STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345434	A. BUILDING _____ B. WING _____	C 07/25/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CARVER LIVING CENTER	303 EAST CARVER STREET DURHAM, NC 27704

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The survey team entered the facility on 7/19/19 to conduct a complaint investigation and exited the facility on 7/21/19. Additional information was obtained on 7/23/19 and 7/25/19. Therefore, the exit dated was changed to 7/25/19. Ten of the ten allegations were unsubstantiated.	F 000		
F 610 SS=D	Investigate/Prevent/Correct Alleged Violation CFR(s): 483.12(c)(2)-(4) §483.12(c) In response to allegations of abuse, neglect, exploitation, or mistreatment, the facility must: §483.12(c)(2) Have evidence that all alleged violations are thoroughly investigated. §483.12(c)(3) Prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress. §483.12(c)(4) Report the results of all investigations to the administrator or his or her designated representative and to other officials in accordance with State law, including to the State Survey Agency, within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. This REQUIREMENT is not met as evidenced by: Based on record review, staff, resident, physician, and family interviews, the facility failed to thoroughly investigate an injury for one of four residents (Resident #2) reviewed for accidents. The facility failed to investigate the plausibility of the injury and the discrepancies in Resident #2's statements before concluding the investigation.	F 610	Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice; Resident #2 informed staff on 6/4/19, that she ran into the wall the night before and hurt her legs. Resident #2 was evaluated	8/9/19

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

Electronically Signed | 08/08/2019

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F 610	Continued From page 1 Findings included: Documentation in the facility abuse and neglect protocol stated, "All reports of resident abuse, neglect and injuries of unknown source shall be promptly and thoroughly investigated by facility management." Resident #2 was admitted to the facility on 7/28/17. She had diagnoses of peripheral vascular disease, Diabetes Mellitus Type 2, Depression, acquired absence of right leg below the knee (10/17), acquired absence of left leg below the knee (10/17), and rotator cuff tear or rupture of right shoulder (3/19). Documentation in a quarterly minimum data set assessment dated 4/18/19 revealed Resident #2 was coded as dependent on one person for locomotion on and off the unit. The resident was coded as cognitively intact with a Brief Interview for Mental Status score of 15 out of 15. Resident #2 was coded as incontinent of both bowel and bladder. The assessment listed Resident #2 as being 38 inches tall or 3 foot 2 inches and 164 pounds. Resident #2 received physical therapy services from 4/2/19 to 5/1/19 to increase mobility and decrease pain in her right shoulder. Documentation in the physical therapy progress notes dated 4/2/19 revealed the resident was able to propel her wheelchair 100 feet with a pain level of 8 out of 10. Documentation in the physical therapy progress notes dated 4/25/19 revealed the resident was able to propel her wheelchair 250 feet with a pain level of 4 out of 10. Documentation in the physical therapy discharge summary dated 5/1/19 stated the resident was	F 610	by the Nurse Practitioner and xrays were obtained with results of bilateral femur fractures. Resident #2 was sent to the hospital, where she told the hospital staff that she ran into the wall causing the injuries. On June __6__, 2019, the family spoke with the Administrator, and made an allegation that they felt the injury was a result from something besides Resident #2 running into the wall. The Administrator initiated a 24 hour report for injury of unknown origin on June___6_, 2019, and an investigation was started. Resident #2, staff, physician, nurse practitioner, and other residents were interviewed. Resident #2 continued to say that she ran into the wall causing the injury. The Administrator concluded the investigation on June _11__, 2019 and submitted to the state agency, with conclusion that the facility could not substantiate an incident of unknown origin. On June__17_, 2019, Resident #2 told a staff member that she had fallen in the van when she was being transported back to the facility from a doctors appointment. The administrator was made aware, and investigation was initiated to determine to validity of the allegation. Resident #2, staff members and other residents were interviewed. The facility was not able to validate if the incident had occurred in the van. Yet again on June _20___, 2019, a staff member overheard resident on the phone stating “Im tired of lying. Im going to tell them I fell at home.” The Administrator interviewed Resident #2 regarding this statement and she denied. The family	

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F 610	Continued From page 2 moderately independent for wheelchair mobility. Documentation in the care plan dated as last reviewed on 5/5/19 revealed a focus area for a risk for falls relative to impaired mobility secondary to bilateral lower extremity amputations, psychoactive medication, weakness, balance deficits and open angle glaucoma. One of the interventions was to review information on past falls, attempt to determine cause of falls, record possible root causes, remove any potential causes if possible, and educate resident/family/caregivers/interdisciplinary team as to causes. Documentation on a facility resident sign out/in sheet revealed Resident #2 signed out of the facility on 6/2/19 at 2:20 PM. There was no signature or time documented for the resident's return to the facility on 6/2/19. Documentation in the nursing notes dated 6/3/19 revealed Resident #2 went out for an orthopedic appointment regarding her right shoulder. Documentation in a physician progress note dated 6/4/19 at 2:33 PM revealed Resident #2 was complaining of bilateral knee pain. The documentation stated, "She states she was in her wheelchair and bumped into the door last night while trying to maneuver in her room. She states she hit the door quite hard and has had pain since then. She states both knees are painful, and acetaminophen is not helping the pain. She states it is a constant, throbbing pain that currently is an 8/10, but reports it was up to a 10/10 last night. She has been up in her wheelchair at her baseline today, and states the	F 610	were interviewed and they denied that an incident occurred at home or while she was with them. A complete and thorough investigation was conducted by the facility each time the resident made a statement regarding how her injury occurred. The Administrator submitted an addendum to the 24 hour/5 day on August 8, 2019, that was originally submitted on June _6___, 2019, to include, that after the 5 day was submitted, the facility received information on June __17__ , 2019, of possible cause of injury, but after thorough investigation the facility was unable to determine the actual cause of the incident. Address how the facility will identify other residents having the potential to be affected by the same deficient practice; Current facility residents that have had injuries of unknown origin are at risk to be affected by the alleged deficient practice. The facility completed an audit of incidents dated May 1, 2019 through August 8, 2019, to identify residents with injuries of unknown origin. There were no injuries of unknown origin identified. There were no other 24 hour/5 day reports of incidents of unknown origin for the dates May 1, 2019-August 8, 2019. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur; On July 29, 2019, the Regional Clinical	

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F 610	Continued From page 3 pain is not worse, but is not better. No other complaints." The progress note revealed a full assessment including her skin, with no notations of bruising. The documentation of the assessment of the resident's skin in the progress note stated, "Left shoulder with evidence of excoriation, but no visible rash." The documentation of the assessment of the resident's extremities in the progress note revealed both her knees were swollen but had no redness. Documentation in a nursing note dated 6/4/19 at 4:36 PM stated, "Resident [complained of] pain in legs and NP (nurse practitioner) made aware and saw resident who stated she hit her legs by running into wall last night on accident. NP wrote order for X-ray to [bilateral] knees for [increased] pain and also order written for Tramadol [as needed]. Will continue to monitor." Documentation in a nursing note dated 6/4/19 at 8:10 PM revealed the resident was sent to the emergency room due to a pain level of 10 out 10. The documentation stated, "When EMS (Emergency Medical Services) arrived resident told EMS personnel she had ran [into] the wall on the previous day, although resident did not inform the writer. X-ray results were in at the moment and EMS got a copy of the result." Documentation on x-ray results of the knees and upper thighs of Resident #2 dated 6/4/19 revealed she had fractured both her legs above the knee and had very weak bones or osteopenia. The nurse practitioner (NP #1) who wrote the 6/4/19 progress note was interviewed on 7/19/19	F 610	Director provided education to the Director of Nursing and the Administrator regarding completion of a thorough investigation related to allegations and the process for competing an addendum and submitting to the state agency if more information is received after the 5 day report is submitted. The Administrator will review and approve 24 hour and 5 day investigations prior to submission to the state agency, to validate that a thorough investigation has been conducted. If more information is received after the 5 day has been submitted, the Administrator will re-open the investigation and submit the additional information to the state agency as an addendum to the original investigation. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; The Administrator and/or the Director of Nursing will review 24 hour/5 day reports weekly for 4 weeks then monthly for 2 months, to validate that a thorough investigation was completed and the reports were submitted to the state agency. The Administrator and/or the Director of Nursing will review the audits monthly to identify any patterns or trends and will adjust the plan as necessary to maintain compliance. The Administrator and/or the Director of Nursing will review the plan during the monthly QAPI meeting and the audits will	

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F 610	Continued From page 4 at 4:15 PM. NP #1 stated she saw Resident #2 on a regular basis since September of 2018. NP #1 revealed she saw Resident #2 on 6/4/19 due to the resident's complaint of pain in her knees. NP #1 indicated the resident told her she had bumped into the door with her knees while in the wheelchair on the night of 6/3/19. NP #1 described the resident's upper legs as swollen and tight with the resident being in extreme pain. NP #1 stated she ordered x-rays and pain medication for the resident. NP #1 stated she did not see Resident #2 again until the morning of 6/6/19 and looked at the x-rays at that point. NP #1 stated she questioned if Resident #2 ran into a wall causing the injuries to her legs and she ordered bone density testing. NP #1 stated, "My major concern was a low velocity fracture is the Hallmark of osteoporosis." NP #1 stated she was further involved in the investigation because the family of Resident #2 became concerned on 6/6/19 that something else besides Resident #2 bumping into a wall had happened to cause the fractures. NP #1 stated that the Administrator told her the van driver had stated Resident #2 had bumped into a wall while at the orthopedic appointment on 6/3/19. NP #2 stated she called the orthopedic office and spoke with the physician's assistant. The Physician's assistant told NP #1 the orthopedic appointment on 6/3/19 was uneventful, Resident #2 did not hit a wall at the orthopedic appointment and was assisted with locomotion inside the orthopedic office. NP #1 indicated she could not be certain of the cause of the resident's injuries to her legs because later the resident changed her version of cause of the injuries. NP #1 stated it was plausible the resident's injuries could have occurred if the resident ran into a wall.	F 610	continue at the discretion of the QAPI committee.	

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The nurse aide (NA #1), who was working on 6/3/19 and 6/4/19 from 7:00 AM to 7:00 PM with Resident #2, was interviewed on 7/19/19 at 5:01 PM. NA #1 indicted she worked with another nurse aide (NA #2) on the hallway for Resident #2 on the same days and the same hours, 7:00 AM to 7:00 PM. NA #1 indicated the two nurse aides worked together to care for Resident #2 on 6/3/19 and 6/4/19, but NA #2 was assigned to care for Resident #2. NA #1 stated Resident #2 told her she ran into a wall with her wheelchair and she was in a lot of pain. NA #1 indicated Resident #2 was complaining of pain when the nurse aides assisted her. NA #1 was unsure of the exact date when Resident #2 complained of pain initially.

The nurse aide (NA #2), who was assigned to care for Resident #2 on 6/3/19 and 6/4/19 from 7:00 AM to 7:00 PM, was interviewed on 7/19/19 at 5:15 PM. NA #2 indicated she was uncertain of the date, but she recalled Resident #2 complaining of a lot of pain when she received care at 4:30 PM. NA #2 indicated Resident #2 had not complained that morning prior to her evening complaints of pain on that day. NA #2 stated the legs of Resident #2 were swollen and sore. NA #2 stated the resident told her she had run into a wall causing injury to her legs. NA #2 was unsure of the exact date when Resident #2 initially complained of pain to her, but she knew the resident's nurse was aware of the pain on that day.

The nursing supervisor (Nurse #1), who was working on 6/3/19 and 6/4/19 from 7:00 PM to 7:00 AM, was interviewed on 7/20/19 at 8:53 AM. Nurse #1 stated she was alerted by a nurse that Resident #2 was in pain on the evening of 6/4/19. Nurse #1 indicated she went to talk to the

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resident and assess the situation. Nurse #1 stated Resident #2 had never complained of pain to such a great extent. Nurse #1 revealed the resident's legs were inflamed and tender. Resident #2 told Nurse #1 she needed to go to the hospital. Nurse #1 indicated she asked the resident what happened. Nurse #1 said she questioned if it was cellulitis or perhaps somebody dropped the resident. Nurse #1 indicated Resident #2 offered no explanation at that point. Nurse #1 stated EMS was called, and she overheard Resident #2 tell the EMS staff she had hit a wall with her wheelchair. Nurse #1 stated she asked the Resident why she did not tell her she hit a wall. Nurse #1 said she knew at that point that x-rays were taken of the resident's legs, so she went to look at them. Nurse #1 stated she was very surprised when she removed the x-ray results from the fax machine because of the extent of the fractures. Nurse #1 stated, "This kind of fracture just doesn't seem like she hit a wall. I felt like she was not telling the truth."

The nurse (Nurse #2), who was assigned to monitor Resident #2 from 4:30 PM to 7:00 PM on 6/4/19, was interviewed on 7/20/19 at 9:25 AM. She stated she received report from the nurse (Nurse #3) who was assigned to the resident from 8:00 AM to 4:30 PM on 6/4/19. Nurse #2 stated she was told Resident #2 was in pain on the evening of 6/4/19. She stated the Resident did not tell her what happened, but she had heard she ran into the wall at the end of the ramp in the building. Nurse #2 stated, "Her story didn't add up until she told the truth a week or two later."

The nurse (Nurse #3), who was assigned to Resident #2 from 8:00 AM to 4:30 PM on 6/3/19 and 6/4/19, was interviewed on 7/20/19 at 9:29

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AM. Nurse #3 indicated Resident #2 did not complain of pain until approximately 2:30 PM on 6/4/19 when she was up in her wheelchair. Nurse #3 stated NP #1 was coming down the hall, so she asked NP #1 to assess Resident #2. Nurse #3 stated she heard Resident #2 tell NP #1 she had hit a wall while in her wheelchair. Nurse #3 stated Resident #2 was able to wheel herself in the wheelchair.

The nurse aide (NA #3), who was assigned to care for Resident #2 from 7:00 AM to 7:00 PM on 6/2/19, was interviewed on 7/20/19 at 10:22 AM. NA #2 indicated she assisted Resident #2 with her morning care and assisted Resident #2 into the car when she went to visit her family at the hospital. NA #2 stated that Resident #2 was not injured in the transfer into the car to leave with her family.

Record review of hospital records for Resident #2 for an admission on 6/4/19 at 9:05 PM revealed documentation in the history of present illness the resident drove her wheelchair into the wall by accident and sustained bilateral distal femur fractures. Resident #2 was re-admitted to the facility on 6/5/19 at 4:30 PM.

Record review of the hospital records for Resident #2 for an admission on 6/6/19 revealed documentation in the history of present illness that stated, "The patient was recently briefly admitted to [hospital name] on the [orthopedic] service from 6/4-6/5 after presenting from [facility] with bilateral distal femur fractures after reportedly driving her wheelchair into a wall at the facility. Orthopedics elected to manage her fractures nonoperatively since she has been non ambulatory for over a year. The patient's [family

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member] is concerned about the circumstances of the patient's injury as he does not feel she is strong enough at baseline to propel a wheelchair with enough force to fracture her legs. He is not aware of any falls at the facility, but he says he has asked [the facility] to look into things further with the staff."

Resident #2 was interviewed on 7/19/19 at 9:49 AM. She stated she thought she broke her legs when she fell out of her wheelchair when the van driver stopped short while transporting her to an orthopedic appointment on 6/3/19. Resident #2 further explained the details of the fall in the van. The van driver picked her up after the appointment and did not put a seat belt on her. The wheelchair was strapped to the van, but she didn't have a seat belt on. She stated she was looking at her phone when all the sudden the van stopped short and she was unable to stop herself from hitting the seat in front of her and falling on the floor of the van on her knees. The van driver pulled over the van and put the flashers on. He asked her if she was alright and she told him her knee hurt. He kept asking her if she was alright. He picked her up and put her back in the chair. He told her he would then put the seat belt on. She stated the van driver begged her not to tell anyone about the fall or he would lose his job. She stated the van driver then went on to pick up the other resident from dialysis without calling someone or notifying anyone of her fall in the van. She stated the van driver then returned both the residents to the facility without notifying anyone she had fallen. She stated her knee was hurting but she waited until the next day to tell NP #1 about her pain. She stated an x-ray was taken but she was in so much pain she was sent to the hospital. She stated she was sent back to the

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facility but did not remember how she got there. She stated the next morning she could not speak and was sent back to the hospital. She stated she found out in the hospital she had broken both her legs. She said she told the hospital she ran into a door because she did not want the van driver to lose his job. She stated the van driver visited her twice in the hospital. On the first visit the van driver came to the hospital and saw her family in the room and she was told by her family he quickly left. The resident stated the van driver came to the hospital again and he told her to not tell anyone she fell in the van or he would lose his job. The resident stated when she returned to the facility from the hospital, she told the Administrator she hit a wall. The resident stated she was very sorry she had lied and felt she needed to tell the truth. She stated she told her family on that Saturday (6/15/19) about the fall in the van and on Monday (6/17/19) she went to the Administrator and told the truth about the fall in the van. Resident #2 stated that the Administrator was upset with her lying because she had already notified the state offices that the fall was a result of the resident running into the wall with her wheelchair. Resident #2 revealed the Administrator had questioned her if anything had happened when she went out with her family (on 6/2/19) to possibly cause the injuries to her legs. Resident #2 stated that she told the Administrator nothing happened to injure her when she went out with her family (on 6/2/19) to visit a family member in the hospital. Resident #2 explained that the nursing home facility staff assisted her into the car to go to the hospital. Resident #2 explained that the hospital staff assisted her out and then back into the car when she was at the hospital. Resident #2 stated that her family did assist her back into her wheelchair from the car

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when they arrived back to the facility on 6/2/19, but her family did not drop her.

Resident #2 was interviewed again on 7/25/19 at 11:45 AM. Resident #2 clarified that she did not have any lunch on 6/3/19, although an early lunch had been ordered for her. Resident #2 stated she left in the facility van at around 11:25 AM for her appointment at the orthopedist office. Resident #2 further clarified that after she left her appointment, she asked the van driver to stop for lunch at a seafood restaurant. She stated she ordered shrimp, fish, and okra. She stated the fall in the van was after she ate her food. She said she was not able to finish all her food and she had closed the food container to save it for later. She stated that the food and her phone fell on the floor of the van when she fell to her knees. Resident #2 stated the van driver picked her up under her shoulders and put her back in her wheelchair after the fall but did not hurt her in doing so. Resident #2 did not recall the time that she left the orthopedic appointment or where the van pulled over after she fell.

A family member of Resident #2 was interviewed on 7/19/19 at 1:52 PM. The family member stated she had been in the room when the van driver visited the resident on her first admission to the hospital. The family member stated she also knew that the van driver visited her mother a second time when she was in the hospital. The family member stated she felt the facility was trying to intimidate Resident #2 by questioning her about the events of 6/2/19, when the resident was visiting with family. The family member stated Resident #2 did not have any pain or injuries when she was with her family on 6/2/19. The family member did not want Resident #2 to

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be intimidated by the facility Administrator anymore, so she requested that Resident #2 no longer be questioned by the facility staff regarding the cause of the fractures to her legs.

The van driver was interviewed on 7/20/19 at 3:14 PM. He stated he could not remember the exact details of the van ride with Resident #2. He stated she took her to [an orthopedic appointment] at 1:00 PM on 6/3/19. He stated Resident #2 called him when the appointment was over, and he returned to pick her up. He strapped the wheelchair into the van and secured the resident with a seat belt. He stated Resident #2 complained of shoulder pain. He stated that because the resident was hungry, he stopped at [seafood restaurant] and bought her some shrimp. He said she ate the shrimp in the van and asked if she could ride along to get the next resident at dialysis. He said he picked up the next resident and took both residents back to the facility. He stated that Resident #2 did not fall at any point in the ride. He said he did visit the resident in the hospital twice because he visits a lot of residents in the hospital and he considers many of them his friends. The van driver stated on the first visit he made to visit the resident in the hospital he saw that she was okay because many family members were in the room, so he only stayed briefly. The van driver stated that on the second visit to the resident in the hospital they discussed how she seemed unable to recognize anybody on the first visit. The van driver re-iterated that Resident #2 did not fall in the van when he transported her on 6/3/19. The van driver was asked why Resident #2 would lie about a fall in the van and accuse him of not buckling her in. The van driver stated that any answer he would give would only be speculation and he only

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wanted to give truthful information.

Record review revealed the facility faxed a 24-hour self-report of an injury of unknown source on 6/6/19 at 1:04 PM regarding Resident #2. The documentation in the report stated the date of the incident was on 6/3/19 and the facility became aware on 6/4/19 at 2:00 PM. The documentation of the allegation details revealed the facility reported Resident #2 ran hard into the door with her manual wheelchair on 6/3/19 and the injury was of known origin.

Record review revealed the facility faxed a 5-day self-report of an injury of unknown origin on 6/11/19 at 12:47 PM as a follow up to the initial 24-hour report dated 6/6/19. The documentation in the 5-day report revealed Resident #2 reported she ran into a wall to the facility nursing staff and EMS staff. Documentation in the report stated, "On 6/6/19 [Resident #2's] family reported to the Director of Nursing [name], Administrator [name], and unit coordinator [name], they felt that [Resident #2's] injuries did not occur as stated above so an investigation began of injury of unknown origin alleged by [Resident #2's] family. During our investigation, it was found that resident had went out with her family on 6/2/19 and returned that evening. No injuries or incidents were reported. She was transported to an appointment on 6/3/19 by our facility. No incidents or accidents were identified however [Resident #2] did report to our driver, [Driver name] that she was having pain in her legs and that she had run into a wall. This conversation was after the appointment which prompted an interview with the office staff. [NP #1 name], NP called that office on 6/6/19 and spoke with staff. No incidents or injuries were identified while there. Facility staff

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interviews began on 6/6/19 for any reported or witnessed injury or incident of [Resident #2]. This interview did not reveal any witnesses of the above stated incident. [Resident #2 was interviewed 6/11/19 after her return from a hospital stay on the events that took place starting in 6/3/19 and she reported that she ran into the wall across from her room while coming out of her door and that she did not report this incident right away until the next day when her pain became worse. After a thorough investigation, the allegation of [Resident #2] injury of unknown source reported by her family is unsubstantiated."

A record review of the facility's investigation revealed a statement from the previous Director of Nursing who ended her employment with the facility on 6/28/19. The documentation stated, "At [8:35 AM] on 6/20/19 [staff member name], 100-unit manager came to my office and reported that [staff member name] at [8:30 AM] reported a conversation she had with [NA #3] on 6/15/19 when [NA #3] reported while caring for [Resident #2] (the) resident reported she was going to go to the administrator on Monday and report what really happened and that she was going to stop lying and that her kids had dropped her on the floor. At [8:40 AM] this new information on this open investigation was reported to the Administrator [name]."

A record review of the facilities investigation also revealed an undated statement from NA #3. The documentation revealed, "[Resident #3 told me she ran into the wall in her wheelchair. Then couple days later [Resident #2] told me [family] had dropped her. June 14th, Friday during her personal care she asked me would I think less of

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her (if she) [Resident #2] wanted to tell me what really happened to her. [Van Driver] had slammed on the brakes (and) she fell onto the floor. [Van Driver] picked her up and put (her) back into the seat. I [NA #3] responded back to her (Resident #2) to go and talk to the Director of Nursing or Administrator."

An interview was conducted with the facility Administrator on 7/19/19 at 3:41 PM. She stated Resident #2 was alert and oriented and typically a good historian of the facts. The Administrator revealed the resident changed her version of the circumstances surrounding the injury to her legs many times. The Administrator indicated the facility initiated an investigation into her injuries on 6/6/19 after the family of Resident #2 raised concerns. The facility administrator stated the facility concluded the investigation after doing interviews with the nursing staff, interviews with the resident on multiple occasions, an interview with the orthopedic appointment staff member, an interview with the van driver, and concluded the resident hit a wall as she stated. The Administrator stated that it came to her attention on 6/18/19 Resident #2 changed her story and said she fell in the van returning from an orthopedic appointment. The Administrator stated that at that point the facility re-interviewed the van driver and suspended him pending an investigation. The Administrator stated Resident #2 was interviewed several more times, the van driver was fired, and an immediate plan of correction was put in place. The Administrator revealed the residents, who had taken van rides in the 30 days prior to the alleged fall in the van, were interviewed. None of the residents interviewed had any concerns with either of the van drivers or reported any incidents happening

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on a van ride. The Administrator wanted the family, the resident, and the van driver to sit down and have a meeting to discuss the van ride, but the family declined this meeting and it was never held. The Administrator stated that the family of Resident #2 had dropped her on a previous visit home. The Administrator indicated she felt the family of Resident #2 had dropped her on the visit outside the facility on 6/2/19.

An interview was conducted with the facility Administrator again on 7/23/19 at 12:20 PM. The facility Administrator confirmed a full investigation into the injuries for Resident #2 was not initiated until 6/6/19 because the family of Resident #2 voiced concerns as to how the injuries occurred. The Administrator indicated the facility had no reason to doubt the resident's version of how she broke her legs. The Administrator stated, "Several scenarios came out of her (Resident #2's) mouth." The Administrator acknowledged the resident stated on various occasions she wheeled herself into a wall in her room, into a wall across the hall, into wall at the end of the ramp, into a door, and into the doorframe as an explanation of her injuries. The Administrator acknowledged the facility did not have a reenactment of the circumstances of the injury, the facility did not investigate the physical plausibility of the resident's legs hitting the wall, and physical therapy was not consulted into the plausibility of Resident #2 propelling herself with enough force into a wall to break her legs. The Administrator stated the facility could have had a more systematic approach in the investigation.

An interview was conducted on 7/25/19 at 12:42 PM with the facility medical director and the physician for Resident #2 (MD #1). MD #1

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explained that NP#1 was in the facility when Resident #2 initially complained of pain and NP#1 ordered an x-ray. MD #1 stated she was called that same evening (6/4/19) for an order to send Resident #2 to the hospital because she was in a significant amount of pain. MD#1 stated she was aware Resident #2 was sent back to the facility with a diagnosis of bilateral fractured femurs. MD #1 stated she was not at the facility when the resident returned to the facility and first spoke with Resident #2 after the resident returned to the facility from a second hospital visit. MD#1 explained she relied on information from Resident #2 to determine the cause of the fracture. MD#1 indicated the resident initially gave the reason for the fractures was her wheelchair running into a wall or a door. MD #1 indicated the facility was trying to figure out how, when and where this happened. MD#1 stated, "How could this even be possible? But she is alert and oriented. This was her story. Initially I doubted she sustained the fractures running into a wall. I was thinking in my mind, she must have brittle bones. I was thinking how this could happen." MD #1 revealed the family of Resident #2 was very suspicious of the story of Resident #2 running into a wall and with everyone repeatedly asking the resident what happened, the truth came out. MD #1 stated she personally went to Resident #2 and asked her to really tell her the truth as to what happened. MD #1 stated the resident told her she fell in the van hurting her legs. MD #1 stated Resident #2 told her she had not wanted to tell the truth. MD #1 said she was told by Resident #2 that she had initially lied about running into a wall. MD #1 did not know why Resident #2 lied. MD #1 stated, "A fall in the van makes more sense based on the bilateral fractures. We all know there was an incident in the van based on what I was told. I do

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F 610	Continued From page 17 not know the truth or what happened. I must go on the facts. I know she has osteopenia. I cannot be certain as to what happened to cause the fractures."	F 610		