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February 14, 2013

James M. Boles
President and CEO
People, Inc.
1219 North Forest Rd.
PO Box 9033
Williamsville, N.Y. 14231-9033

Dear Mr. Boles:

The Commission on Quality of Care and Advocacy for Persons with Disabilities (the Commission) has concluded its investigation into the July 10, 2011, incident involving a former resident of one of the Individualized Residential Alternative's (IRA) operated by People, Inc., in which the resident (hereafter referred to as Elizabeth Bern, a pseudonym) suffered a spiral fracture of the left humerus. This letter has been revised from its original to remove any identifying personal and clinical information protected from public disclosure.

The Commission first became aware of the incident in the spring of 2012, when Ms. Bern's mother sent a letter expressing concern that two investigations into this incident conducted by People, Inc. were deficient in a number of ways. Based on its review, the Commission agrees that the investigations conducted by People, Inc. were deficient; but that People, Inc.'s finding substantiating neglect on the part the three accused staff was appropriate. The Commission, however, questions why People, Inc. failed to discipline one staff member despite the fact that contradictory statements were offered by the staff and falsification of the resident's medication administration record (MAR) was confirmed.

To conduct its review, the Commission obtained copies of the two investigations conducted by People, Inc., the agency's taped interviews, personnel files, clinical record information for Ms. Bern and medical records related to the treatment of the injury and subsequent rehabilitation.

On January 22, 2013, the Commission sent People, Inc., a draft letter of findings regarding its investigation which you responded to on February 4, 2013. People, Inc.'s responses have been incorporated into each finding along with the Commission's reply, if applicable. People, Inc.'s entire redacted response is attached to this letter.

Chronology of Events

- On Sunday, July 10, 2011, Ms. Bern, along with three other residents of the IRA, attended a circus in the community. While leaving the circus, Ms. Bern fell. A direct care staff person (staff #1), who was supervising the individuals at the circus, assisted Ms. Bern up and returned to the IRA at approximately 9:00 p.m.
- Upon return to the IRA, a second direct care worker (staff #2), was just ending her shift. Reportedly, another resident told staff #2 about the fall, but that Ms. Bern was okay. A third direct care worker, (staff #3), who was also at the IRA, signed that she applied powder and foot cream to Ms. Bern at 9:00 p.m. and then ended her shift at 9:15 p.m.
- At 9:45 p.m. that evening, staff #1 completed a “body check sheet” and an “agency incident report” recording that Ms. Bern had a “minor injury.” Reportedly, while assisting Ms. Bern into her pajamas, Ms. Bern complained of arm pain and an inability to extend her arm more than half-way up. Ms. Bern complained on more than one occasion that evening that her arm hurt. At approximately 11:00 p.m. that evening, staff #1 contacted the home’s program manager to report the incident and stated that (according to the program manager) Ms. Bern was not complaining of any pain. According to staff #1, that night Ms. Bern slept comfortably.
- Again, according to staff #1, the next morning, July 11, 2011, Ms. Bern came downstairs for her 6:00 a.m. medication and complained that her arm was hurting. Staff #1 stated that she checked the arm and added additional information (bruise on left upper arm) to the body check sheet. Later that morning, at 7:00 a.m., staff #1 recorded in the MAR that she again applied powder and foot cream to Ms. Bern’s feet; and recorded in her procedure record that she supervised Ms. Bern brushing her teeth (the time was not recorded in the procedure record).
- At 7:01 a.m. that morning, staff #4, a direct care worker at the IRA, reported to work. According to staff #4, staff #1 shared information about the fall and that Ms. Bern was complaining of arm pain. Staff #4, however, stated that Ms. Bern was not downstairs upon staff #4’s arrival at the residence and that Ms. Bern did not come downstairs at any time that morning. Staff #4 said that when checking-in on another resident that morning around 7:30 a.m., staff #4 looked-in on Ms. Bern and observed the resident sleeping. At 9:00 a.m. that morning, staff #4 reported checking again on Ms. Bern, who staff #4 reported “couldn’t get out of bed because [Ms. Bern’s] arm hurt.”
- At 9:15 a.m. that morning, a registered nurse arrived at the residence. The nurse reported finding Ms. Bern in bed in a supine position, with the right knee swollen and a “few bruises” on her left upper arm. The nurse stated that Ms. Bern was in pajamas which were wet from urine and that there were dried feces on her pajamas and body. The nurse said that the urine was “a ring around... sheets and just in the middle was wet but the outside ring was dry.” The nurse felt this was a “clue that Ms. Bern was obviously in pain and not willing to get up throughout the night to go to the bathroom.” The nurse assisted Ms. Bern to the shower and get dressed and instructed staff to call Ms. Bern’s primary medical doctor for an appointment.
- Staff #4 took Ms. Bern to the primary physician at 10:30 that morning. The physician’s notes record that staff stated that Ms. Bern “Had been in normal health until yesterday when Ms. Bern tripped at the circus and hit her knee and shoulder. The staff noted the

right knee was swollen. No change in ambulation. Able to dress herself this am.” The physician notes further reflect that although Ms. Bern’s shoulders showed “no superficial abnormalities” Ms. Bern “did refuse to move her left shoulder.” The physician ordered an x-ray of Ms. Bern’s left shoulder but stated “most likely will be negative.” After the physician’s visit, staff #4 returned Ms. Bern to the IRA where she was then taken by staff #5 to Western NY Imaging Group for the x-ray.

- At 12:30 p.m., the x-ray revealed that Ms. Bern had an “oblique fracture of the proximal left humerus and a small subacromial spur.” Ms. Bern never completed the exam at Western NY, but was ordered to go immediately to Buffalo General Hospital’s emergency room for treatment.
- Buffalo General Hospital examined Ms. Bern and also took an x-ray which revealed a “spiral fracture mid diaphysis of the left humerus with moderate displacement and angulation of the fracture fragments. No associated shoulder or elbow fracture or dislocation seen. Osteopenia. Degenerative changes to right knee.” Impression noted as “humeral fracture.”
- On July 19, 2011, nine days after the incident occurred, People, Inc. initiated an investigation into the incident. The first interviews and pictures were completed on July 21, 2011. As a result of the investigation, an allegation of neglect was substantiated against staff; however, it was not clear from the investigation what action or actions were considered negligent on the part of the staff members involved.
- On November 28, 2011, People re-opened its investigation of the incident after Ms. Bern’s mother expressed dissatisfaction to OPWDD about the findings and recommendations of the first investigation. OPWDD agreed to conduct a second investigation jointly with People, Inc., which concluded on January 23, 2012. This second investigation found numerous deficiencies with the first investigation, which People, Inc., has addressed.

Commission Findings

1. Both investigations by People, Inc., were deficient.

The Commission found both investigations to be deficient and not comprehensive. Specifically, the Commission found:

- The nine-day delay in starting the investigation resulted in the delay of interviewing witnesses and the potential loss of critical information surrounding the incident. Additionally, it provided witnesses time to discuss their impressions of what occurred, thus influencing everyone’s recall of the incident and subsequent care.
- There was a significant delay (11 days) in interviewing the Ms. Bern, which may have resulted in the loss of pertinent information regarding the incident, details of the fall, and how and by whom Ms. Bern was assisted after the fall.
- Photographs were not taken immediately following Ms. Bern sustaining the injuries.

- Both investigations either missed contradictions in staff statements or decided not to confront interviewees on the contradictions. For example, during the first interview, staff #1 claimed to have checked on Ms. Bern during the night. However, in the second interview staff #1 stated that she did not check on Ms. Bern that evening.
- Both investigators failed to obtain minute-by-minute detail of Ms. Bern's activities from the time she arrived at the circus to the arrival at the emergency room, which would have provided more details of the incident and identified all potential witnesses to be interviewed. For instance, it is still unclear exactly what time Ms. Bern spent at the circus and when she returned home, as neither investigation inquired about the time of events.
- Investigators provided interviewees with incident details and asked leading questions instead of soliciting information from the interviewees.
- Investigators did not highlight that Ms. Bern is usually independent in ADLs, including being able to put on a seat belt, and is left-handed, the arm that was fractured. Therefore, her inability to complete these tasks independently after the fall should have been identified as a red flag for an injury.
- Investigators did not identify a list of all people present at the residence, throughout the time period under review, as possible witnesses and therefore did not interview all potential witnesses.
- The investigations did not describe the clothing Ms. Bern was wearing throughout the time period under review nor the vehicle(s) Ms. Bern was transported in throughout this incident. Ms. Bern got into and out of an agency vehicle with a fractured arm eight times between the fall and going to the ER; yet, no one described her condition or demeanor during these transports.
- People, Inc. did not seek explanation regarding how Ms. Bern had dried feces and urine on her and in her bed at 9:00 a.m. on July 11, 2011. Yet, Ms. Bern reportedly came downstairs twice between 6:00 a.m. and 7:00 a.m. to take medications (self-administered from a locked box in the staff office, which she would have had to unlock independently), have a body check sheet completed and eat breakfast without staff #1 noticing feces and urine on her.
- None of the staff actions noted in Ms. Bern's Individual Protective Oversight Plan (IPOP) such as conducting checks during shift changes, at meal times and at medication administration times were identified by investigators as opportunities during which Ms. Bern would have had to use her injured arm. Staff was not questioned by investigators about whether these required IPOP staff actions took place.

OPWDD found similar deficiencies in its review of People, Inc.'s first investigation. As a result, People, Inc., made numerous revisions to its policies and procedures.

People, Inc., response: People, Inc. disagreed that the investigation as finalized was "deficient" and pointed out that OPWDD and three separate People, Inc., departments reviewed the investigation and deemed it "thorough." People also stated that it is unclear

how many of the items mentioned by the Commission would have a meaningful impact on the resolution of the incident, and that while some of the items “may have arguably represented best practices, they did not result in a deficient investigation as defined by Part 624 regulations.”

Commission reply: The 11 issues raised by the Commission are areas in which the investigators should reevaluate their actions to improve future investigations. Not only are the investigative techniques best practices, they are basic skills that all investigations should incorporate. The fact that People, Inc., a large and sophisticated agency, did not incorporate these techniques is incredible to the Commission. The Commission maintains that both investigations were deficient.

2. People failed to discipline staff even though conflicting statements were made and documents appeared to be falsified.

Staff members made a number of conflicting statements in the two investigations that were never reconciled. For instance, in the first investigation, staff #1 stated that she checked on Ms. Bern during the evening of the fall and that Ms. Bern was sleeping comfortably. In the second investigation, staff #1 stated that she did not check on Ms. Bern that evening. Additionally, the next morning, staff #1 claimed that when Ms. Bern came downstairs around 6:00 a.m. to take medication, Ms. Bern complained of arm pain. Reportedly, Ms. Bern returned to bed and then came back downstairs at 7:00 a.m. to self-administer medications, eat breakfast and then return to the bedroom again. Staff #1 reported on the MAR that powder and foot cream was applied at 7:00 a.m. that morning. Staff #1 also recorded in a procedure record that she supervised Ms. Bern with tooth brushing that morning. However, staff #4, who arrived at 7:00 a.m. that morning, stated that they did not see Ms. Bern downstairs upon arrival and that it was only after the nurse arrived around 9:00 a.m. that Ms. Bern was assisted out of bed. The nurse stated that Ms. Bern was found in bed with pajamas wet from urine and dried feces on the pajamas and body. Yet, no one from People, Inc. questioned these contradictions or the apparent false reporting by staff #1 in the MAR and procedure record.

People, Inc. response: People, Inc., disagreed with the Commission’s finding stating “In regard to item 2 we disagree that People, Inc., failed to discipline employees. Many of the so-called inconsistencies referred to in the letter arose after months of re-interviews and by the time the report was finalized further action against staff #1 was moot.”

Commission reply: Other than staff being retrained, the Commission found no evidence that staff were disciplined in response to the investigations into the injury. While staff #1 and the house manager were moved to other residential sites, it was not in response to People, Inc.’s investigation of this incident. As noted in another section of People, Inc.’s letter, staff #1 was not very cooperative during the investigations. The Commission contends that a staff person unwilling to cooperate during an investigation should be a red flag to an agency. Staff #1’s behavior, coupled with People, Inc.’s conclusion that staff #1 could not have completed the foot treatment, although she signed the MAR as having done so, warranted a Human Resources Department response.

3. People, Inc., inaccurately reported the incident and subsequent events

According to staff statements, Ms. Bern complained of arm pain immediately after the fall on July 10, 2011, and continued to state it hurt that evening. However, the agency

incident report makes no mention of Ms. Bern's complaints throughout the evening and inaccurately described the incident as: "On Sunday, 7/10/2011, Ms. Bern fell while at the Circus, an incident report & body check sheet were completed. Monday morning (7/11/2011) Ms. Bern complained of pain in her left arm."

In addition, People, Inc.'s initial investigator inaccurately related twice under description of the incident in the investigation report that it wasn't until "Monday morning (7/11/2011), Ms. Bern complained of pain in her left arm." Also, in the report the investigator writes "RN did assessment, MD appointment was made, and Ms. Bern received x-rays at MD office, and went to BGH where it was diagnosed as a closed fracture of humerus." Although this is technically accurate, noting the time of day would let the reader know that it took several hours from when Ms. Bern was first seen by the nurse at 9:00 a.m. until arrival at the hospital at 1:30 p.m. that afternoon.

Finally, the second investigative report is misleading as it states that staff #1 and the house manager were moved to other agency operated IRAs as a result of the agency investigations of this incident; when in fact, each staff person was moved to another IRA based on their actions in subsequent unrelated incidents.

People, Inc.'s response: People, Inc., disagreed with the Commission's finding stating "We disagree with the finding that People, Inc. inaccurately reported the incident." The limited space on the 147 form allows for only a concise description of an incident. In addition, "more importantly, regardless of perspective on the exact language, neither of these items have any relevance to, nor impact on the resolution of the primary issues of the case."

Commission reply: The Commission disagrees that the fact that Ms. Bern complained of pain immediately upon falling and during the evening was irrelevant for the incident report narrative. OPWDD and the Commission review incident reports as they are received and/or entered into IRMA. A narrative describing that an individual complained of pain immediately after a fall in the evening, complained of pain during the hours subsequent to the fall and then did not receive medical attention until late the following morning would elicit questions. The investigator knew the facts before writing up the report. The items have relevance to the accurate portrayal of what occurred.

4. The Commission agrees with People, Inc.'s determination that staff were negligent.

Despite the deficiencies in both investigations, the Commission agrees with People, Inc.'s determination that staff members #1, #4 and the house manager neglected the resident when they failed to obtain timely medical intervention. Interview statements make it clear that the resident was complaining of pain from the time of the fall while leaving the circus on the evening of July 10, 2011, through the morning of July 11, 2011. In addition, the resident exhibited signs of pain by an inability to complete usually independent activities of daily living (ADLs). However, the resident's injury went unaddressed for approximately 12 hours.

People, Inc.'s response: People, Inc., disagreed with the Commission's finding stating that they "never determined negligence. It is not clear that "negligence" occurred. Our investigation looked at Part 624 from a QI perspective."

Commission reply: The Commission concurred with People's determination that "the allegation of neglect is substantiated."

5. The cause of the resident's fracture was inconclusive but most likely the result of the fall.

The two investigations conducted by People, Inc., never addressed the question as to what caused Ms. Bern's fracture. Instead, it was assumed that the cause was the fall. The Commission asked its Medical Review Board (MRB) to review the case and determine the cause of the fracture. The MRB opined that the cause of the fracture was inconclusive; specifically stating:

"The spiral fracture is consistent with a fall in which Ms. Bern either reached out to catch herself by putting [a] hand out to break [the] fall, or while pushing herself up when being assisted by someone else. This fracture appears to have happened innocently, rather than deliberately. Ms. Bern's osteoporosis made ... bones weaker and someone trying to help Ms. Bern up by holding her upper arm could have innocently caused this fracture. The injuries to her right side could have occurred if Ms. Bern landed on her right side when she fell. This fracture is not indicative of abuse or deliberate trauma."

The MRB based its finding on its review of the circumstances surrounding the fall, a review of Ms. Bern's medical records and a review of the x-rays. The MRB also found that the ligament damage sustained by Ms. Bern was most likely caused by the fracture sustained, and was compounded by Ms. Bern's age and osteoporosis. The MRB further opined that Ms. Bern could have chronic ligament damage as a result of the fracture.

People, Inc.'s, response: People, Inc., agreed with the Commission's finding.

Lastly, your letter states that "The CQC investigators when they were here in October asked if this matter had been submitted to our insurance carrier and demanded written proof of the same." This is untrue. While reviewing staff #1's personnel file, there was a notation that People, Inc.'s, insurance company had been notified. The Commission asked the HR department if the notification to the insurance company was in reference to the incident under review and the person printed out a copy of the notation and provided it to the Commission. Your characterization that we demanded written proof is incorrect.

The Commission considers this review completed. We will be forwarding this letter and your response to OPWDD. The Commission appreciates the assistance provided by your staff during this review. Please feel free to contact me at 518-388-0520, should you have any questions.

Our findings letter, your reply, and our response, if any, will be publicly available and may be posted to the Commission's website. Confidential or privileged material will be redacted prior to any such disclosure.

Sincerely,

Pamela A. Williams
MHFRS II
Fiscal Bureau

cc: OPWDD



People Inc

Where your world opens up

February 4, 2013

Pamela A. Williams, MHFRS II
Fiscal Bureau - State of New York
Commission on Quality Care and Advocacy
For Persons with Disabilities
401 State Street
Schenectady, NY 12305-2397

[REDACTED]
Dear Ms. Williams:

I am writing on behalf of People Inc. in response to your letter dated January 22, 2013 on behalf of the Commission on Quality of Care and Advocacy for Persons with Disabilities (CQC) regarding the incident involving [REDACTED] occurring on July 10, 2011.

Thank you for your letter and analysis. People Inc. has a long history of cooperation with OPWDD and CQC to work to improve the quality of care we provide. We look forward to any insights and recommendations provided by CQC that we can implement.

Let me first comment on the substantial efforts of People Inc. in regard to reviewing this situation. The matter was first reported as a reportable injury. That was later upgraded and an investigation was completed by our QI on or about 7/29/2011. Because of items that [REDACTED] mother expressed, People Inc. approached the local DDSO to become involved in the situation, even offering to let them do the investigation. Our thought was [REDACTED]'s mother would not be satisfied with any investigation or resolution we performed. While the OPWDD declined to become involved in performing the investigation per se they did provide substantial comments resulting in several months of additional investigation and responses. In fact OPWDD was intimately and actively involved in this matter in an oversight role. The vigor in which this matter was pursued by People Inc. even resulted in one of the staff contacting the HR department because she felt the QI investigator was too aggressive. The final investigation was not closed until March of 2012 and was over seventy pages when completed. Over twenty individuals were interviewed and many re-interviewed, policies and procedures were modified and many staff were retrained. We have taken all steps reasonably within our power to thoroughly investigate this matter and implement appropriate corrective steps. The investigation was closed by our SRC and accepted by OPWDD.



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James M. Boles, Ed.D. President and CEO

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Mary Ann Kedron, Ph.D. Chairperson, Board of Directors

OPWDD in a letter dated July 12, 2012 to [REDACTED]'s mother noted the investigation was determined to be "thorough" by the Division of Quality Improvement, Office of Investigations and Internal Affairs and the Director of Nursing and Health Services. The matter is long closed.

We were also contacted by the Department of Health responding to a complaint of [REDACTED]'s mother but they declined jurisdiction. Additionally, we are aware of a number of individuals contacted by [REDACTED]'s mother and we made all levels of management available to her for countless conversations to provide her with adequate opportunity to express her concerns.

Significantly we learn from your letter that after a several month review by CQC the primary substantive issues are in relative agreement; [REDACTED] who has osteoporosis, fell at the circus, broke [REDACTED] arm in the fall and ideally should have received medical attention sooner. No specific regulatory or statutory deficiencies were noted and no further findings regarding part 624 were suggested.

In an attempt to respond fully I see two areas you may be seeking input on. The first being the actions in regard to the employees named in the letter and the second being the numbered sections (items 1-5).

In regard to the employees, it should be noted that [REDACTED] went out on leave in February of 2012 and never returned. She was resigned from the agency thereafter. She refused to answer any inquiries and was effectively out of contact prior to the matter being finalized. Thus further action in regard to her became moot. As to the other employees [REDACTED] and [REDACTED] it was felt the corrective action taken in regard to them was sufficient. It is not clear from your letter what further steps you feel should be taken in regard to them or the probative value relative to the quality of care provided.

In regard to the Commission's findings listed in items 1-5, there is no list of recommendations or items to implement, more a list of concerns some we feel are contextually out of place and some using seemingly inapplicable terms. Consider section 4 on page 5 entitled "The Commission agrees with People's determination that staff were negligent". The term "negligent" is inapplicable to this situation. People Inc. never determined negligence. Our investigation was related to part 624, it was not a criminal or tort investigation. The finding dealt with definitions under 624. The CQC investigators when they were here in October asked if this matter had been submitted to our insurance carrier and demanded written proof of the same. Is the focus Quality Improvement or is it related to a legal perspective?

In regard to item 1 we disagree that the investigation as finalized was "deficient". I point to the above referenced letter of our regulatory oversight agency OPWDD and the three separate departments that independently reviewed this matter in great detail all finding the same, "thorough". I am fairly confident that few investigations/incidents have ever gotten this level of review, revision, additions and remedial efforts. When taken in context of the findings and

actions by People Inc. to address the issues it is unclear how many of the items mentioned under item 1 would have a meaningful impact on the resolution of the incident. While some items listed may arguably represent best practices and have already been included in agency procedures the same do not result in a deficient investigation under the definition contained in part 624.

In regard to item 2 we disagree that People Inc. failed to discipline employees. Many of the so-called inconsistencies referred to in the letter arose after months of re-interviews and by the time the report was finalized further action in regard to [REDACTED] was moot.

In regard to item 3 we disagree with the finding that People Inc. inaccurately reported the incident. Apparently the initial 147 is being quoted and it is intended to be a quick summary to start the process. The form itself provides a small area to fill in; and should be "concise". See OPWDD form 147 instructions. I am not aware of the incident description on the 147 being referred to like this before, it being such a minor item in the scope of the incident. Additionally the document as written is accurate. [REDACTED] fell at the circus and complained of pain the next day. I am assuming the Commission is desirous of including more items in the description regarding [REDACTED] expression of pain the night before. While such items may be relevant in the substance of the investigation they do not make factually accurate statements inaccurate. The letter also says, the investigator said it "wasn't until Monday morning" that [REDACTED] complained of pain in [REDACTED] arm. That is not what the investigator said; there is nothing affirmatively stating [REDACTED] did not complain before then. The "description of incident" is as an overview reflecting the investigators first information not a comprehensive list of all facts or findings. The investigation goes on to fully outline a number of items directly related to this issue. When taken as a whole there was clearly no intent to be inaccurate about anything. In both the 147 and investigation it appears a case of preferring additional language, in effect a judgment call, but it does not point out factually inaccurate statements. More importantly, regardless of perspective on the exact language, neither of these items have any relevance to, nor impact on the resolution of the primary issues of the case.

As to the reason for the employees move there are a number of factors that go into such decisions the investigator may not know all of them but generally speaking those moves arose out of the situation at hand either directly or indirectly. Again the relevance of such things is not clear to me.

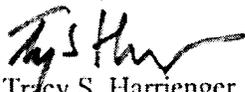
In regard to item 4, because of differing applicable standards, which I will be glad to discuss in detail with you, as noted above People Inc. never determined negligence. It is not clear that "negligence" occurred. Our investigation looked at part 624 from a QI perspective.

In regard to, item 5 we are in agreement that the most likely cause of the break was the fall.

Because this matter deals specifically with the review of a QI investigation and is part of the QI process all privileges applicable to such process apply to this letter and any correspondence related to it generated by this agency or your office.

If you should have any questions in regard to anything herein please do not hesitate to contact me. I know this is a complicated matter and we are open to any further conversations to clarify and QI matters or answer any questions of the family. We look forward to continuing our cooperation with CQC.

Sincerely,

A handwritten signature in black ink, appearing to read "Tracy S. Harrienger". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Tracy S. Harrienger, Esq.
General Counsel