

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 04/14/2015
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 14G302		(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 04/09/2015	
NAME OF PROVIDER OR SUPPLIER FORTY-FOURTH STREET PLACE				STREET ADDRESS, CITY, STATE, ZIP CODE 1479 SOUTH 44TH STREET DECATUR, IL 62521			
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W 000	INITIAL COMMENTS			W 000			
W 120	<p>INCIDENT INVESTIGATION</p> <p>Incident of 3/30/15 /IL 76115 - W120 483.410(d)(3) SERVICES PROVIDED WITH OUTSIDE SOURCES</p> <p>The facility must assure that outside services meet the needs of each client.</p> <p>This STANDARD is not met as evidenced by: Based on observation, interview and record review, the facility failed to ensure the Day Training (DT) site provided training to their staff for the use of the wheelchair lift on the bus and put safeguards in place for the use of the wheelchair lift on the bus for 1 of 1 individuals in the sample who fell off the wheelchair lift on the DT bus, sustaining injuries requiring Emergency Room treatment and hospitalization, (R1).</p> <p>Findings include:</p> <p>R1 is a 75 year old female with diagnoses of severe Intellectual Disabilities, History of Seizure Disorder, Hypertension, and Arthritis, per the 10/17/14 Annual Interdisciplinary Team (IDT) Evaluation.</p> <p>In review of a report to the Illinois Department of Public Health (IDPH), undated, it states that on 3/30/15, R1 was transported to the ER (Emergency Room) by the EMT (Emergency Medical Technician) service. This report further states that the DT staff were lowering R1 on the lift when the wheelchair rolled forward and R1 fell forward to the ground. R1 was transported to the</p>			W 120			

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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W 120	<p>Continued From page 1</p> <p>ER and admitted. R1 sustained a laceration to the right forehead.</p> <p>In review of R1's "Wheelchair/Gait Protocol", dated 11/13/13, it states, R1 "should use the wheelchair for transportation to and from DT. While on the van R1 shall remain in her wheelchair and use van seat belts. Upon arrival to either facility R1 should ambulate with stand by assist, rolling walker, and gait belt. R1 should walk during the day and evening in the facilities as much as tolerated.</p> <p>According to R1's Physical Therapy (PT) Evaluation, dated 9/3/14, R1 uses a rolling walker with contact guard in ambulation and requires a wheelchair for outdoor activities for long distances as needed.</p> <p>According to the 10/7/14 Occupational Therapy (OT) Evaluation, R1 is to use a wheelchair for long distances secondary to decrease in balance and increase in knee pain. R1 is contact guard assist during ambulation with rolling walker.</p> <p>In review of the facilities investigation, E1 (Administrator) provided the DT's "Accident/Incident Report" dated 3/30/14. This report states that the "wheelchair lift was going down to transport (R1) from bus to ground. Front lock gave away during midlift." This DT report was signed by Z1 (DT Day Vocational Trainer) and Z2 (DT Training Specialist).</p> <p>In review of the DT's Policy and Procedure titled "Safety Training", dated 3/30/11, under section 12., states, "All employees who utilize an agency vehicle to transport individuals shall complete Transportation Training as part of their JST which</p>			W 120			

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W 120	<p>Continued From page 2 shall be provided by their supervisor/designee."</p> <p>In an interview on 4/8/15 at 12:03 PM, when asked if there was a specific policy or procedure regarding the use of the bus wheelchair lift, Z3 (Transportation Supervisor) stated, training is done step by step when staff are hired and they use the lift every day. When asked how staff are trained to use the lift, Z3 stated, one person operated the lift, they are trained to lock both wheelchair brakes and to hold onto the wheelchair during the use of the lift. Z3 further stated that there are always 2 staff on the bus, and the second person is unlocking the wheelchairs, pulling the chairs off the lift and securing them in the bus. Z3 also stated that the bus and lift were checked after the incident and there was nothing wrong with it.</p> <p>In an interview on 4/8/15 at 11:08 AM, when asked what happened to R1, Z1 (Day Vocational Trainer) stated that the chair stop disengaged on the front of the lift which caused R1 to fall. Z1 stated that she always locks her side of the wheelchairs when they are on the lift. Z1 further stated that the bus had been repaired the week before because the rubber on the chair stop was broken. Z1 stated that the area is approximately 8 inches. Z1 stated that when she was lowering R1, the chair stop disengaged and R1 fell off the lift and that she threw the wheelchair to the opposite side of where R1 fell. Z1 further stated that R1 was approximately 5 feet from the ground when this occurred. Z1 also stated that R1 was not moving around in her wheelchair during this process of using the lift. When asked about assisting R1 with First Aide, Z1 stated that she told Z2 (Training Specialist) to get the First Aide Kit, but the facility staff had already gotten theirs.</p>	W 120			

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W 120	<p>Continued From page 3</p> <p>When asked how often she receives training on the use of the lift, Z1 stated she was trained one time, but she does it every day.</p> <p>In an interview on 4/8/15 at 11:40 AM, Z2 stated that Z1 locked R1's wheelchair on her side and preceded to push the button to lower the lift. Z2 stated that Z1 had her hand on the wheelchair. Z2 also stated that as the lift started going down, R1 went off the lift, Z1 could not grab her fast enough before she hit the ground. When asked if there is routine training on the lifts, Z2 stated, no.</p> <p>On 4/8/15 at 3:15 PM, Z1 was observed to lock her side of the wheelchair and E6 (Direct Service Person - DSP) locked the other side of wheelchair, both staff holding wheelchair as the lift was lowered to the ground. During this observation, Z1 pointed to the front of the lift and stated that this is the chair stop. Surveyor noted this is the ramp at the end of the lift to assist in a smooth transition off the lift.</p> <p>On 4/8/15 at 3:45 PM, R1's wheelchair was observed. Both wheelchair locks noted to work and wheelchair did not move when the brakes were engaged. E7 (Direct Service Person - DSP) was present during this observation.</p> <p>In an interview on 4/3/15 at 9:12 AM, E4 (DSP) stated that before this incident, she has never known the DT staff to lock the brakes on the wheelchairs when using the lift.</p> <p>In an interview on 4/8/15 at 8:45 AM, E2 (Supervisor) stated that the DT staff had not been locking the brakes on the wheelchairs prior to the incident.</p>	W 120			

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W 120	<p>Continued From page 4</p> <p>In an interview on 4/8/15 at 2:58 PM, E6 (DSP) stated she was heading back outside after bringing an individual into the house, she saw R1 on the lift and the next thing she saw R1 on the ground. E6 stated it happened so quick. E6 stated she was not sure if R1's wheelchair brakes were locked. E6 stated she saw R1 bleeding and called for E1 (Administrator), and got the facilities First Aide Kit because Z1 said they didn't have one.</p> <p>In an interview on 4/8/15 at 3:10 PM, E7 (DSP) stated she was standing in the doorway of the facility and the next thing R1 fell to the ground. E7 also stated that Z1 threw R1's wheelchair to the side at the same time R1 fell to the ground.</p> <p>In an interview on 4/4/15 at 10:10 AM, E3 (Licensed Practical Nurse) stated that the following day (3/31/15) she saw R3 put on the lift, Z1 locked one brake of the wheelchair and then Z1 started to lower R3. E3 stated that she stopped Z1 and told her that both brakes needed to be locked. E3 further stated that Z1 did the same with R2 and that E3 stopped Z1 and told her that both brakes needed be locked.</p> <p>In an interview on 4/3/15 at 9:50 AM, E1 (Administrator) stated that she was here when R1 fell off the lift. E1 stated that she went out and started First Aid on R1. E1 also stated that Z1 stated that there was no First Aid equipment on the bus. E1 stated that R1 fell approximately 5 feet. R1 sustained a laceration to above her right eyebrow and bruises.</p>	W 120			