MAJOR UNUSUAL INCIDENT REPORT Home Facility: DA Resident Name: Last Incident Information Date: 1214198 Time: 1827 p.m. Other: Workshop Home \_\_\_\_ Location: Describe nature and extent of the incident in detail: Witness Information Address Name / Title Supervisor Staff Use p.m. Reported by: Cheryl Stewart ATS a.m. Date: Incident Reported If yes, what time? 1831 a.m. p.m. No 911 Called Emergency Information \_\_\_\_\_ Time \_\_\_\_\_ a.m. p.m. If yes: Location\_\_\_ Was resident transported? Was resident admitted to the Hospital? Reported to: Record Name, Date and Time reported for each of the following. Administrator on Call Devis Hort 12/4/98 1840 Case Management 1:11 W: Son 2230 Social Services \_\_\_ Parent / Guardia Attending Physician \_ Orders given: \_\_\_ a.m. p.m. Date: \_\_\_\_\_ Time: \_\_\_\_\_ Physician's Response Describe any additional pertinent information /action taken: YS 120/70-68-R18 except eve Date 12-1 Supervisors' Signature/ Title ROUTING: Document Signature and Date Nurse on Duty Witness Nursing Manager Social Services Executive Director \*Note any further follow-up on the back of this form. MUI Case File 12/13/2010 11:30:30 AM

12/4/8 Could s in her Statement and the Charge of Lauren a She cla pido discharge to agree to water four & down both halls

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Brenda Bailey

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### Doty House Residential Incident Report Follow Up December 8, 1998

**Incident Summary** 

On Friday December 4, 1998 in the evening a resident left the facility through an exit door by room #2 without sounding the warning buzzer to alert staff.

**Incident Investigation Summary** 

On Saturday December 5, 1998 about 8:00am, I verified that the buzzer wasn't functioning properly and tested the other four doors and the buzzers did sounded.

**Corrective Action** 

On Monday December 7, 1998 a broken wire to the magnetic devices was found and repaired. Support Services will include checking the buzzers with their monthly emergency equipment inspection starting immediately.

Roger Smith, Manager of Support Services

### DH RES PROCEDURE FOR STAFF BREAKS

Each staff person will receive two 10 minute breaks per shift. A break cannot be taken until the staff person has been on duty for at least 11/2 hours. prior to taking a break the staff person must sign-out on the sheet at the Nurses Station giving the time that she/he left the floor. Upon returning to duty, the staff person must sign-in giving the time of return to the floor.

Anyone working 5a-9a will receive one 10 minute break which can be taken after the morning routine has been completed.

12/10 hillits 1st Dondation 3 " Mil to put strop between fagge 3/10 min breaks at discression of Sugar. no with in the 1st 11/2 has Charl Stated so on break implying I'll lover Insin answer Criple of? Said gaing on break she agreed France Wassing American General General General Cheryl was growing bother only providing not followed was stope didn't sign out. I feire on alarm on door broken landing door but to alarmo Lewen WK has sentilet harmes but can still slip out of apairs.

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ON 12.4-98 at approx63000 I was finishing my last med pass, I went into the Day Room on the boy's side April & consider asked me a grestian regularding Othe Kursing care of the twins, then . told me they were going on break. I went back to the NUTSE station & continued my work. Craystal come into the main Nurse Station & Said Lauren was missing -(Notin how wheel chair). Assimmediate soprech started, all rooms were checked, All staff on duty were told to help in The search, the online building was sounded 911 was called. Some of the staff went outside to search the grounds. Test Eisele got into her car i searched the neighborhood. I again rechecked the resident's rooms/building then Tou came back with housen I checked hauren's vital signs, did a nerocheck, budy check & Rom check. No apparent 55 of injury noted. Lauren was given a bath, diaper change is clean clothes.

### BUTLER COUNTY COMMUNITY SUPPORT SERVICES UNUSUAL INCIDENT EVALUATION FORM

TO: Debbie Ewers

FACILITY: Addities 1st Foundation

RE: Lauren

**INCIDENT DATE: 12/4/98** 

LOCATION OF INCIDENT: Abilities 1st Foundation

**BRIEF DESCRIPTION OF UNUSUAL INCIDENT:** 

Lauren was found outside the building unattended.

### **EVALUATION REPORT:**

Community Support Services (CSS) has received and reviewed the summary of your findings and action taken in this case. The steps taken to prevent a reoccurrence of this type of incident and your decision to take disciplinary action against the staff assigned to Lauren is appropriate and CSS has no further recommendations.

TITZ.

Jimmie Hardin, MUI Coordinator

DATE: January 12. 1999

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#066N

### UNUSUAL INCIDENT REPORT FORM

DATE: 12/5/98 Time:	a.m./p.m	n. REPORT TAKEN BY:	
CLIENT NAME: Japren		s.c.:	
ADDRESS: Whilte SP Middle Middle Mid			
REPORTED BY:	, AGENCY/FA	ACILITY:	
PHONE:			
THAT INCIDENT OCCURRED.			
STAFF INVOLVED:			
OTHERS NOTIFIED: Law Enformation BCHS - CS BCHS - AN ODMRDD - ODMRDD -	cement If so If so If so If so CSS If so Licensure If so	o, by whom: When: o, by whom: When: When: o, by whom: When: When: o, by whom: When: When: When: when: When: When: When:	
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## **Abilities First Foundation**

In Robert B. Gardner Center

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FAXSIMILE TRANSMITTAL COVER SHEET

Date:	17/15/98	
Time:		And the Best State of the State
To: Name	Jimmie Hardin	
Firm		***
Address		
FAX#		
Phone #		
From: Name	Dennis Grant	
Firm City FAX#	Abilities First Foundation Middletown, Ohio 45044 (513) 423-1717 Phone # (513) 423-9496	
Number of	Pages, Including Cover Sheet	
Message:	:	

Formerly Doty House, Inc. 4710 Timber Trail Drive Middletown, OH 45044-5399 313/423-9496



4710 Timber Trail Drive Middletown, Ohio 45044 513-423-9496 Fax 513-423-1717

In The Robert B. Gardner Center

December 15, 1998

Jimmie Hardin Coordinator of Major Unusual Incidents Butler County Board of MRDD 449 Patterson Dr. Fairfield, OH 45014

Re: Incident regarding Lauren

12/4/98

Dear Jimmie,

Per our discussions on 12/9/98 and 12/11/98, I wanted to write and summarize our findings and actions taken regarding the incident which occurred on 12/4/98 at our Doty House facility. As you are aware, Lauren was able to slip out of her wheelchair and exited our building through the east exit door from Doty House at approximately 6:00 p.m.. Although we were unaware that she had left the building for three to five minutes, she was located and returned to the building within nine minutes of the time the nursing staff was notified of her being missing.

I will attempt to explain the multiple extenuating circumstances surrounding and contributing to this event. Lauren was being watched by one of our Active Treatment Specialists (ATS), Stephanie, on the women's side of Doty House and was returned to the men's side of the unit and placed in her wheelchair with the assistance of another ATS, Jenny. Jenny, however, was not the person assigned to care for the group of four residents which included Lauren. As a result, she went on providing care for her group and did not directly notify the ATS responsible for Lauren's care at that time, April. When another ATS, Cheryl, returned from her break, she advised both April and Jenny that they could go take a break themselves since she had now returned, implying that she would watch their residents for them. Unfortunately, Cheryl then proceeded to give one of her residents a bath which to some degree precluded her providing the regular monitoring for the other residents on the men's side at that time. It is important to note that Jenny, one of the ATS' who was now leaving on break also assisted Cheryl in placing one of her residents in the tub and therefore, was fully aware that Cheryl would be occupied with other duties beyond monitoring the residents in her area.

Expanding the Doty House tradition of care

April and Jenny did follow procedure before going on a break by checking in with the nurse on duty and advising her that they were going to be leaving the floor. They signed out the key for the center exit door and left the building. It was implied by their telling the nurse that they were going on break that they had made arrangements for the residents to be watched and/or cared for by another ATS. However this was not specifically stated but only assumed as part of our generally accepted procedures. The nurse was not aware that Cheryl was giving a bath at that time. Within several minutes, it was noticed that Lauren was not in her chair and after a quick search of the premises, determined that she must have exited the building. As previously noted, from the time it was found that she was out of her chair, it was less than 10 minutes before she was returned safely to our facility.

Beyond the various elements of human error noted above, it must be stated that we have been struggling with how to better manage Lauren's behavior and prevent her from getting out of her wheelchair. As we do not wish to unnecessarily restrain her, we have not installed a center strap in the seat of her wheelchair which would keep her from slipping out from under her harness and tray. We have, in fact, been very concerned about the possibility of her choking as she attempts to slip underneath her harness. However, based upon previous citations for restraining her, we have not been able to resolve this issue even though it was addressed with the IHP team, including her family at the most recent meeting approximately one month ago. In addition, as part of our fact finding as to how this possibly occurred, we discovered that the alarm buzzer on the east exit door of Doty House through which she went out was not working at that time. Apparently, one of the wires to the magnetic connection had been broken and therefore, when she opened that door, the alarm was not activated.

Based upon the facts listed above, we have taken several steps already to resolve this situation and prevent it from happening again in the future. I will list those actions below for your review.

- 1. The alarm on the east exit door of Doty House was repaired on 12/5/98.

  Furthermore all of the alarms on exit doors were inspected and a more frequent schedule for inspection has been scheduled with Support Services.
- Our policy regarding employees going on breaks has been reviewed and is being revised. In the interim, all employees have been asked to review and sign memorandum outlining the procedures for securing a specific ATS to watch their group and identifying that person on the sign-out ledger when they go on break. In addition, all nurses/supervisors have been advised that no more than one ATS is to go on break at any one time when residents are present in the building. This has also been conveyed to staff and will be reviewed as part of a formal policy change at our upcoming staff meeting on 12/18/98.
- Disciplinary action has been taken with the employees that were directly involved with this incident.

The ATS directly responsible for Lauren's care since was part of the assigned group, April, has received a written disciplinary communication. The ATS who implicitly agreed to monitor Lauren as well as the remaining residents while simultaneously giving a bath to one of her assigned residents, Cheryl, will receive an oral warning and be further advised as to proper procedure and the inappropriateness of her actions.

Jennifer, the ATS who assisted in putting Lauren in her chair as well as helping Cheryl place a resident in the bath will receive a coaching note as part of a disciplinary action in her personnel file. It appears that she neglected to advise April that Lauren was back and in spite of being fully aware that Cheryl was to bath a resident, still expected her to monitor the remaining residents.

Stephanie, the ATS who brought Lauren back to the boy's side for April to take over her care, will be coached by the supervisor as well regarding the need to only return residents to the individual responsible for the assigned group in the future. No formal disciplinary action will be taken against her for this. However, we will also be establishing this as a standard procedure for all staff to follow.

This incident has obviously raised many issues and caused us to take a close look at some of our policies and procedures and where some improvements are warranted. We believe that with the actions taken above, the likelihood of any similar event occurring at Doty House is extremely remote. We will also be exploring other issues with regard to Lauren's needs in reference to her chair, but are uncertain as to what the outcome of this will be.

After reviewing this summary, please do not hesitate to call me with any questions you have. I would be happy to provide clarification regarding any of the actions described above. I can be reached at (513) 423-9496 during normal business hours. Thank you again for your time and consideration in this matter.

Sincerely,

Dennis G. Grant

**Director of Client Services** 

pjr/dgg/MUI 120498



## **Abilities First Foundation**

In Robert B. Gardner Center

## FAXSIMILE TRANSMITTAL COVER SHEET

Date:	12-14-78
Time:	
To: Name	Jimmie Hardin BCBMR/DD
Firm	BCB MR/OD
Address	
	513-867-5783
FAX#	2/3-8/41 3 18-1
Phone#	
From: Name	Debbie Ewers
Firm City	Abilities First Foundation Middletown, Ohio 45044 (513) 423-1717 Phone # (513) 423-9496
FAX# Number of	
Message:	The Activity Schedule for L.C. per
<b>.</b>	your request-
***	

### Activity Schedule for Client #1

Weakday (School in Session)

Morning Care and prepare for school

\*3:30p-3:45pToileting
3:45 p-4:30p Physical Activity- Nurse will feed sometime during this period
4:30p-5p Offer quiet activity in J-seat, ball pool, swing, etc.

\*5:00p-5:15p Toileting
5:15p-6p-Physical Activity
6p-6:30p Offer quiet activity

Repeat process until bath time If Client #1 appears tired attempt bedtime process and monitoring

# Weekend, Holldays, School not in session

Morning Care and Breakfast

\*8:30a-8:45a Toileting

8:45a-9:30a Physical Activity

9:30a-10:00a Quiet Activity

\*10:00a-10:15a Toileting

10:15a-11:00a Physical Activity

11:00a-11:30a Quiet Activity

11:30a-1:00p In chair (lunch during this time)

1p-4p Physical Activity (\* Toileting at 1p, 2:30a) Allow rest as indicated

\*4p-4:15p Toileting and Feeding

4:15p-5:30p Physical Activity or group Activity with monitor

\*5:30p-5:45p Toileting

5:45p-6:30p Physical Activity or Quiet time (Client's choice)

## Repeat process until bath time

If Client # 1 appears tired attempt bedtime process and monitoring

\*- Document each time on Toileting Goal in Program Book

1) LOCATION CODE

#### BUTLER COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES CASE MANAGEMENT SERVICES

2) CONTACT CODE

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HAME:	LAURE	in .		(159	99)			MANAGER: Johnson Wardin DATE: 12/30/98	
DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
12/07/98	01:15:00	01:30:00	В	J	0	٧	1	Received call from Debbie Ewers re Lauren getting out of the build undetected. Alarm as checked and a wire had shorted out. Lauren was found across the street by the nurse. She was checked very carefully nothing out of order no injuries. Staff assigned was on the men wing because she had men in her group as well. Staff on men wing brought Lauren over and left her with another staff but not the one she was assigned to. Statements have been collected and incident report finished. CSS will Pick up today but due to computer traning tomorrow will be able to respond to Debbie until Mednesday.	ut
12/07/98	02:45:00	03:30:00	C	I	o	٧	3	Picked up information from Debbie Ewers at Abilities 1st Foundation reincident involving Lauren. Agreed to review this information on Wednesday due to computer workshop on Tuesday and call Debbie on Wednesday to discuss CSS opinion. Debbie stated this had happened once before at another facility they operate in another county and nothing was done in they have no president. Advise her this doen not apply in this county.	A 1H1
12/09/98	02:00:00	02:20:00	B	J	0	٧	1	Received call from Debbie Ewers re some question CSS had on this case and another resident. April Martin was assigned to Lauren and she failed to get premission to go on break and asked no one to watch Lauren while she was on break. Two staff stated in there written statement that spril laught when Lauren was found. According to Debbie, Lauren can walk but is keep in the wheelchair when she can't be 1-1. This is what Abilities ist was cited for in the pass so they had this approved by special team. Lauren is also blind in her right eye which makes this incident more serious.	8
12/10/98	01:30:00	01:50:00	В	j	O	٧	1	Returned call to Keith Benner Lauren SC. He stated he had gotton a call from Lauren's dad and he wondered if anyone from CSS was looking into the matter. Stated yes and CSS would be interviewing staff today at 3:00pm. Agreed to keep Keith informed and he could follow up with Lauren's dad. Returned call to Dennis Grant at Abilities 1st, not left message that CSS would be there today at 3:00pm and would speak with him at that time.	

3) SERVICE CODE

4) SERV NEEDS CODE

1) LOCATION CODE

A. Hospital

#### BUTLER COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES CASE MANAGEMENT SERVICES

2) CONTACT CODE

G. With Individual

B. In Office C. Residential Fac/Home D. Place of Employ/Day Prog/School E. Transport of Client F. Other			I.	With	h Esi h Esi	senti: senti:	uat/Pho al Otho al Otho	er r/Phone	M. Crisis Intervention N. Information/Referral C. U.I.R. P. Service Monitoring Q. Service Coordinating	S. Interpersonal T. Monitoring U. Comprehensive Evaluation V. U.I.R. Follow-up W. Crisis Resolution X. Other Y. Team Meeting	w w •• •
SERVICE F	ERIOD: 12/	01/98 - 12	:/31,	/98				RY DIAG CO	OE: 03190		
NAME: DOB:	LAURE	Ń		(159	<del>)</del> 9)			MANAGER:	knimes Hardin	DATE: 12/30/98	
DATE	START	END	1	2	3	4	UNITS		CASE/PROGRESS NOTES	C	4
12/10/98	02:30:00	04:00:00	C	1	0	V	6	involving Cheryl wi to Lauren alarm ie the door. pretainin Dennis or Lauren be on. It wa prevent t	Lauren. There will be two a ll receive a oral warning an will receive a written warn a wire was loose and the also Dennis stated this problem at the this conversation and to Debbie and faxed to CSS. Alving able to slip out of here suggest that a strap could his but it would be consider	Ewere to discuss this incident staff who will be disciplined. One nd the other April, who was assigned ning. There was a problem with the arm didn't go off when Lauren open would be corrected. Information the actions taken will be completed by lso there was some discussion about W/C with the seatbelt and the harness d be placed between her legs to red as a restraint. Called the SC and a look into getting this done.	JHJ
12/10/98	12:30:00	12:47:00	8	J	0	٧	1	checked t in a part tomorrow. contact t premissio arrangeme	he achdule to see wh was the icular order. Saked if she was One won't be in until Mondo he supervisor at the time of an for the staff assigned to	ere today. arranged to meet with staff would arrange for other staff ay will meet them. Asked if she would f the incident to see if she gave Lauren to take brake and if she was on brake. Will interview	jhj
12/11/98	10:00:00	12:30:00	D	I	<b>.</b>	V	10	constant she was p by her si other stu lot of ac school gr ie the mo there is home. Law period of	state of motion from the timut back in. During this entide. She knocked over everytiments at every opportunity. Attivities with Laurer to keep ounds and other places in the ment she is put back in her know way she could be keep ours seem to realize that she	me she was let out of her W/C until ire time she side had to constantly be hing in her path and accusted the Mrs Ott, her teache stated they do a p he busy. She takes walks around the he building. Lauren father was right W/C her whole demener changes but out of the chair all day at school or a will be out of the W/C for a short h action in as she can and seem to	141

3) SERVICE CODE

L. Needs Assessment

4) SERV NEEDS CODE

R. Housing/Placement

1) LOCATION CODE

#### BUTLER COUNTY BOARD OF MENTAL RETARDATION AND DEVELOPMENTAL DISABILITIES CASE MANAGEMENT SERVICES

2) CONTACT CODE

A. Hospital B. In Office C. Residential Fac/Home D. Piace of Employ/Day Prog/School E. Transport of Client F. Other				Witi Witi	n Inc n Ess n Ess			ituation	
SERVICE P	ER100: 12/	01/98 - 12	/31	/98		, <del>,</del>	PRIM	RRY DIAG CODE: 03190	,
NAME:	LAURE	N		(159	99)		MEDIC	CAID # CAID	
DOB:							CASE	HANAGER: Jerme Landin DATE: 12/36/98	
DATE	START	END	1	2	3	4	UNITS	CASE/PROGRESS NOTES	CM
12/11/98	12:30:00	01:45:00	C	1	0	٧	5	Discussed recommendation but none was feasible due DHS Licensure regulation. However, Dennis did agree to raise Lauren bed rail higher to prevent her from climbing out during the night. Dennis explained that the same thing CSS witnessed at the school is what she doe at home when she gets out of bed. One of her roommates has a feeding pump and she has knocked it over during the night. She litterly tears up the room when she gets out of bed at night. There is an alarm that alerts the nurse when she gets out of bed bu before the nurse canb respond Lauren ha nearly destroyed everything in her room. Dennis stated they plan to move Lauren and two other residents near to the nurses station. This should cu down on response time. If dad approve, raising the bed rail should help.	) :
12/14/98	08:10:00	08:28:00	5	J	0	٧	1	Spoke with Mr School. Explained that CSS could not make a case either way. He is correct that when Lauren is in the chair she seems to just go limp and ceast to exist but by that same token when she was out of the chair she was in constant motion and knocked over everything not tied down as well as jump and fall on the other kids. He talked about last year and how Lauren performed in a different way in the classroom. He explained the teache didn't use the chair and only had to use verbal promps to re-direct her. CSS agreed to follow up with class rm consultent to get involved. Talked about modification Doty House agreed to make re Lauren's bod and move her closer to the nurses station. Also CSS would try to get her out of doty house into supported living. Will call him after meeting Tues,	JHJ
12/14/98	09:15:00	09:55:00	F	I	0	V	3	Discussed classroom observation and CSS's conversation with Lauren father with Sandy Steiger and Loral Lovely. Sandy state she would be meeting with Cathy the classroom consulant for Creekview on Wadnesday of this week. Laurel explained that Lauren being in a W/C this year is a regression from last year. She explained that there was a change in teacher this year and that may be the cause of Lauren being back in the W/C. She stated she feit Lauren has regressed this year. Sandy agreed to look in to this matter and keep Laurel informed.	h m

3) SERVICE CODE

4) SERV NEEDS CODE