie downs were	V 110		

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V 110	Continued From page 6	V 110		

difficult to attach and maintenance would have needed to attach them
- when the driver made a turn, client #4 fell and hit her head on the floorboard of the van
- client #4's head did swell and she said her head hurt
- staff #28 returned to the facility ad got ice for her head; she also had flesh wounds on the hand
- client #4 said she still wanted to go on the outing; she did not loose consciousness and seemed fine

During an interview on 3/19/19, staff #28 reported:
- he had worked with the company in different capacities for 6 years
- he had completed Safe Driving training prior to the incident with client #4 and had it since the incident
- the PD set up the Lindley College Safe Driving class for him after the incident
- the Lindley College Safe Driving training was more specific to "these" consumers and using the van while the other training was more for transporting a client in your personal vehicle but he trained to utilize tie down prior to the training the PD set up after the incident
- he was the assigned driver for the outing
- he had to assist his assigned client in the rest room and by the time he got on the van with his client, the wheelchair clients and staff were already secured in the van
- staff #28 pulled out of the driveway and started around the roundabout and client #4 shifted and her wheelchair fell over; staff #28 stopped the van and assisted client #4 up and then pulled back in front of the facility
- client #4 remained in the van while staff #28 alerted his supervisor and got ice to apply to client #4's head

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V 110	Continued From page 7 - client #4 sustained a knot on her head, not as big as a quarter - 4 straps were fastened to client #4's chair but they were loose when she fell Review on 4/12/19 of the Plan of Protection completed and signed by the Program Director, dated 4/12/19 revealed: What will you immediately do to correct the above rule violations in order to protect clients from further risk or additional harm? All day program staff will receive the Tie-down training to ensure safety of consumers in wheelchairs during transport. Staff will receive this training regardless of if they are a driver or not. All new staff will receive Tie-down training as part of their hiring process for the day program. Prior to the initiation of this survey, an incident occurred with a driver that we did retraining with to ensure staff competency. Describe your plans to make sure the above happens? Our transportation department will keep the record of staff receiving the Tie-down training and give re-training when needed. Our operations representative will ensure all tie-downs and other materials are present and in working order. Documentation of trainings will be maintained in personnel records. Client #4, diagnosed with Moderate Mental Retardation, Quadriplegia Cerebral Palsy and who is wheelchair dependent, was not properly secured in a wheelchair van by staff who were not	V 110		

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V 110	Continued From page 8 trained to secure her. The staff that was trained failed to check the security of the wheelchairs prior to driving the vehicle. Even after client #4's wheelchair fell and she sustained injuries, responsible staff did not re-secure the wheelchair with the correct number of tie down straps. Not employing the appropriate number of tie-down straps and un-trained staff securing wheelchair clients was detrimental to the health, safety and welfare of of clients not able to secure themselves. This is a Type B rule violation and must be corrected within 45 days. An administrative penalty of $200.00 per day will be assessed for each day beyond the 45th day the deficiency remains out of compliance.	V 110		
V 118	27G .0209 (C) Medication Requirements 10A NCAC 27G .0209 MEDICATION REQUIREMENTS (c) Medication administration: (1) Prescription or non-prescription drugs shall only be administered to a client on the written order of a person authorized by law to prescribe drugs. (2) Medications shall be self-administered by clients only when authorized in writing by the client's physician. (3) Medications, including injections, shall be administered only by licensed persons, or by unlicensed persons trained by a registered nurse, pharmacist or other legally qualified person and privileged to prepare and administer medications. (4) A Medication Administration Record (MAR) of all drugs administered to each client must be kept current. Medications administered shall be recorded immediately after administration. The MAR is to include the following: (A) client's name;	V 118		

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V 118	Continued From page 9 (B) name, strength, and quantity of the drug; (C) instructions for administering the drug; (D) date and time the drug is administered; and (E) name or initials of person administering the drug. (5) Client requests for medication changes or checks shall be recorded and kept with the MAR file followed up by appointment or consultation with a physician. This Rule is not met as evidenced by: Based on record review and interview, the governing body failed to assure medication administration records (MAR's) were kept current for 1 of 4 audited clients (#1). The findings are: Review on 3/15/19 and 3/19/19 of client #1's record revealed: - an admission date of 5/1/18 - diagnoses including Developmental Disability and Diabetes - physician's orders dated 3/16/18 that client #1 could check her own blood sugar before lunch and with instructions that she could calculate and inject, with supervision, 10 units of Novolog pre-lunch daily - there was no evidence of MAR's to reflect Novolog was administered daily before lunch Review on 3/18/19 and 4/12/19 of personnel records revealed the Program Director (PD) and Qualified Professional #2 were received Diabetes Management Training on 10/15/16. During an interview on 3/19/19, client #1 reported:	V 118		

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V 118	Continued From page 10 - she had been coming to the facility since last year and liked it - she came to the facility on Tuesdays and Thursdays - staff watched her when she checked her blood sugar - she used an insulin pen to inject her own insulin - staff watched her while she administered her insulin - she did not take her insulin today because her blood sugar reading was 69 During an interview on 3/15/19, the PD reported the facility did not maintain MARs for client #1 because she administered her own insulin.	V 118		