Allegation
On March 7, 2017, the Office of the Inspector General received a reported allegation of neglect from a complainant. It is alleged that, on March 4, 2017, individual XXXXX was admitted at the hospital, in the intensive care unit, in critical condition because of falling out of his wheelchair, while transferring to the toilet, on the evening of March 3, 2017. XXXXX sustained a subdural hematoma and may require surgery; it was also reported XXXXX sustained a fractured leg, during October 2016. The complainant was suspicious that XXXXX could sustain such a serious injury, if staff were present when he fell, on March 3, 2017.

Synopsis
On February 10, 2017, XXXXX fell and sustained a minor injury to his head. Staff on scene followed proper agency protocol, in reporting the injuring and instructions were given to monitor XXXXX for any changes. There were none. On March 3, 2017, XXXXX fell again, while transferring to the toilet. The staff on scene was unable to break his fall and the injury to XXXXX’s head reopened but was treated with first-aid. Again, staff followed proper agency protocol, on reporting the incident and injury and instructions were given to monitor XXXXX for any changes. On the morning of March 4, 2017, XXXXX did not act his normal self and staff followed protocol, in reporting his condition to the team leader and agency nurse; however, it was not until another staff person arrived on scene, later that day, to take XXXXX to an urgent care clinic, per direction from the nurse, was it determined to call 911 for XXXXX, based on his altered mental state. XXXXX was transported to the hospital and diagnosed with a traumatic subdural hematoma. XXXXX was admitted to the intensive care unit, neuro unit and eventually to a skilled nursing facility, in hospice care for this injury and other medical issues. Considering all the available information regarding XXXXX’s care, XXXXX reported that, even if XXXXX’s medical evaluation had not been delayed, his treatment and outcome would likely have been unchanged. However, XXXXX’s health and safety was placed at substantial risk, when he was not evaluated in a timely manner, due to apparent agency systemic communication and staffing issues. It was also determined the agency staff and the agency itself, provided adequate medical care and personal care to XXXXX, regarding his fractured leg.

Findings
Based on the facts in this case the following was concluded: The allegation of neglect is substantiated against Trinity Services, Inc.

Recommendations
The Office of the Inspector General recommends the following: The agency considers development and training of a protocol, allowing staff to communicate directly with agency medical staff, about a situation,
so all information can be obtained first hand and questions could be asked by medical staff, of the direct
caregiver. If unable to assess the individual in person, agency medical staff must ask direct questions to
properly assess the individual’s status. The agency ensure that adequate and appropriate staffing is
provided, based on the needs of the individuals. And, the agency considers development and training of an
appropriate protocol, for calling 911 vs. non-emergency transportation of an individual, to an emergency
room for additional evaluation of a potential illness/injury.