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W 000	INITIAL COMMENTS At the time of the annual survey, the investigation of #84216-I was also completed. The investigation resulted in a deficiency cited at W189.	W 000		
W 189	STAFF TRAINING PROGRAM CFR(s): 483.430(e)(1) 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. This STANDARD is not met as evidenced by: Based on observation, interviews and record review, the facility failed to ensure staff were appropriately trained to provide for client safety when transported. This affected 1 of 1 client involved in the investigation of #84216-I (Client #4). Finding follows: Record review on 7/24/19 revealed the facility investigation regarding an incident involving Client #4 on the afternoon of 7/08/19. Client #4 had the top part of her left big toe partially severed off as the result of an accident with a mechanical bus lift. The incident occurred at approximately 3:00 p.m. when Client #4 left the day program to return to the facility, along with the other residents. Client #4 used a borrowed wheelchair from the day program, not her own wheelchair. The Lead Direct Support Professional (LDSP) wheeled Client #4's wheelchair onto the lift platform of the bus. The facility used the Washington County (WC) Mini-Bus that day, because the agency van was not working. After	W 189		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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the LDSP wheeled Client #4 onto the lift platform, she entered the bus to wait for Client #4 to raise up in the lift, in order to then assist Client #4 to maneuver into the bus. The WC Mini-Bus Driver then operated the lift to raise Client #4 up to the floor of the bus. As the lift was rising, Client #4 got her left big toe in a gap between an upright metal plate and the lift platform. The metal plate lowered down when the lift reached the floor of the bus, which resulted in part of Client #4's toe getting pinched/severed off.

Additional record review revealed Client #4 was 34 years old with a diagnosis including profound intellectual disability, impulse control disorder, intermittent explosive disorder, autistic disorder, anxiety disorder related to major depressive disorder, cerebral palsy with left hemiparesis, generalized seizure disorder and thoracolumar scoliosis. Client #4 was non-verbal, without functional communication. She had behavior support programs in place to address target behaviors of aggression and self-injurious behavior (hitting self and banging head on objects). Client #4 used a wheelchair for mobility, but had the ability to stand from her wheelchair. Client #4's annual Plan of Care (POC) dated 5/01/19 noted Client #4 "regularly refused to wear socks and shoes. She occasionally allowed staff to assist her with putting them on her, but quickly removed them and may get agitated if staff prompted her too much to put or keep them on." The POC made no reference to using the vehicle lift to transport Client #4.

According to a staff training sheet located in Client #4's record, Client #4 would be "utilizing a wheelchair with a seat belt for mobility until further notice." Staff signed the training sheet on

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11/19/18 and 11/20/18. Client #4's annual POC's adaptive equipment list included, "Wheelchair with self-removable seatbelt."

Observation of the WC Mini-Bus on the morning of 8/01/19 revealed a small bus with a side lift. The lift platform had rails on each side, with a safety belt that could be attached between the two rails, to prevent a wheelchair from rolling forward, off of the lift. The lift raised from the ground to the floor of the bus, a distance of approximately 3 1/2 feet. As the lift rose, a metal plate at the back of the lift (near the bus) was in an upright position, creating a gap of 2-3 inches between the lift platform and the metal plate. When the lift reached the floor of the bus, it stopped and the metal plate went down, as a sort of ramp between the lift platform and the floor of the bus. The gap between the metal plate and the lift platform closed.

When interviewed on 7/31/19 at 12:15 p.m. the LDSP confirmed she wheeled Client #4 in the wheelchair to the lift platform of the WC Mini-Bus on the afternoon of 7/08/19. She put Client #4 on the lift platform facing forward toward the bus. She said Client #4 had bare feet, which was typical. The LDSP said she had not attempt to put shoes on the client. The LDSP said there were no foot rests on the wheelchair, which was typical. Client #4 didn't like the foot rests to be on the wheelchair, because she liked to propel the wheelchair with her feet. The LDSP said she saw that Client #4's feet were on the floor of the lift platform. The Bus Driver attached the safety strap that went behind the wheelchair. The LDSP got on the bus and waited in the open lift area for the lift platform to raise up with Client #4. The Bus Driver operated the lift controller. The LDSP

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said Client #4 had her toe/foot caught or stuck between the floor of the lift platform and a raised metal plate at the back of the platform (closest to the bus). The LDSP said she said to the driver something like, "Her toe is stuck!" but the driver didn't appear to hear and kept raising the lift. The lift raised up to the floor of the bus and the metal plate lowered, which closed the gap between the plate and the lift platform. Client #4's left big toe was pinched/caught in between the metal plate and the lift platform. Client #4 began screaming and crying and the Bus Driver lowered the lift. Client #4's left big toe bled a lot. The staff provided emergency medical attention and called 911. The LDSP said Client #4 was often barefoot when using the lift, on the WC Mini-Bus and on the agency lift vans. There had never been a problem with getting her toe or foot caught in the past.

During a follow-up interview on 8/01/19 at 11:45 a.m., the LDSP said she didn't recall ever being trained or told to try to put Client #4's shoes on her during transportation on a lift van/bus. She said it was common practice for Client #4 to come home from the day program with bare feet. The LDSP confirmed the wheelchair Client #4 used that afternoon was borrowed from the day program and didn't have a lap belt. The LDSP said Client #4 had a lap belt on her personal wheelchair, but wouldn't leave it on. The LDSP had worked at the agency since 4/30/19.

During a follow-up interview on 8/05/19 at 11:00 a.m., the LDPS said she did not recall the Bus Driver had ever told her to put clients in wheelchairs on the lift facing forwards or backwards. The LDSP said the Bus Driver allowed her to put Client #4 on the bus lift on the

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afternoon of 7/08/19 and said nothing about how to do it.

When interviewed on 7/31/19 at 10:20 a.m. the facility Registered Nurse (RN) said she regularly worked the first shift and assisted clients to get on the van to go to the day program. The RN said Client #4 didn't like to wear shoes. Client #4 would typically tolerate having shoes on when transported to the day program in the morning. Client #4 typically returned from the day program with no shoes on. The RN said she had reminded staff to try to put shoes on Client #4 when she was transported on the lift van/bus. Client #4 usually didn't have foot rests on wheelchair because she didn't like them. She liked to propel the wheelchair with her feet.

During a follow-up interview on 8/01/19 at 11:55 a.m. the RN said Client #4's personal wheelchair had a Velcro lap belt/seat belt, which the client could remove. She said Client #4 always undid the wheelchair seat belt/lap belt if staff tried to fasten it. She said Client #4 had the ability to stand up from her wheelchair.

When interviewed on 7/31/19 at 10:35 a.m. the QIDP stated Client #4 didn't like to wear anything on her feet, such as shoes, socks or slippers. Client #4 also didn't like foot pedals on her wheelchair because she propelled the wheelchair with her feet. The QIDP said Client #4 was not required to wear shoes when transported on a lift van/bus, but she was encouraged to wear shoes during transports. Sometimes Client #4 would become upset and aggressive if staff tried to force her to wear shoes when she didn't want to.

When interviewed on 8/01/19 at 10:50 a.m. the

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Bus Driver said the REM staff person wheeled Client #4 onto the lift platform and the Bus Driver operated the lift. The Bus Driver said the REM staff person wheeled Client #4 face forward (facing the bus) onto the lift. The Bus Driver said she had asked REM staff several times in the past to wheel the clients backwards onto the lift, but they did things their own way. She said she didn't ask the REM staff on that afternoon to wheel Client #4's wheelchair backwards onto the lift. The Bus Driver said Client #4 was barefoot, which was not unusual. When she had transported the Client #4 in the past, the client usually had shoes on in the morning on the way to the day program, but was typically barefoot in the afternoon when she left the day program. The Bus Driver said the wheelchair Client #4 used that afternoon had no foot rests and Client #4 didn't have a lap belt on. At one point as the lift was being raised, Client #4 briefly partially stood and then quickly sat back down. She also hit herself in the head. The Bus Driver heard the REM staff person say "Stop," but she thought the staff person was talking to Client #4. The Bus Driver raised the lift to the bus and the metal plate/flap came down, even with the floor of the bus. The Bus Driver immediately lowered the lift when she realized something was wrong.

When interviewed on 8/05/19 at 11:40 a.m., the Program Supervisor (PS) said she observed clients loading on the Washington County Mini-Bus on the morning of 7/08/19. It was her third day of work and she watched the routine. The PS said when Client #3 was on the lift rising up to the bus, the PS noticed the toes of Client #3's shoes looked like they were going to get caught in the gap between the metal plate and the lift platform. The PS pulled Client #3's legs

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W 189	Continued From page 6 back, from the metal plate. The PS said she thought she mentioned this concern to the LDSP, who also assisted clients to get on the bus. The PS didn't recall if she mentioned it to the Bus Driver. She said the clients in wheelchairs were put on the lift facing forward toward the bus and she didn't recall any conversation regarding whether to place the clients's wheelchairs forwards or backwards. Review of Client #4's nurse's notes on 8/01/19 revealed an entry dated 7/09/19. According to the nurse's note, Client #4 sustained an injury to her left great toe on 7/08/19, which resulted in a "fracture and amputation." Client #4 went to the local emergency room and was transferred to the University of Iowa Hospitals and Clinics (UIHC) emergency room. A UIHC orthopedist removed additional bone from Client #4's toe and stitched up the injury. Client #4 was discharged from the emergency room and returned to the facility during the early morning of 7/09/19. The agency's policy Transportation and Use of Company and Personal Vehicles directed, "Based on individual support needs, consideration should be paid to ensure safety and proper supervision during transition times." The policy also noted, "If an individual has special safety, behavioral, or physical considerations that require them to have specialized supervision during transportation, this should be specifically noted in the individual's authorized plan."	W 189		
W 440	EVACUATION DRILLS CFR(s): 483.470(i)(1) The facility must hold evacuation drills at least quarterly for each shift of personnel.	W 440		

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This STANDARD is not met as evidenced by:
Based on interview and record review, the facility failed to conduct quarterly fire drills on the first and third shifts over the past year. This potentially affected 8 of 8 clients residing at the facility (Clients #1- #8). Finding follows:

Record review on 7/24/19 revealed the facility conducted a first shift fire drill (between 6:00 a.m. and 2:00 p.m.) on 10/30/18, 1/26/19, 3/24/19 and 7/21/19. There was no fire drill conducted on the first shift in April, May or June of 2019, resulting in a four month time period between the March and July first shift fire drill.

Further record review on 7/24/19 revealed the facility conducted a third shift fire drill (between 10:00 p.m. and 6:00 a.m.) on 9/25/18, 1/23/19, 4/18/19 and 6/25/19. There was no fire drill conducted in October, November or December of 2018, resulting in a four month time period between the September 2018 and January 2019 third shift fire drill.

When interviewed on 8/01/19, the Qualified Intellectual Disability Professional (QIDP) acknowledged the missing quarterly fire drills for the first and third shifts over the past year.