Ohio Department of Developmental Disabilities

Division of Information Systems

10-12

DODD INCIDENT REPORT (ITS)

Incident Number			Group Name	
2014-[redacted]0553			BUTL	
Client Number	Client Name	Gender	Waiver Type on Incident\Create Date	AgeAtDiscovery
[redacted]	[redacted]LAUREN 350 Kolb Drive Fairfield, OH 45014	F		27

Final Due Date	Incident Date	Discovery Date	Created Date	Fax Date
1/2/2015		11/18/2014	11/19/2014	

Category: Significant Injury — Injury (Known) — Fall

Substantiated Category: Was Substantiated

Injuries

Severity: Moderate — Cause: Undetermined — Result: Bone Fracture(s) — Location Chest/Torso/Back

Supervision: Minute visual checks / awake time — Met

Behavior Support Plan: No — Restrained from 0 to 0 Days — Restrained by:

Law Enforcement Involved: No

Location: Non-County Operated Program — Living Arrange: DODD Licensed Facility — Residence — ICF/DD

Incident Provider: 910027 TAKODA TRAILS

Residential Provider: 910027 TAKODA TRAILS

Workshop:

Notifications

Provider: 11/18/2014

Guardian: 11/18/2014

County: 11/18/2014

Coroner

Notified: — Accepted: — Autopsy:

Rec. Closure: 1/2/2015

Rec. Closure By: Rebekah Lyons

Incident Review Status: Closed

Closed Date: 1/2/2015

Investigated By: Investigative Agent Rebekah Lyons

Closed By: Rebekah Lyons

Last Change By: Rebekah Lyons

PPI\Witness Name	Relation

Initial Report 2053201

On 11/18/14, Lauren [redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time.
<Karen S Bessette Added on 11/19/2014>

Immediate Action 2053202

Assessed by Takoda Trails nursing staff when bruising was noted to her shoulder, neck and chest.
Sent to orthopedist for evaluation and received diagnosis of fracture.
<Karen S Bessette Added on 11/19/2014>

Final Report 2069783

Q)List of persons interviewed and documents reviewed
A)Interviews/Statements:
N/A

Documents Reviewed:
Ohio DODD ITS Report
Incident reports
Past MUI involving Lauren
ISP/Health assessment
Email Correspondence
Special Team Meeting notes
MAR
Witness Statements
Web research
UI log

Q)Summary of interviews and documents reviewed
A)Lauren is a 27 year old female who resides at Takoda Trails, an ICF-DD. This investigation was completed by Tanya Vance, Investigator/TAkoda Trails, with additional information provided by this IA. This IA is in agreement with all conclusions.
ICF summary reviewed: Lauren resides in home [redacted] at Takoda Trails. Her level of supervision is 5 minute checks during normal waking hours (visual range while out of bedroom and walking around). She is on visual range when outside and in the community and at CLW (day program). Lauren is NPO and receives all nutrition and medications through G-tube. Lauren is blind and has history of accidentally closing her fingers in doors. There are body audits done on Lauren 3x a day to ensure there are no injuries. An incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a bodysuit at all times. Laren's code status is full code. He guardian is her father [redacted] Lauren's primary diagnosis is Profound MR. She has secondary diagnoses of CP, Seizure D/O, Cortical blindness, Multiple Ottis Media, S/P PO tubes, History of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastonomy w/Nissen, Chronic Periodonitis, Anhidrosis, and None serile Cataracts. On 11/18, LPN Sandy Osterberger was preparing to administer bolus medication to Lauren when she observed bruising to her chest and right shoulder and neck area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 1cm x 1cm raised area to the right scapula. Sandy made this investigator and DON aware of this report immediately. COTA Jason Bode was also present with nursing for this assessment. An Appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon

(Dr. Gangle). Dr. Gangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a wheelchair and wear the sling as tolerated and a follow up appointment was made for 4 weeks (12/15). A special team meeting was held and her level of supervision was increased.
All staff that worked with Lauren in the past week, including CLW staff were interviewed and witness statements were obtained. When interviewing staff members in the home, it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been seen or reported in the 2 weeks prior to the day it was reported. During the interview process, there was some information that was passed on to this investigator that could possibly be the cause of the injury. On 11/2, Lauren was being given her PM shower when RS1 Isaidy Dela Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Isaidy reported she went over to secure her and Lauren hit the wall in the shower stall, striking her head as she lowered her to the floor and called for assistance. When I asked Isaidy if Lauren struck the wall with enough force to cause that type of injury, she replied that she thought so. I asked her during the interview if she had seen the bruise and she told me that she had, but since the incident had already been reported, she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 18th. This also is comparable to the timeline that Dr. Gangle estimated the bruise as being at least 2 weeks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 19th where Lauren was sent to the ER due to being non-compliant with treatment by the nursing department at Takoda. She received derma bond for closure of a cut above her left eye. Lauren's level of supervision was increased to 1:1 status when she returned to the facility after treatment. An in-service was implemented that morning, making staff aware of the change in supervision level as well as instructions for staff to use a gait belt at all times and to keep her in arm's reach 24/7. This is the most likely scenario of how Lauren sustained the injury.
Lauren will follow up with orthopedic surgeon Dr. Gangle for 4 week follow up. She will also be seen by Dr. Zakem (PCP) on next clinic day. Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status. A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift. The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.
ITS reviewed: Lauren had a previous injury in 2003 due to her getting her hand stuck in a door.
<Rebekah Lyons Added on 1/2/2015>

Findings and Conclusions 2069784

All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.
<Rebekah Lyons Added on 1/2/2015>

Cause And Contributing Factors 2069785

- Likely a fall due to seizure activity.
<Rebekah Lyons Added on 1/2/2015>

Prevention Plan 2069786

- Lauren followed up with orthopedic surgeon Dr. Gangle and Dr. Zakem (PCP) as recommended until she has healed.

- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.
<Rebekah Lyons Added on 1/2/2015>

MUI Report:
Individual: Lauren [redacted]
Investigator: Rebekah Lyons
Incident Number: 2014-009-0553
Category: Significant Injury
Date: 1/2/15

INITIAL STATEMENT:
It was reported to the Office of Incident Review/OIR on 11/18/14, Lauren was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time. An MUI for significant injury was filed on behalf of Lauren.

LIST OF PERSONS INTERVIEWED AND DOCUMENTS REVIEWED
Interviews/Statements:
N/A

Documents Reviewed:
Ohio DODD ITS Report
Incident reports
Past MUI involving Lauren
ISP/Health assessment
Email Correspondence
Special Team Meeting notes
MAR
Witness Statements
Web research
UI log

SUMMARY OF INTERVIEWS/DOCUMENTS REVIEWED

Lauren is a 27 year old female who resides at Takoda Trails, an ICF-DD. This investigation was completed by Tanya Vance, Investigator/TAkoda Trails, with additional information provided by this IA. This IA is in agreement with all conclusions.

ICF summary reviewed: Lauren resides in home [redacted]t Takoda Trails. Her level of supervision is 5 minute checks during normal waking hours (visual range while out of bedroom and walking around). She is on visual range when outside and in the community and at CLW (day program). Lauren is NPO and receives all nutrition and medications through G-tube. Lauren is blind and has history of accidentally closing her fingers in doors. There are body audits done on Lauren 3x a day to ensure there are no injuries. An incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a bodysuit at all times. Lauren's code status is full code. He guardian is her father [redacted] Lauren's primary diagnosis is Profound MR. She has secondary diagnoses of CP, Seizure D/O, Cortical blindness, Multiple Ottis Media, S/P PO tubes, History of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastonomy w/Nissen, Chronic Periodonitis, Anhidrosis, and None serile Cataracts. On 11/18, LPN Sandy Osterberger was preparing to administer bolus medication to Lauren when she observed bruising to her chest and right shoulder and neck area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 1cm x 1cm raised area to the right scapula. Sandy made this investigator and DON aware of this report immediately. COTA Jason Bode was also present with nursing for this assessment. An Appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon (Dr. Gangle). Dr. Gangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a

wheelchair and wear the sling as tolerated and a follow up appointment was made for 4 weeks (12/15). A special team meeting was held and her level of supervision was increased.

All staff that worked with Lauren in the past week, including CLW staff were interviewed and witness statements were obtained. When interviewing staff members in the home, it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been seen or reported in the 2 weeks prior to the day it was reported. During the interview process, there was some information that was passed on to this investigator that could possibly be the cause of the injury. On 11/2, Lauren was being given her PM shower when RS1 Isaidy Dela Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Isaidy reported she went over to secure her and Lauren hit the wall in the shower stall, striking her head as she lowered her to the floor and called for assistance. When I asked Isaidy if Lauren struck the wall with enough force to cause that type of injury, she replied that she thought so. I asked her during the interview if she had seen the bruise and she told me that she had, but since the incident had already been reported, she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 18th. This also is comparable to the timeline that Dr. Gangle estimated the bruise as being at least 2 weeks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 19th where Lauren was sent to the ER due to being non-compliant with treatment by the nursing department at Takoda. She received derma bond for closure of a cut above her left eye. Lauren's level of supervision was increased to 1:1 status when she returned to the facility after treatment. An in-service was implemented that morning, making staff aware of the change in supervision level as well as instructions for staff to use a gait belt at all times and to keep her in arm's reach 24/7. This is the most likely scenario of how Lauren sustained the injury.

Lauren will follow up with orthopedic surgeon Dr. Gangle for 4 week follow up. She will also be seen by Dr. Zakem (PCP) on next clinic day. Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status. A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift. The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.

ITS reviewed: Lauren had a previous injury in 2003 due to her getting her hand stuck in a door.

FINDINGS AND CONCLUSIONS

All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.

CAUSE AND CONTRIBUTING FACTORS

- Likely a fall due to seizure activity.

PREVENTION PLAN

- Lauren followed up with orthopedic surgeon Dr. Gangle and Dr. Zakem (PCP) as recommended until she has healed.
- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.

Nancy Morris

From: Nancy Morris
Sent: Tuesday, January 06, 2015 11:25 AM
To: Tanya Vance
Cc: Leia Snyder (lnsnyder@butlerdd.org)
Subject: summary 14-0553 encrypt
Attachments: [redacted]SI 14-0553 summary.pdf

Hi Tanya,
This summary references the incident which was discovered on 11/18/14. The guardian will also be notified.

Sincerely,
Nancy

Office of Incident Review &
Quality Assurance
282 N. Fair Avenue
Hamilton, OH 45011

BUTLER COUNTY
Board of
DEVELOPMENTAL DISABILITIES
Supporting Possibilities

T: 513.785.2800
OIR Fax: 513.887.8028
QA Fax: 513.820.5087
www.butlerdd.org

WRITTEN SUMMARY OF INCIDENT

Date: 1/6/15

To: [redacted] Guardian
Tanya Vance, Takoda Trails
Leia Snyder, BCBDD Quality Assurance Director
From: Rebekah Lyons, IA/Butler County Board DD

Name: Lauren[redacted]
Incident Number: 2014-009-0553
Type of Incident: Significant Injury

Statement of Incident: It was reported to the Office of Incident Review/OIR on 11/18/14, Lauren was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time. An MUI for significant injury was filed on behalf of Lauren.
Findings: All information given indicates that Lauren received diagnosis of a closed fracture of the right clavicle on 11/18. This was based on observation the same day of bruising by the nurse at Takoda Trails. All staff were interviewed and it was believed this injury was caused from a fall that occurred on 11/2 due to seizure activity. This timeline was in agreement with the physician's estimate of when the incident likely occurred. Appropriate supervision levels were met and it is found that staff acted appropriately in this incident.
Prevention Plan:

- Lauren followed up with orthopedic surgeon Dr. Gangle and Dr. Zakem (PCP) as recommended until she has healed.
- Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to 1:1 status.
- A STM was held 12/2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1:1 staffing ratio. Some ideas presented were a trial helmet, re-inservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed, as well as 10 minute checks for third shift.
- The team met again on 12/5 to discuss how Lauren is adjusting to the changes implemented on 12/2. Lauren has adjusted with no major issues and will continue the current level of supervision.
- The team will continue to make adjustments to Lauren's care plan to keep her safe.

The information contained in this letter is provided to you in accordance with ORC 5123:2-17-02. You may dispute the findings of this report by submitting a letter of dispute and supporting documentation to the county board superintendent, or to the director of the Ohio Department of DD if the department has conducted the investigation, within fifteen calendar days following receipt of the summary. An individual may receive assistance from any person selected by the individual to prepare a letter and provide supporting documentation. If you have any questions, please call 513-785-4674 and ask to speak to the IA listed above.

Cc: MUI File

RL/nam

PLEASE NOTE THAT OUR PHONE NUMBER HAS CHANGED TO 513-785-4674 OR 513-785-2800.

Nancy Morris

[redacted]

From: DODDInfo_doNotReply@dodd.ohio.gov
Sent: Friday, January 02, 2015 2:52 PM
To: Karen Bessette; Rebekah Lyons; Rebekah Lyons; Nancy Morris
Subject: ITS Info on MUI: 2014-009-0553 Sent: 1/2/2015 2:52:03 PM

Importance: High

IncidentStatus Changed From (Open With Information Submitted) To Closed
Currently: 1/2/2015 2:52:03 PM
Decided Category: Significant Injury

This email has been auto-generated by DODD at the request of: Rebekah Lyons (rllyons@butlerdd.org). If you are not the intended recipient of this email you are asked to please forward the email immediately to Application.Support@dodd.ohio.gov and then delete any further copies that you have. DO NOT REPLY TO THIS E-MAIL

Ohio Department of Developmental Disabilities

Division of Information Systems

DODD INCIDENT REPORT (ITS)

Incident Number			Group Name	
2014-009-0553			BUTL	
Client Number	Client Name	Gender	Waiver Type on Incident\Create Date	AgeAtDiscovery
[redacted]	[redacted]LAUREN 350 Kolb Drive Fairfield, OH 45014	F		27

Final Due Date	Incident Date	Discovery Date	Created Date	Fax Date
1/2/2015		11/18/2014	11/19/2014	

Category		Substantiated Category	Was Substantiated
Significant Injury	Injury (Unknown)		

Injuries			
Severity: Moderate	Cause: Undetermined	Result: Bone Fracture(s)	Location Chest/Torso/Back

Location	Living Arrange: DODD Licensed Facility		
Non-County Operated Program		Residence	ICF/DD

Incident Provider: 910027 TAKODA TRAILS
Residential Provider: 910027 TAKODA TRAILS
Workshop:

Notifications	Coroner		
Provider: 11/18/2014	Notified:	Accepted:	Autopsy:
Guardian: 11/18/2014	Rec. Closure	Rec. Closure By	
County: 11/18/2014	Incident Review Status		
	Open with Information Pending		
	Closed Date	Investigated By	
		Investigative Agent Rebekah Lyons	
	Closed By	Last Change By	
		Karen Bessette	

ICF Case.
12-17 Emailed Tanya Vance requesting follow-up + report.

PPI\Witness Name	Relation

Initial Report	2053201

On 11/18/14, Laure[redacted] was diagnosed with a broken clavicle. The origin of the injury is unknown, but abuse or neglect are not believed to be a factor at this time.
<Karen S Bessette Added on 11/19/2014>

Immediate Action	2053202

Assessed by Takoda Trails nursing staff when bruising was noted to her shoulder, neck and chest.
Sent to orthopedist for evaluation and received diagnosis of fracture.
<Karen S Bessette Added on 11/19/2014>

Karen Bessette

From: Karen Bessette
Sent: Thursday, November 20, 2014 9:01 AM
To: Tanya Vance (tvance@takoda-trails.net)
Cc: Rebekah Lyons
Subject: LC MUI#2014-009-0553

This is to inform you that an MUI has been filed for Lauren [redacted] for Significant Injury. This is based on her being diagnosed with a broken clavicle on 11/18/14. Rebekah Lyons has been assigned this case.
Please provide your investigation report and any other information pertinent to this case to Rebekah.

Karen Bessette
Intake Investigative Agent
Butler County Board of DevelopmentalDisabilities
282 N. Fair Avenue
Hamilton, OH 45011
(513) 867-5992
fax: (513) 887-8028

☐ UI ☐ See Attached Documentation

☑ MUI #2014-009-0553 Due Date: 1-2-15

IA Assigned: Bekah

Individual's Name: Lauren [redacted]

Incident Date: unk Time: _____

Reported By: Sandy Osterberger-TT Contact #: _____

☐ Incident Report ☑ On-Call Log ☐ Phone Call ☐ E-mail ☐ In Person

Date/Time incident was reported to BCBDD (either on-call or to any CB staff): date: 11-18-14 time: 4:44pm

Date/Time Incident was reported to OIR: date: 11-19-14 time: _____

Residential Provider: Takoda Trails Day Program Provider: _____

SSA: _____ Developmental Specialist: _____

Guardian: _____ Waiver Nurse: _____

Description of Incident: ☑ See attached description if checked

Follow-Up/Recommendations:

☐ Requested Incident Report ☐ Requested Other Documentation: _____

ON CALL FORM

Fill in completely and send to mui@butlerdd.org by 9:00 am.	
Completed By: Michelle Reed	Individual's Assigned SC (if known):
Date of Call: 11/18/14	Time of Call: 4:44 PM
Name/Title of Caller: Sandy Osterberger	Telephone Number: 513-616-2746
Individual's Name (s): Lauren [redacted]	Provider:
Incident Date/Time: 11/18/14	Location: Takoda Trails

Description of Incident: (Who, what, when and where. List any witnesses.)
Staff noticed this morning that Lauren had some bruising in her chest area and on her should and neck. They consulted with their PT who felt that she needed to be seen by an orthopedist. Sandy reported that Lauren was currently still at appt. but she had received the information that Lauren has a fractured clavicle. SSA asked if they had any idea of what happened and she said that they arent sure. She has a seizure disorder and may have fallen or gotten up and ran into a wall.

Were there any injuries? Describe:
Fractured clavicle

Immediate Actions (What was done to ensure the immediate health and welfare of the individual?)

- ☐ Individual was assessed for injury/illness by direct care staff, name/result:
- ☒ Individual was assessed by a medical professional, name/location:
- ☐ A medical professional was consulted, name/title:
- ☐ Police were called, response:
- ☐ Wellness Check Requested, result:
- ☐ Ambulance/911 was called, response:
- ☐ Individual was transported to urgent care/hospital, location:
  Admitted? ☐ Yes ☐ No ☐ Unknown
- ☐ Mobile Crisis was called, response:
- ☐ Increased supervision, describe:
- ☐ Staff was placed on leave, name/details:
- ☐ Access to PPI prevented, explain how:
- ☐ Medications/cash/property secured, describe:
- ☐ Additional staffing added to the home, describe:
- ☐ Alternative placement was arranged, describe:
- ☐ Discussed safety plan with individual or other involved party, describe:
- ☐ **Other, please describe:**

☐ **CHECK HERE if additional information is available in a case note.**

Notifications:

Person Notified	Name/Title	How/By Who?	Date/Time
Guardian/Advocate			
Support Broker			
Provider			
Law Enforcement **ANY potentially criminal**	Jurisdiction:		
Children Services **ANY potentially criminal <22**			
Coroner **ANY death**			
Superintendent **ANY death**			
IA **ANY ALLEGED OR SUSPECTED abuse, neglect, theft or death**			
Assigned SC			
Other:			
Other:			

*The on-call report will be forwarded to designated parties by MUI office.

Empowering People
Home Management Manual – Residential – Routine Paperwork
Unusual Incident Report

Major Unusual Incident: ☐ Yes ☐ No If yes Category: ☐ A ☐ B ☐ C
**Regardless of time or day, Major Unusual Incidents are to be called immediately to the AOC or designee*

Resident Name: Lauren [redacted] Address: 360 Kolb Dr.
Date: 11/18/14 Day of Week: Tuesday Time: 8am AM PM
Staff Involved: _____ Witnesses: _____
Home: #500 Site Occurred: Takoda Trails

Must write incident report for each person involved. Use initials for other housemates if needed to mention in report.

TYPE OF INCIDENT – Please check all that apply

Medical (Resident Related)
___ Med error - person responsible for Med Pass: _____
___ Wrong time ___ Wrong dose ___ Wrong person ___ Blood exposure
___ Wrong med ___ Wrong route ___ Med omitted from (check one)
___ Med (pill) found ___ Med documentation error ___ Med refusal ☐ Staff
___ Med dropped ___ Possible injury to resident ___ Seizure ☐ Resident
___ Possible bruising ___ Minor injury to resident ___ Resident to Dr. or ER
✓ Unobserved injury ___ Dietary related problem ___ Accident – Resident
___ Other (describe): _____ ___ Illness ___ Fall

Behavioral (Resident Related)
___ Verbal Aggression (VA) ___ Self Injurious Behavior (SIB) ___ Theft - ☐ under $100. ☐ Over $100.
___ Property Destruction (PD) ___ Peer to Peer Incident ___ Elopement
___ Physical Aggression (PA) ___ Inappropriate sexual contact ___ Damage to personal property
___ Other (describe): _____ _____ Work order number

Operations/Maintenance ☐ Check if Work Order Written
___ Item broken ☐ Check if item can be repaired ☐ Check if item was discarded
___ Auto accident ___ Damage to Agency property
___ Other (describe): _____
Other describe): _____

OBJECTIVE DESCRIPTION OF INCIDENT
Describe specifically what happened BEFORE the incident: Administering bolus x medications to resident

Describe the incident: Bruising yellow in color noted to chest (R) side shoulder & neck area. Also hand. Raised area to top of shoulder

Describe the intervention(s) used and effectiveness: Seen by PT. Read N/O X-ray of (R) Shoulder

Behavior Plan Followed? ☐ Yes ☐ No ☐ Not applicable ☐ Protective Hold used? ☐ Yes ☐ No
Protective Hold in Behavior Plan? ☐ Yes ☐ No Used for medical purposes? ☐ Yes ☐ No

Duration: _____ (Minutes) Alternatives attempted: _____

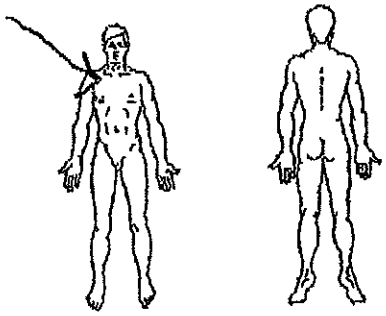
(If not in Behavior Plan and Protective Hold is used; incident becomes a Major Unusual Incident.)

Type of Protective Hold: ☐ Lower Figure Four ☐ Parallel Hold ☐ Limited Security Hold
☐ Full Security Hold ☐ Rvse. Cradle Transport ☐ Rvse. Cradle Take Down ☐ Other: _____

MEDICAL
Medical Treatment Necessary? ☑ Yes ☐ No Medical treatment outside of facility? ☑ Yes ☐ No
Explain treatment: sending to Dr. Gangle @ Tri-health for examination @ 3:15 pm Rec'd Dx Fracture R clavicle
Who performed medical treatment: murano
Nurse's comments: Bruising to shoulder approx 4 inches x 6 inches yellow in color. Raised area 1cm in height 1cm x 1cm around.
Nurse's signature: S Osterberger Lpn Date: 11/18/14

BODY PART AFFECTED BY THE INCIDENT:
Use ink to circle on the figure any bruises, cuts, marks, etc.
If no visible signs at the time, circle area and note possible type of injury:

- ☑ Bruise
- ☐ Possible bruise
- ☐ Bite
- ☐ Bleeding
- ☐ Fracture
- ☐ Other: _____
- ☐ Rash/redness
- ☒ Scratch
- ☑ Swelling
- ☐ Laceration



WHO WAS NOTIFIED AT TIME OF INCIDENT *(include date & time):*
☐ Guardian Name [redacted] Date 11/18/14 Time 9:45 am
☑ Administrator Date 11/18 Time 9:45 Special Instructions Given _____
☐ DON Date 11/18 Time 8am Special Instructions Given _____
☑ MUI Unit Tonya Date 11/18 Time 9am Special Instructions Given _____
Michelle Reed 11/18 5pm
☐ SSA(waiver only) Date _____ Time _____ Special Instructions Given _____

QIDP/HMA IMMEDIATE FOLLOW-UP: _____

REPORT COMPILED BY: S Osterberger Lpn 11/18/14
Name Title Date

Manager Review: _____
Name Title *(If Other than Manager)* Date

QMRP Review: _____
Date
☐ No Additional Follow-up Needed
☐ See Behavior Plan
☐ See Attached Follow-up Report

Administrator Review: _____
Name Date

Medical Director: _____
Name Date

Date/Time MUI was forwarded to MUI Investigator: _____

Revised 9/1/2013 KAM

Consumer Detail Report

CARTER, LAUREN

Organization: Butler County

Plan Year Start: | Early Track Num: | Local ID: | SSN: | Resident Num: | Medicaid Num: | Birth: | Gender: F

Primary Funding Source:

Mailing Address: 350 KOLB DR
FAIRFIELD OH 45014-

Other Address:

Phone:
Primary: ( ) -
Secondary: ( ) -

E-mail Address:

File Location:

Notes:

All Classifications:

Classification	Start Date	End Date
Waiting List Letter October	10/28/2014	01/01/2064
Lives in a Butler County ICF/IID	01/01/2001	01/01/2061
Consumer	01/01/2001	12/31/2056

Relationships:

Relation	Name/Organization/Vendor	Address	Phones / Email
Parent	[redacted] Greg	[redacted] Lebanon OH 45036-	Primary: [redacted] Pager: ( ) - Secondary: [redacted] Cellular: ( ) - Fax: ( ) - Email:

Waiting Lists:

Butler County	Status	Date On	Emergency	Priority	Date Off
45 IO Waiver	Waiting	04/23/1997 00:00			

Ohio Department of Developmental Disabilities

Division of Information Systems

List All Notifications of Abuse/Neglect and Major Unusual Incidents for Client [redacted] LAUREN with Incident/Discovery Date
Between Jan 1, 2000 and Nov 20, 2014
Total Incidents: 8

Incident Number	Client Name	Incident Provider	Residential Provider	Workshop Provider	Incident Date	Discovery Date	Final Report Due	Rec Closure Date	Incident Category	Incident Category 2	Incident Category 3	Substantiation Category	Substantiation Category 2	Substantiation	Incident Location
2003-009-0277	[redacted] LAUREN		TAKODA TRAILS		10/18/03	10/27/03	12/10/03	11/21/03	Injury	Accident					Non-County Operated Program
2006-009-0214	[redacted] LAUREN		TAKODA TRAILS		5/8/06	5/8/06	6/20/06	6/20/06	Alleged Abuse - PHYSICAL	Unknown		Alleged Abuse - PHYSICAL	Unknown	Insufficient evidence	Non-County Operated Program
2008-009-0102	[redacted] LAUREN		TAKODA TRAILS		2/26/08	2/26/08	4/8/08	4/8/08	Misappropriation	Money	Staff	Misappropriation	Money	Substantiated	Non-County Operated Program
2008-009-0104	[redacted] LAUREN		TAKODA TRAILS		2/28/08	2/28/08	4/10/08	4/10/08	Alleged Abuse - PHYSICAL	Staff		Alleged Abuse - PHYSICAL	Staff	Insufficient evidence	Non-County Operated Program
2010-009-0006	[redacted] LAUREN	Empowering People Inc. dba CLW	TAKODA TRAILS		1/6/10	1/7/10	2/22/10	2/22/10	Unapproved Behavior Support	Mechanical	Locked seatbelt/ vest - not during transport				Non-County Operated Program
2011-009-0282	[redacted] LAUREN	The Creative Learning Workshop, LLC	The Creative Learning Workshop, LLC		7/21/11	7/21/11	9/15/11	9/15/11	Alleged Neglect	Supervision	Staff	Alleged Neglect	Supervision	Substantiated	Non-County Operated Program
2014-009-0477	[redacted] LAUREN	TAKODA TRAILS	TAKODA TRAILS		10/2/14	10/2/14	11/17/14	11/7/14	Alleged Neglect	Supervision	Staff	Alleged Neglect	Supervision	Substantiated	Non-County Operated Program
2014-009-0553	[redacted] LAUREN	TAKODA TRAILS	TAKODA TRAILS			11/18/14	1/2/15		Significant Injury	Injury (Unknown)					Non-County Operated Program

Takoda Trails

MUI/UI Investigation Form

Individuals Name Lauren [redacted]

Date of Incident: 11-18-14

Description of Incident: Significant Injury

Immediate Action: Resident was taken to orthopedic surgeon for assessment on the day that the injury was discovered.

Trend/Pattern No

Summary of Investigation: Lauren is a 27 yr old Caucasian female that resides in home [redacted] at Takoda Trails. Lauren's level of supervision is 5 minute checks during normal waking hours [visual range while out of bedroom and walking around. She is on visual range when outside and in the community and at CLW. Lauren is NPO and receives all nutrition and medications through via G-tube. Lauren is blind and has a history of accidentally closing her fingers in doors. There are body audits done on Lauren 3 x a day to ensure there are no injuries. An incident report is to be completed if an injury is noted. She is on 15 minute bed checks at night. Lauren is ambulatory and requires a gait belt when outside or other areas that are unfamiliar to her. She also wears a bodysuit at all times. Lauren's Code Status is Full Code. Her guardian is her father [redacted] and his mailing address is [redacted] Lauren's primary diagnosis is Profound MR. She has secondary diagnoses of Cerebral Palsy, Seizure D/O, Cortical blindness, Multiple Ottis Media, S/P PE tubes, History of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastromy w/Nissen,Chronic Periodonitis, Anhidrosis, and Nonserile Cataracts. On 11-18 LPN Sandy Osterberger was preparing to administer bolus medications to Lauren when she observed bruising to her chest and right shoulder and neck area. She noted that bruising was yellow in color and measured approximately 4 inches x 6 inches. She also noted a 1cm x 1cm raised area to right scapula. Sandy made this investigator as well as DON aware of this report immediately. COTA Jason Bode was also present with nursing for this assessment. An appointment was made for Lauren to be seen that afternoon by an orthopedic surgeon [Dr. Gangle] Dr. Gangle diagnosed Lauren with a closed fracture of the right clavicle and gave orders to keep Lauren in a wheelchair and wear the sling as tolerated and a follow up appointment was made for 4 wks.[12-15-14 at 10:30am.] A special team meeting was held and her level of supervision was increased.

Outcome: All staff that worked with Lauren in the past week including CLW staff were interviewed and witness statements were obtained. When interviewing staff members in the home it was determined that third shift staff complete Lauren's hygiene and get her dressed in the morning. The second shift staff would observe Lauren in the shower where they are able to complete an assessment. There were no witness statements that could confirm that this injury had been seen or reported in the 2 weeks prior to the day it was reported. During the interview process there was some information that was passed on to this investigator that could possibly be the cause

of the injury. On 11-2 Lauren was being given her PM shower when RSI Isaidy Dela Cruz reported that Lauren fell in the shower during what appeared to be a seizure. She reported that Lauren appeared to become weak and unsteady while standing in her shower holding the grab bar. Isaidy reported she went over to secure her and Lauren hit the wall in the shower stall striking her head as she lowered her to the floor and called for assistance. When I asked Isaidy if Lauren struck the wall with enough force to cause that type of injury she replied that she thought so. I asked her during the interview if she had seen the bruise and she told me that she had but since the incident had already been reported she assumed that the bruise was a result of that incident and that it would not require any further follow up. This is the only staff statement that confirms that a bruise was there other than the nurse's report on the 18th. This also is comparable to the timeline that Dr. Gangle reported that he estimated the bruise as being at least 2 wks old due to the brownish, yellow coloring. This is the only documented incident that would be a possibility of the origin of the injury. There was an injury that was reported on third shift the night of the 19th where Lauren was sent to the emergency room due to being noncompliant with treatment by the nursing department at Takoda. She received derma bond for closure of a cut above her left eye. Lauren's level of supervision was increased to a 1 on1 status when she returned to the facility after treatment. An inservice was implemented that morning making staff aware of the change in supervision as well as instructions for staff to use a gait belt at all times and to keep her in arms reach 24/7. This is the most likely scenario of how Lauren sustained this injury.

Recommendations/Prevention plan

Lauren will follow up with orthopedic surgeon Dr. Gangle for 4wk follow up. She will also be seen by Dr. Zakem [PCP] on next clinic day.

Level of supervision was increased to 5 minute checks on third shift and a few days later increased again to a 1 on 1 status.

A STM was held 12-2 to discuss Lauren's level of supervision and the best options to keep her safe when removing her 1 on 1 staffing ratio. Some of the ideas that were presented were a trial helmet, reinservice staff on keeping her shoes on when she is out of her room. They also discussed plastic furniture that would be age appropriate. Her dresser was put in her closet and the night stand was removed. Her bean bag chairs were taken out of her room and placed in the living room. The idea for gripper socks was discussed as well as 10 minute checks for third shift. The team met again on 12-5 to discuss how Lauren is adjusting to the changes implemented on 12-2. Lauren has adjusted with no major issues and will continue the current level of supervision. The team will continue to make adjustments to Lauren's care plan to keep her safe.

Completed by Investigator: _____ **Date:** 11-22-14

Reviewed by Administrator: _____ **Date:** 11.28.14

HEALTH

FUNCTIONAL ASSESSMENT **IP DATE:** 4/2/2014

Resident's Name: Lauren [redacted]

Code Status: Full

DOB: [redacted]

General Medical: Lauren is seen throughout the year on a routine and as needed basis. Nurses are in contact with the physician at the point of any change in condition that warrants physician intervention. 8/1/13 Sent to Mercy Fairfield ER for noted facial laceration. An examination was completed with sutures used for closure of the wound. Lauren returned home with N.O.'s to remove sutures in 5 days complete Neurochecks per protocol and follow up with Dr. Zakem on the next clinic day. 9/23/13 Seen by Dr. Zakem in clinic for follow up from recent ER visit for a fall. An examination was completed with all discharge instruction reviewed and N.N.O.'s or concerns noted with the area noted to be healed. 9/24/13 Sent to Mercy Fairfield ER where an examination and x-rays were completed for a noted bruise to the right arm. Lauren returned home with a diagnosis of Arm Bruise, N.N.O.'s and a recommended follow up later with Dr. Zakem if problems arise. 10/3/13 Received N.O. for Miralax 17gm in 8 oz of water QD for constipation. 10/22/13 Annual Flu Vaccination was administered in the left deltoid with no adverse reactions noted. 2/14/14 Sent to Mercy Fairfield ER for noted laceration over the left eye. An examination was completed with surgical glue used for closure of the wound. Lauren returned home with N.N.O.'s and recommendations to follow up with Dr. Zakem on the next clinic day and Neurochecks completed per protocol. 2/17/14 Received N.O. for Diastat 5mg rectally for seizure activity lasting longer than 5 minutes. 3/3/14 Seen by Dr. Zakem in clinic for follow up from recent ER visit for a fall. An examination was completed with all discharge instruction reviewed and N.N.O.'s or concerns noted with the area noted to be healed.

Physical Exam: 2/4/14 Seen by Dr. Zakem in clinic where an annual physical/pre-op dental examination was completed with N.N.O.'s. All medications, labs and consultations were reviewed with no other noted concerns.

Annual TB: 2/5/14 Annual PPD was administered in the right forearm with negative results and no adverse reactions noted.

Dental: 2/20/13 Seen at Miami Valley Dental where an examination, cleaning and x-rays were all successfully completed under General Anesthesia. N.N.O.'s or concerns were noted with a recommended follow up in 1 year. Scheduled at Miami Valley Dental to be seen under general anesthesia for yearly examination and cleaning.

Vision: 5/8/13 Seen by Dr. Sawyer in vision clinic where an examination was completed with adnexal erythema noted to the left eye. Received N.O. for Tobradex to the left eye BID and a recommended follow up in 2 months for more lid views. 7/30/13 Seen by Dr. Metzger in vision clinic where an examination was completed with the previous Blepharitis noted to be better bilaterally. N.N.O.'s or concerns were noted with a recommended follow up in 10 months.

Podiatry: 1/23/13 Seen by Dr. Kuvshinikov in podiatry clinic where an examination was completed with toenails trimmed and debrided bilaterally with N.N.O.'s and a recommended follow up PRN.

Neurology: Lauren is currently on Keppra for seizure control. Routine labs are drawn to monitor the levels of the noted medications. Seizures are noted to be controlled within the last year with Dr. White monitoring all lab results and graphic sheets as needed. 2/17/14 Seen by Dr. White in Neurology clinic where an examination was completed with all medications and seizure logs reviewed. Received N.O. to obtain a Keppra level on the next lab day and follow up in 6 months.

Psychiatry: Lauren is not currently on any psychotropic medications therefore psychiatric intervention is not warranted at this time.

GYN/Mammo: Guardian refuses any GYN examinations at this time. Mammograms are not indicated at this time due to Lauren's age.

Allergies: Sulfa, Reglan, Surgical Tape

Diagnosis: Profound MR, Cerebral Palsy, Seizure Disorder, Cortical Blindness, Multiple Otitis Media, S/P PE Tubes, Hx of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastromy with Nissen, Mycotic Nails, Chronic Periodontitis, Nonsenile Cataract, Anhidrosis, Dermatophytosis of Nail, Mechanical Ptosis, Blindness Both Eyes Impair Level.

Medications: Tylenol 160mg q4h/prn-elevated temperature, Diastat 5mg PRN-seizures, Claritin 10mg qd-allergic rhinitis, Keppra 1000mg bid-seizures, Fluticasone Nasal Spray 50mcg qd-allergic rhinitis, Miralax 17gm in 8oz. H2O qd-constipation, Bactroban-Clotrimin Cream to G-Tube site bid-preventative, Laclotion 12% bid-anhidrosis bilateral feet.

Signature: _____ **Title:** _____ **Date:** _____

TAKODA TRAILS

350 KOLB DRIVE * FAIRFIELD, OHIO 45014 * Phone: (513) 874-0423 * Fax: (513) 874-0598

We are committed to making a difference...one individual at a time.

Name	[redacted], Lauren	DOB	12-Sep-87
Gender	Female	Home #	4
Religion	Non-Denominational	Race	Caucasian
EC Name	[redacted]	EC Phone	[redacted]

MEDICAL INFORMATION

Allergies	Sulfa, Reglan, Surgical Tape	Code Status	Full Code
Prim Diag	Profound MR		
Sec Diag	Cerebral Palsy, Seizure D/O, Cortical Blindness, Multiple Otitis Media, S/P PE tubes, Hx of Intermittent Herpetic Stomatitis, Allergic Rhinitis, Constipation, S/P Gastromy w/Nissen, Mycotic Nails, Chronic Periodontitis, SEE BELOW FOR ADDTNL DX's:		
Attending Physician	Dr. Stuart Zakem Paper: 742-6730		
Primary Physician	Same as above		

FINANCIAL INFORMATION

SS #	[redacted]	Medicare	[redacted]
Case #		Medicaid	[redacted]
County	Butler	Private Ins info	

NOTIFY IN EMERGENCY

ALWAYS NOTIFY TAKODA TRAILS IN CASE OF AN EMERGENCY.

EC Name	[redacted]	EC Phone	[redacted]
EC Relationship	Guardian/Father		
EC Address	[redacted]		
Alternate Contact	ADD'L DX's: Nonsenile Cataract, Anhidrosis, Dermatophytosis of Nail [redacted]		

Admission Date:12/23/02 Updated: 6/7/13 jln

Takoda Trails

Special Team Meeting

Name of Individual: Lauren [redacted] **Home/Unit:** [redacted]

Date of Meeting: 12/5/14

Discussion & Opinions:

Team met to discuss how Lauren is adjusting to her new level of supervision. Lauren has adjusted fine this far with no problems. Team agrees to continue level of supervision and plan

Kimberly Burkholder QIDP 12.5.14
Signature/Title/Date

TAKODA TRAILS

DATE: 12.2.14 Time: hrs:_____ min:_____

TITLE OF IN-SERVICE: STM Lauren [redacted]

Verification/Presenter(s) Signature: Print Last Name

Attendance: Signature indicates that person(s) in attendance will be responsible for this in-service information and will perform their job duties accordingly.

PRINT NAME	FACILITY
[signature]	Takoda
Lori Bale, RDLD	TT
Kimberly Burkholder	TT
Steve Higgins	TT
Tarsen Bale	TT

Takoda Trails

Special Team Meeting

Name of Individual: Lauren [redacted] **Home/Unit:** [redacted]

Date of Meeting: 12/2/14

Discussion & Opinions:

Team met to discuss Lauren's supervision level and ways to keep her safe.

remove 1:1 supervision

- trial helmet
- re-inservice on shoes
- plastic furniture?
- put dresser in closet
- remove night stand
- remove bean bags - put in living room
- grip socks?
- lotion morning and night
- 10 min checks for third
- out of room until bathing or toileting

Kimberly Buskidder 12/2/14

Signature/Title/Date

Special Team Meeting
Signature Sheet
Lauren [redacted]
12/5/14

The following people were invited and served on this Individuals Team:

Signature and Title:

Kimberly Burkholder QIDP

[illegible], OT

[illegible] R. [illegible], PTA

[illegible]

[illegible]

☐ Individual was not in attendance at today's meeting because ______________________

____

____

As a result of missing his/her special team meeting, the IP was reviewed with him/her by:

____
Signature/Title/Date of Review

☐ The guardian was not in attendance at today's meeting because ______________________

____

____

Takoda Trails
Special Team Meeting Consent

Name of Individual: **IP Span:**

Date of Meeting:

JICK RESPONSE - EMPOWERING PEOPLE, INC.

Full Facility Name: INDIAN TRAILS

Incident Date: 11/18/14

Clinical Consultant (RN) reviewer of QR: CINDY ROWE

Incident Time:

Primary ICD-9 Dx Code [redacted]

Person/Title Reporting: LYNNE WHITAKER, RN

Social Security # [redacted]

Resident Name: LAUREN [redacted] Male or Female: FEMALE

Incident Type

2nd Tier Events In Bold Types Require Immediate Notification Via Phone

- Allegation of Causing Harm or Death ☐
- Allergic Reaction Resulting In Significant Harm / Death ☐
- Appliance / Equipment Related Injury ☐
- Ashpyxiation / Drowning ☐
- Avoidable Stage III, IV, or Unstageable In-House Developed ☐
- Body Alteration, Lost Limb, Wt Loss, Infect., Pressure Ulcer ☐
- Choking or Aspiration Requiring Nsg. Intervention, Heimlich ☐
- Closed Head Injury Leading to Death or Serious Injury ☐
- Dehydration Developed In-House Requiring Hosp. or IV ☐
- Discharge AMA ☐
- Electric Shock With Death ☐
- Elopement With or Without Injury ☐
- Fall With Injury Requiring Outside Treatment ☐
- Fire, Flood or Other Reason to Evacuate ☐ (Record All for Res Name)
- Heat Exposure or Burn - Chemical, Smoking, Thermal ☐
- Homicide or Suicide - Attempted or Actual ☐
- Impaction Requiring Hospitalization ☐
- Prohibited Sexual Contact ☐
- Incident of Equipment Malfunction Without Injury ☐
- In-House Fracture ☑
- Kidnapping ☐
- Media or Police at Facility ☐
- Med / Treatment Error/Omission with Harm ☐
- Med Error Resulting in Injury, Hospitalization or Death ☐
- PT / INR of 9 or Greater ☐
- Restraint / Bed Entrapment With Injury ☐
- Restraint / Bed Entrapment Without Injury ☐
- Sig. Lacerations or Unusual Events Resulting In Hosp. Visit ☐
- Physical/Sexual/Verbal Abuse/Peer-to-Peer w/injury ☐
- Unresolved Resident / Family Complaint ☐
- Suspicious / Accidental Death ☐
- Visitor incident With Injury (complete as possible) ☐
- Unapproved Behavior Support with injury ☐

Incident Location:

Activity Room ☐ Dining Room ☐ Lounge ☐ Resident's Room ☐
Basement ☐ Hallway ☐ Outside ☐ Shower ☐
Bathroom ☐ Lobby ☐ Nurses' Station ☐ Other: UNKNOWN

Video Camera

Does your facility use video cameras? Yes ☐ No ☐
If yes, was this incident caught on camera? Yes ☐ No ☐
If yes, where is the video being stored?

Description of Incident: (If Incident is a MUI, may also send MUI reporting form)

LARGE YELLOW BRUISE NOTED TO (R) CHEST, NECK + BACK. AREA APPROX. 4 INCHES x 6 INCHES - IRREGULAR IN SHAPE. RAISED AREA APPROX 1CM x 1CM x 1CM. RED IN COLOR TO TOP OF RIGHT SHOULDER. THIS AREA ~ 1CM x 1CM x 1CM. RED IN COLOR TO TOP OF RIGHT SHOULDER. JASON BODE, PTA LOOKED AT AREA WITH NURSING + RESIDENT SEEN BY DR. GANGLE, ORTHO THAT DAY

Resident Outcome: 1) type of injury 2) where is resident 3) what type of tx is required 4) If sent out when/if resident expected to return.

CLOSED FRACTURE OF (R) CLAVICLE NOTED ON XRAY. MD ORDER TO KEEP IN W/C + WEAR SLING AS TOLERATED. F/U IN 4 WEEKS - 12/15/14 @ 10 am. MD FELT INJURY 1-2 WEEKS OLD D/T COLORATION OF BRUISING.

Family Response:

FATHER OK WITH FRACTURE - FEELS THAT WE WON'T BE ABLE TO KEEP HER IN A WHEELCHAIR

Director of Nursing Response:

Progress Notes reviewed ☐ Yes ☐ No
Unusual Incident Report reviewed ☐ Yes ☐ No
Date Investigation will be completed by: ______
MUI sent to County Board ☐ Yes ☐ No

cc: Attorney/Ernest Auciello/Tucker-Ellis

11/01/14 [redacted] LAUREN 63

ACETAMINOPHEN 160MG/5ML LIQUID -IE TYLENOL
TAKE 5ML (160MG) PER FEEDING TUBE EVERY 4 HOURS AS NEEDED FOR ELEVATED TEMP
12/23/02 M31126546

DIASTAT ACU 2PK-5,7.5,10MG 5-7. F
INSERT 5MG PER RECTUM AS NEEDED FOR SEIZURES >5MIN R
N
10/17/14 R1856785H

NAPAP 160MG/5ML SOLUTION -IE Napap (acetaminophen)
GIVE 20.3ML (650MG) PER G-TUBE EVERY 4 HRS AS NEEDED MINOR PAIN
++MAX 4GM AP/AP/DAY++
12/01/11 R15851187

ONDANSETRON HCL 4MG TABLET -IE ZOFRAN 4MG F
TAKE 1-2 TABLETS PER MICKEY TUBE EVERY 12 HOURS AS NEEDED FOR R
NAUSEA FOR 12 DOSES (STOP) N
04/24/14 R18072722

FLUTICASONE PROPIONATE 120 MCG 7:30AM
INSTILL 2 SPRAYS IN EACH NOSTRIL DAILY IN THE MORNING (ALLERGIC RHINITIS)
01/18/10 R17663426

LEVETIRACETAM 100MG/1ML SOLUTIO -IE KEPPRA 7:30AM
TAKE 10ML (1000MG) PER FEEDING TUBE TWICE A DAY DX:SEIZURES

03/26/12 R18070610 7:30PM
LORATADINE 10MG TABLET -IE CLARITIN 7:30A
TAKE 1 TABLET PER TUBE DAILY (ALLERGIC RHINITIS) (HOUSE STOCK)

05/01/12 R16259927
POLYETHYLENE GLYCOL 17GM/1DOSE -IE MIRALAX 7:30AM
DISSOLVE 17GM IN 8OZ OF FLUID AND TAKE PER TUBE DAILY DX: CONSTIPATION
05/14/13 R18243633

APPLY ALPHA HYDROX SKIN LOTION TO BILAT FEET EVERY EVENING FOR DRY SKIN

10/01/08 A3591005 10P
COMPOUND DRUG UNIT 7:30AM
CLOTRIM:BACTROBAN CREAM 1:1 -- APPLY TOPICALLY TO G-TUBE SITE TWICE A DAY (PREVENTATIVE)
04/20/08 M31127427 7:30PM

LACLOTION* 12% LOTION -IE LAC HYDRIN
APPLY TO BOTH FEET TWICE A DAY PER DCS (ANHYDROSIS)

02/09/10 R14214042

MAY CRUSH MEDS

**** CODE STATUS ****

FULL CODE

*** DIET ORDER ***

NPO

*** ENTERAL FEEDING/FLUSH ORDERS ***
FIBERSOURCE HN @ 375CC 4 TIMES A DAY PER MIC TUBE
FLUSH G-TUBE WITH 225ML WATER 4 TIMES A DAY
FLUSH MIC TUBE WITH 200ML CRANBERRY JUICE DAILY
VERIFY PLACEMENT OF MIC TUBE VIA ASPIRATION AND AUSCULTATION PRIOR TO ANY ADMINISTRATION
CHECK RESIDUAL OF MIC TUBE AND HOLD IF >100CC FOR 1 HOUR
FLUSH MIC TUBE WITH 30ML WATER AT BEGINNING AND END OF EACH TUBE FEED
FLUSH MIC TUBE WITH 15ML WATER AFTER EACH MED PASS
FLUSH WITH 5CC OR GREATER OF WATER BETWEEN EACH MEDICATION

*** LABORATORY ORDERS ***
ANNUAL CBC, CAP, TOTAL CHOLESTEROL: OCT

*** PPD/MANTOUX ORDER ***
ANNUAL PPD: FEB

*** PLAN OF TREATMENT ***
CLEANSE MIC SITE WITH SOAP & WATER, APPLY DRAIN SPONGE AS NEEDED
SKIN ASSESSMENT EVERY WEEK (FRI)
KEEP HEAD OF THE BED ELEVATED 30-45 DEGREES FOR 30 MINUTES AFTER BOLUS FEEDING
CHECK FOR IMPACTION AND REMOVE MANUALLY AS NEEDED
MICKEY FEED TUBE 18F 2.5CM -REPLACE AS NEEDED

*** VITAL SIGNS / WEIGHT ***
CHECK WEIGHT & VITAL SIGNS AND RECORD EVERY MONTH BY THE 15TH (6P-6A)

*** ANCILLARY ORDERS ***
PODIATRY SERVICES ARE INDICATED FOR THIS PATIENT DUE TO THICKENED MYCOTIC DISCOLORED AND OR INGROWN TOENAILS THAT COULD CAUSE PAIN OR INFECTION
PODIATRY, DENTAL, OPTHALMOLOGY, OPTOMETRIST, AUDIOLOGIST CONSULT AS NEEDED

DIAGNOSIS CONTINUED

RETARDATION, CHRONIC SUPPURATIVE OTITIS MEDIA, CONSTIPATION

PHYSICIAN'S SIGNATURE:_____ DATE:_____
ABOVE ORDERS REVIEWED BY:_____ DATE:_____

PHYSICIAN : STUART A. ZAKEN 513-748-6730
ALT PHYS :
PTYP- DHUMM SEX F DOB [redacted]
PT.ID : ADMIT-
ACC- 63

ALLERGIC RHINITIS, D/O VISUAL CORTEX ASSOC W/CORTICAL BLINDNESS, HERPETIC GINGIVOSTOMATITIS, OTH FORM EPILEPSY & RECUR SEIZURE NO INTRACT EPIL, INFANTILE CEREBRAL PALSY, PROFOUND MENTAL
Sulfa (Sulfonamide Antibiotics); Reglan; Adhesive Tape

11/01/14

[redacted] AUREN 63

INFLUENZA VACCINE: "INJECT 0.5ml IN ONE TIME ONLY DURING FACILITY FLU VACCINATION PROGRAM (Unless contraindicated due to allergies - Refer to chart)

MOBILITY AS PER PLAN OF CARE
MAY HAVE THERAPEUTIC LOA DAY WITH MEDICATIONS SENT
MAY HAVE P.T., O.T., SPEECH EVALUATION AND TREATMENT AS INDICATED PER IPP YEAR
MAY LEAVE FACILITY FOR SCHEDULED WORKSHOP AND OUT OF FACILITY FUNCTIONS
MEDICATIONS MAY BE GIVEN AT SCHOOL, WORKSHOP OR CAMP
MAY EVALUATE FOR SWIM PROGRAM AND PARTICIPATE IN SWIMMING AS NEEDED
THESE ORDERS ARE GOOD FOR 60 (SIXTY) DAYS
MEDICATION ADMINISTRATION TIME MAY BE DELAYED IF RESIDENT IS OUT OF THE BUILDING
"THESE ORDERS ARE IN EFFECT FOR ONE YEAR UNLESS OTHERWISE DESIGNATED OR LIMITED BY LAW"
"UNLESS ORDERD AS AN EMERGENCY MEDICATION OR SPECIFIED AS A STAT BY THE PHYSICIAN, ALL ORDERS ARE PRESUMED TO BE ADMINISTERD ON THE FIRST SCHEDULED MEDICATION TIME FOLLOWING THE NORMAL DELIVERY BY THE PHARMACY"
"PATIENT MAY BE EVALUATED AND BY PROVIDE CONTRACT WITH MOBILE CARE GROUP FOR AUDIOLOGIST AND OR PSYSICIST SERVICES"

*** BOWEL PROTOCOL ***

BISACODYL 5MG TAB EC -IE DULCOLAX 5MG TABLET STEP 1: IF NO BM IN 48 HOURS GIVE BISACODYL (10MG) 2 TABLETS BY MOUTH X 1 (OR USE SUPP) PRN
BISAC-EVAC 10MG SUPP.RECT -IE BISAC-EVAC OR: GIVE BISACODYL SUPPOSITORY (10MG) INSERT 1 RECTALLY X 1 PRN ENEMA DISPOSABLE 19G-7G/118 ENEMA -IE FLEET STEP 2: IF DISACODYL NOT EFFECTIVE OVERNIGHT, CHECK FOR IMPACTION DIGITALLY & REMOVE PRN FOLLOW WITH FLEETS ENEMA (R) X 1

DIAGNOSIS CONTINUED

RETARDATION, CHRONIC SUPPURATIVE OTITIS MEDIA, CONSTIPATION

PHYSICIAN'S SIGNATURE:_____ DATE:_____
ABOVE ORDERS REVIEWED BY:_____ DATE:_____

ALLERGIC RHINITIS, D/D VISUAL CORTEX ASSOC W/CORTICAL BLINDNESS, HERPETIC GINGIVOSTOMATITIS, OTH FORM EPILEPSY & RECUR SEIZURE NO INTRACT EPIL, INFANTILE CEREBRAL PALSY, PROFOUND MENTAL
Sulfa (Sulfonamide Antibiotics); Keflex; Adhesive Tape

1/01/2014

11/01/14 [redacted] LAUREN 63

ALL MEDICATIONS REVIEWED BY RPH:_____ DATE:_____
__ See report for any noted irregularities.
__ Based upon the information available at the time of review, and assuming the accuracy & completeness of suc it is my professional judgement that at such time, the resident's medication regimen contained no new irregula (as defined in SDH Appendix PP 483.60 (c)).
ORDERS REVIEWED BY:_____
DATE:_____

DIAGNOSIS CONTINUED
RETARDATION, CHRONIC SUPPURATIVE OTITIS MEDIA, CONSTIPATION

PHYSICIAN'S SIGNATURE:_____ DATE:_____
ABOVE ORDERS REVIEWED BY:_____ DATE:_____

TOTAL RX: 12 TOTAL ROUTINES: 8 TOTAL PRN: 4

PHYSICIAN : STUART A. ZAKEN 513-748-6730
ALT PHYS :
PTYP- DHUMM SEX F DOB- [redacted]
PT.ID : ADMIT-
ACC- 63

ALLERGIC RHINITIS, D/B VISUAL CORTEX ASSOC W/CORTICAL BLINDNESS, HERPETIC GINGIVOSTOMATITIS, WITH FORM EPILEPSY & RECUR SEIZURE NO INTRACT EPIL, INFANTILE CEREBRAL PALSY, PROFOUND MENTAL
Bulfa (Sulfonamide Antibiotics); Keflan; Adhesive Tape

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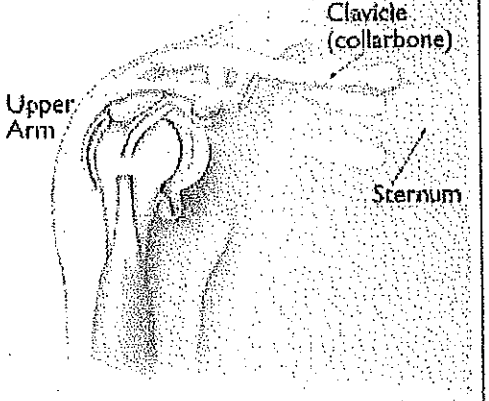
Clavicle Fracture (Broken Collarbone)

A broken collarbone is also known as a clavicle fracture. This is a very common fracture that occurs in people of all ages.

Anatomy

The collarbone (clavicle) is located between the ribcage (sternum) and the shoulder blade (scapula), and it connects the arm to the body.

The clavicle lies above several important nerves and blood vessels. However, these vital structures are rarely injured when the clavicle breaks, even though the bone ends can shift when they are fractured.



The clavicle is part of your shoulder and connects your ribcage to your arm.

Reproduced from The Body Almanac. (c) American Academy of Orthopaedic Surgeons. 2003.

Description

The clavicle is a long bone and most breaks occur in the middle of it. Occasionally, the bone will break where it attaches at the ribcage or shoulder blade.

There are many types of shoul. injuries:

- Fractures are broken bones. Fractures commonly involve the clavicle (collar bone), proximal humerus (top of the upper arm bone), and scapula (shoulder blade).
- Dislocations occur when the bones on opposite sides of a joint do not line up. Dislocations can involve any of three different joints.
  - A dislocation of the acromioclavicular joint (collar bone joint) is called a "separated shoulder."
  - A dislocation of the sternoclavicular joint interrupts the connection between the clavicle and the breastbone (sternum).
  - The glenohumeral joint (the ball and socket joint of the shoulder) can be dislocated toward the fron (anteriorly) or toward the back (posteriorly).
- Soft-tissue injuries are tears of the ligaments, tendons, muscles, and joint capsule of the shoulder, such as rotator cuff tears and labral tears.

The following discussion will focus on fractures and dislocations.

Cause

Fractures

Fractures of the clavicle or the proximal humerus can be caused by a direct blow to the area from a fall, collision, or motor vehicle accident.

Because the scapula is protected by the chest and surrounding muscles, it is not easily fractured. Therefore, fractures of the scapula are usually caused by high-energy trauma, such as a high speed motor vehicle accident. Scapula fractures are often associated with injuries to the chest.

Shoulder Dislocations

- Anterior dislocations of the shoulder are caused by the arm being forcefully twisted outward (external rotation) when the arm is above the level of the shoulder. These injuries can occur from many different causes, including a fall or a direct blow to the shoulder.
- Posterior dislocations of the shoulder are much less common than anterior dislocations of the shoulder. Posterior dislocations often occur from seizures or electric shocks when the muscles of the front of the shoulder contract and forcefully tighten.

Shoulder Separations

Dislocations of the acromioclavicular joint can be caused by a fall onto the shoulde objects. The term "shoulder separation" is not really correct, because the joint injur true shoulder joint.

Symptoms of Fractures

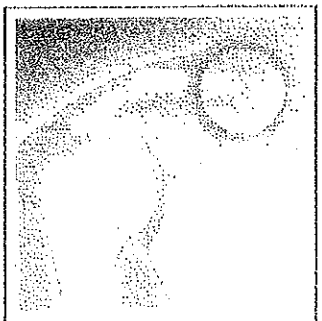
Symptoms of fractures about the shoulder are related to the specific type of fracture.

General Findings

- Pain
- Swelling and bruising
- Inability to move the shoulder
- A grinding sensation when the shoulder is moved
- Deformity -- "It does not look right"

Specific Findings: Clavicle Fracture

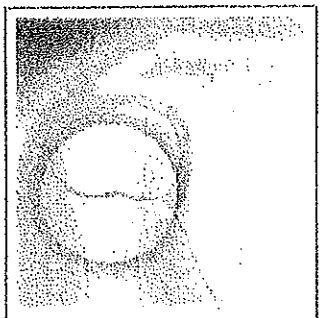
- Swelling about the middle of the collarbone area
- An area that may have a "bump," which is actually the prominent ends of the fracture under the skin
- Shoulder range of motion is limited, although not as much as with fractures of the proximal humerus



Fractured clavicle (collarbone)

Specific Findings: Proximal Humerus Fracture

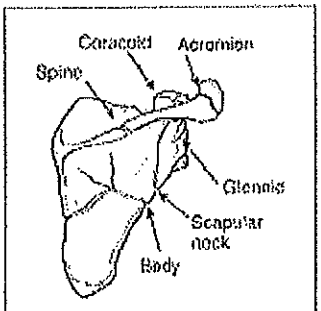
- A severely swollen shoulder
- Very limited movement of the shoulder
- Severe pain



Fractured head of the humerus.

Specific Findings: Scapular Fracture

- Pain
- Swelling
- Severe bruising about the shoulder blade



Fracture patterns in the scapula

(Reproduced with permission from Zuckerman JD, Koval KJ, Cuomo F: Fractures of the scapula, in Heckman JD (ed) Instructional Course Lectures 42. Rosemont, IL, American Academy of Orthopaedic Surgeons, 1993, pp 271-281.)

Specific Findings: Shoulder Separation (Acromioclavicular Joint Separation)

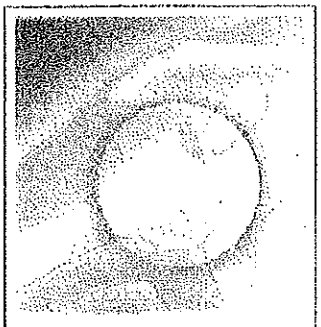
- Pain over the top of the shoulder
- A prominence or bump about the top of the shoulder
- The sensation of something sticking up on the shoulder

An acromioclavicular joint dislocation with extreme elevation of the clavicle.

(Reproduced with permission from Huber GW, Bowen MK: Acromioclavicular joint injuries and distal clavicle fractures. J Am Acad Orthop Surg 1997;5:11-18.)

Specific Findings: Shoulder Dislocation (Glenohumeral Joint Dislocation)

- A prominence about the front of the shoulder
- Inability to move the arm
- An arm rotated outward
- The sensation of a "dead arm"



Shoulder instability

Diagnosis

Most fractures are diagnosed with X-rays of the area and by physical examination. Sometimes, additional imaging techniques, such as computed tomography, are necessary.

Treatment Options

Clavicle Fractures

Most clavicle fractures can be treated without surgery. Surgery is necessary when there is a compound fracture that has broken through the skin or the bone is severely out of place. Surgery typically involves fixing of the fracture with plates and screws or rods inside the bone.

Proximal Humerus Fractur

Most fractures of the proximal humerus can be treated without surgery if the bone fragments are not shifted out of position (displaced). If the fragments are shifted out of position, surgery is usually required. Surgery usually involves fixation of the fracture fragments with plates, screws, or pins or it involves shoulder replacement.

Scapula Fractures

Most fractures of the scapula can be treated without surgery. Treatment involves immobilization with a sling or shoulder immobilizer, icing, and pain medications. The patient will be examined for additional injuries.

About 10% to 20% of scapula fractures need surgery. Fractures that need surgery usually have fracture fragments involving the shoulder joint or there is an additional fracture of the clavicle. Surgery involves fixation of the fracture fragments with plates and screws.

Shoulder Separations (Acromioclavicular Joint)

Treatment of shoulder separations is based on the severity of the injury as well as the direction of the separation and the physical requirements of the patient.

Less severe shoulder separations) are usually treated without surgery.

Severe separations in an upward direction or dislocations in the backward or downward directions often require surgery. Surgery involves repair of the ligaments.

Professional athletes and manual laborers are often treated with surgery, but the results are often unpredictable.

Shoulder Dislocations (Glenohumeral Joint)

The initial treatment of a shoulder dislocation involves reducing the dislocation ("putting it back in the socket"). This usually involves treatment in the emergency room.

The patient is given some mild sedation and pain medicine, usually through an intravenous line. Often, the physician will pull on the shoulder until the joint is realigned. Reduction is confirmed on an X-ray and the shoulder is then placed in a sling or special brace.

Additional treatment at a later date is based on the patient's age, evidence of persistent problems with the shoulder going out of place, and the underlying associated soft-tissue injury (either to the rotator cuff or the capsulolabral complex).

Patients who are 25 years of age or younger generally require surgery. Persistent instability (repeat dislocations) of the shoulder usually requires surgery. Surgery involves repair of the torn soft tissues.

Life After a Shoulder Injury

Life after a shoulder fracture, separation, or dislocation can be greatly affected for several weeks or even months. Most shoulder injuries whether treated surgically or nonsurgically require a period of immobilization followed by rehabilitation.

If the injury was not severe, there is fairly rapid improvement and return of function after the first 4 to 6 weeks. Shoulder exercises, usually as part of a supervised physical therapy program, are usually necessary. Exercises decrease stiffness, improve range of motion, and help the patient regain muscle strength.

What Should You Discuss With Your Orthopaedic Surgeon?

Some of the information you should discuss with your orthopaedic surgeon includes the following:

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Shoulder Trauma (Fractures and Dislocations)

Trauma to the shoulder is common. Injuries range from a separated shoulder resulting from a fall onto the shoulder to a high-speed car accident that fractures the shoulder blade (scapula) or collar bone (clavicle). One thing is certain: everyone injures his or her shoulder at some point in life.

Anatomy

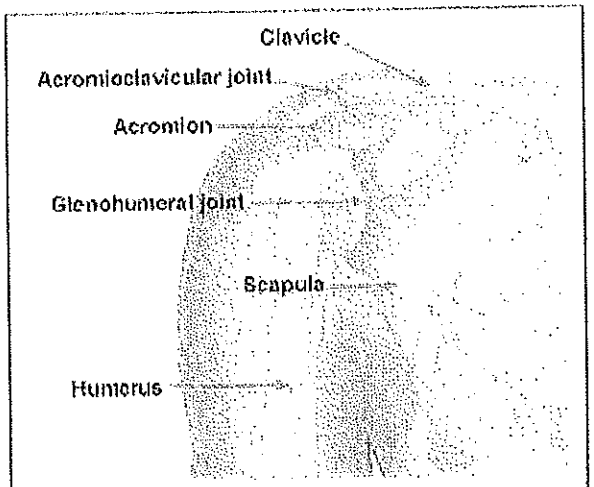
The shoulder is made up of three bones:

- Scapula (shoulder blade)
- Clavicle (collar bone)
- Humerus (arm bone)

These bones are joined together by soft tissues (ligaments, tendons, muscles, and joint capsule) to form a platform for the arm to work.

The shoulder is made up of three joints:

- Glenohumeral joint
- Acromioclavicular joint
- Sternoclavicular joint



Shoulder Anatomy

The shoulder also has one articulation, which is the relationship between the scapula (shoulder blade) and the chest wall.

The main joint of the shoulder is the glenohumeral joint. This joint comprises a ball (the humeral head) on a golf-tee-shaped joint (the glenoid of the scapula).

The bones of the shoulder are covered by several layers of soft tissues.

- The top layer is the deltoid muscle, a muscle just beneath the skin, which gives the shoulder a rounded appearance. The deltoid muscle helps to bring the arm overhead.
- Directly beneath the deltoid muscle is sub-deltoid bursa, a fluid-filled sac, analogous to a water balloon.

Types of Shoulder Injuries

- The exact type of your in
- The severity of the injury
- The treatment plan
- The possible complications
- Whether surgery will be necessary
- When it is expected that you will be maximally improved
- What is the expected outcome will be both in the short term and in the long term

Last reviewed: September 2007

Orthopaedic Trauma Association

Co-developed by the Orthopaedic Trauma Association

AAOS does not endorse any treatments, procedures, products, or physicians referenced herein. This information is provided as an educational service and is not intended to serve as medical advice. Anyone seeking specific orthopaedic advice or assistance should consult his or her orthopaedic surgeon, or locate one in your area through the AAOS "Find an Orthopaedist" program on this web site.

Related Articles

Clavicle Fracture (Broken Collarbone) (http://orthoinfo.aaos.org/topic.cfm?topic=A00072)

Dislocated Shoulder (http://orthoinfo.aaos.org/topic.cfm?topic=A00035)

Fractures (Broken Bones) (http://orthoinfo.aaos.org/topic.cfm?topic=A00139)

Scapula (Shoulder Blade) Fractures (http://orthoinfo.aaos.org/topic.cfm?topic=A00359)

Shoulder Separation (http://orthoinfo.aaos.org/topic.cfm?topic=A00033)

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Takoda Trails - Unusual Incidents

Includes all UIs and MUIs for [redacted] Lauren from 1-1-14 to 11-1-14

Date	Time	Name	MUI	Incident Type	Incident Summary	Prevention Plan
09-Jan-14	9:00 PM	[redacted]	☐	Open Area	during pm hygiene staff reported 0.4 cm x 0.25 cm open area to clients right lower knee	add padding to bed frame and desk
01-Feb-14	8:03 AM	[redacted]	☐	Injury: Scratch/Scrape	Staf attempted to interven client roaing hallways slamming doors	resident observed in dining room when attempted to get up had fell
10-Feb-14	7:12 AM	[redacted]	☐	Injury: Minor Cut	during am hygiene she ran into the corner of her dresser and resulted in a cut under her left eye	padding applied to corners of dresser.
14-Feb-14	3:30 AM	[redacted]	☐	Injury: Minor Cut	resident was in her room when staff heard her screaming and upon checking on her observed a small cut 3cmx1cm to left side of face and 4cmx2cm red bruise noted to top of left shoulder	resident sent to Mercy South ER for follow up plan is to pad door knobs and dressers for Lauren's protection
11-Mar-14	7:57 AM	[redacted]	☐	Injury: Reddened Area	during pericare resident was noted to have a 3cmx2cm reddened area on her knee	total body audits implemented
15-Mar-14	1:30 PM	[redacted]	☐	Open Area	1.4cm x1.3cm open area on her forehead that was an old wound and had reopened	continue body audits
17-Mar-14	4:45 PM	[redacted]	☐	Injury: Scratch/Scrape	staff reported an irregular abrasion on Laurens left wrist	finger guards put on all hinged doors
24-Mar-14		[redacted]	☐	Injury: Scratch/Scrape	Resident noted to have scratch on forehead	attempt to use a headband and continue supervision level
26-Mar-14	10:30 PM	[redacted]	☐	Injury: Scratch/Scrape	Resident noted to have 1.5cmx0.5cm abrasion on right ankle	tube socks purcjased to protect lower leg area
24-Apr-14	4:15 PM	[redacted]	☐	Illness	resident sent home from workshop with elevated temperature and emesis	a new order for potassium chloride 15mls mic tube T/D daily for 9 doses Zofran 4mg tab 1-2 tabs per mic tube a12 hrs prn
08-May-14	10:45 PM	[redacted]	☐	Injury: Scratch/Scrape	While staff was changing Laurens attend they noticed scratched toL upper arm.	Multiple scratched noted to L upper arm. Approx. 0.25cm Areas cleaned with soap and water TAO apply. N.O. TAO BID X 5 days. Staff inserviced on body audits,nail trimmig and BSP for uncooperative behavior.

Date	Time	Name	MUI	Incident Type	Incident Summary	Prevention Plan
19-Jun-14	7:30 PM	[redacted]	☐	Injury: Bruising	Staff was asssiting resident with evening hygiene when they noticed a bruise and scratch on resident's left thigh	QIDP in-serviced staff to intervene if they see the resident about to bump into objects in the house.
30-Jun-14	8:00 PM	[redacted]	☐	Injury: Bruising	Bruise on left side of forhead. Nurse and QIDP both checked Lauen neither one saw a brusie on her forhead.	QIDP informed staff that it was a scar on her forhead.
03-Jul-14	2:20 PM	[redacted]	☐	Illness: Infection	Resident was walking in the hallway when staff noticed her left eye was red	Resident diagnosed with pink eye. Doctor prescribed antibiotic drops 3x/day for 5 days.
01-Aug-14	7:00 AM	[redacted]	☐	Injury: Minor Cut	Lauren was observed when receiving morning hyigene to have blood and her sheets. Left pinky toe noted to have open area with Red drainage. Area cleansed with soap and water TAO applied.	Staff inserviced to dress Lauren first if she is ambulating around room. This way she will have shoes on and avoid further injury.
08-Aug-14	8:00 AM	[redacted]	☐			
08-Aug-14	8:00 AM	[redacted]	☐	Injury: Reddened Area	While walking through kitchen stafff noted L eye was red. Nurse assessed L eyelid red no drainage or pain noted.	Staff will continue current level of supervision, no possible causes inside house found.
08-Aug-14	12:00 AM	[redacted]	☐			
11-Aug-14	9:05 AM	[redacted]	☐	Safety Concern	resident observed bumping her head when she ran into the wall	continue to report injuries so they are addressed in a timely manner and redirect Lauren if you see there might be a potential danger
18-Aug-14	4:59 PM	[redacted]	☐	Injury: Scratch/Scrape	Staff went to get Lauren from her room and noted she was crying and scraming and had a scrape on her shin. Abrasion to left shin red in color noted.	Staff to adhere to 5 min checks to ensure Lauren does not get hurt while she is in her room.
18-Aug-14	4:59 PM	[redacted]	☐	Injury: Scratch/Scrape	resident was noted to have an abrasion to her left shin red in color	Staff will adhere to level of supervision while resident is in her room
18-Aug-14	4:59 PM	[redacted]	☐			
29-Aug-14	9:50 PM	[redacted]	☐	Injury: Scratch/Scrape	Staff reported a 3cmx1cm superficalscratch to right side of hip and a 2cmx1cmscratch to her left elbow.	Staff will continue to redirect alaauren

Date	Time	Name	MUI	Incident Type	Incident Summary	Prevention Plan
25-Sep-14	8:00 AM	[redacted]	☐	Injury: Scratch/Scrape	resident noted to have 2cm in diameter abrasion to left pinky toe	place maint order to have padding reinforced on her furniture

WITNESS STATEMENT

Witness Name: Vickie Hawks

Witness Position:

Witness Date of Hire: 10/23/12

DESCRIPTION OF INCIDENT

Date of Incident: _____ Time of Incident: _____

Location of Incident: _____

Summary: I wasn't Assign to lauren the last two week I didnt see her fall

Vickie Hawks
Signature

11/20/14
Date this statement is completed

Rev: 1/7/14

WITNESS STATEMENT

Witness Name: Cindy De la Cruz

Witness Position:

Witness Date of Hire:

DESCRIPTION OF INCIDENT

Date of Incident: 11-2-14 Time of Incident: 7pm

Location of Incident: Home 5

Summary: I did Notice Some bruising after Lauren's shower incident, but because I had reported the accident I did not think I needed to report the bruising. There was bruising on Lauren's left shoulder and a little down her upper back.

Signature

11-21-14
Date this statement is completed

Rev: 1/7/14

MUI CLOSURE FORM

Must be completed for all MUIs.

INTAKE SECTION	
Incident Number: 553	Individual's Name: Lauren [redacted]
Category: Significant Injury	Circle: Protocol or Non-Protocol
Investigator's Name: RL	DODD Due Date: 1/2
Does the MUI involve a county board unit staff as the PPI?	Yes or (NO)
If Yes, the IA must complete all duties typically completed by the Program Secretary.	

IA SECTION
Include the complete name/address (physical or email) for each person below. Mark N/A if does not apply. If a letter should not be sent, indicate that below and indicate reason.
Individual or Individual's Guardian/Advocate:
[redacted]
Provider(s):
Takoda Trails
Provider(s) at the time of incident (if different than above):
Support Coordinator:
NA
Primary Person Involved: RECEIVES PPI LETTER ONLY, NO SUMMARY LETTER
NA
Date Recommended for Closure 1/2

PROGRAM SECRETARY SECTION
List the date each task was completed below. Mark N/A if the task does not apply.
Date Summary Letters Sent: 1/4
Date of Closure: 1/2
Date Closure Notification Sent:
Date PPI Letter Sent :
Date Death Certificate Sent: