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FAYETTEVILLE VETERANS HOME	1125 NORTH COLLEGE FAYETTEVILLE, AR 72703

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F 000	INITIAL COMMENTS This copy of this 2567 supercedes the previous copy Note: The CMS-2567 (Statement of Deficiencies) is an official, legal document. All information must remain unchanged except for entering the plan of correction, correction dates, and the signature space. Any discrepancy in the original deficiency citation(s) will be reported to the Dallas Regional Office (RO) for referral to the Office of the Inspector General (OIG) for possible fraud. If information is inadvertently changed by the provider/supplier, the State Survey Agency (SA) should be notified immediately. Complaint #18210 was unsubstantiated. Complaint #18195 was substantiated (all or in part) with deficiencies cited at F226 and F323. Complaint #18244 was substantiated (all or in part) without a deficiency.	F 000		
F 226 SS=E	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure that the	F 226		

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

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Abuse Prohibition Policies and Procedures were implemented. The facility failed to ensure a resident injury (fracture), that occurred during a lab draw while resident was resistive, was thoroughly investigated in order to ensure appropriate corrective actions to reduce the potential for further injuries for 1 (Resident #1) of 6 (Residents #1, 2, 4, 6, 7 and 8) case mix residents who was cognitively impaired. The failed practice had the potential to affect 45 residents who were cognitively impaired according to the Administrator on 4/15/13 at 2:00 p.m. The findings are:

1. The Facility's Abuse Prohibition Policy provided by the Administrator on 3/28/13 at 10:10 a.m. documented: "Abuse, Neglect, and Mistreatment, Injuries of Unknown Origin and Misappropriation of Resident Property Policy and Procedure: ... Policy: To ensure the resident is free of verbal, sexual, physical, and mental abuse, corporal punishment, and involuntary seclusion. Procedure: 1 - Any allegation of mistreatment of resident or property will be reported as required by regulations and law. ... 4 - Prevention, Identification and Protection: ... If an employee is suspected of abuse, neglect or misappropriation of resident property, the Administrator/Director of Nursing/RN on duty shall place the employee on immediate investigative suspension while completing an investigation. ... 5 - Reporting: Any employee who suspects an alleged violation must immediately notify the Administrators/Director of Nursing/RN on duty. The supervisor on duty must notify the state agency and the local law enforcement agency as required by state law... 6 - Investigation: The Administrators/Director of

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Nursing/designee will conduct all investigations and record the interviews and results of the investigations. The investigation includes interviews of the alleged perpetrator, other employees or visitors or any resident who might have knowledge of the alleged incident. A review of the resident's clinical record should occur to determine the resident's past history and condition for relevance to the alleged violation. 7 - Corrective Actions: Appropriate steps must be determined and taken to prevent recurrence of the incident. The care plan should reflect the resident's condition and measures taken to prevent recurrence when appropriate ...

2. Resident #1 had diagnoses of Fracture Right Ulna-Closed, Osteoporosis and Senile Dementia with Depressive Features. The Annual Minimum Data Set with an Assessment Reference Date (ARD) of 1/22/13 documented the resident scored 6 (0 - 7 indicates severely impaired) on the Brief Interview for Mental Status, had inattention and disorganized thinking that comes and goes and changes in severity; exhibited no physical Behavioral Symptoms directed toward other during the last seven days of the ARD; required extensive assistance of one staff member with bed mobility, transfer, locomotion on and off the unit and with dressing and was totally dependent on one staff member for toilet use and personal care/bathing; and had no falls with major injuries since prior assessment.

a. A Nurses Notes dated 12/9/12 at 4:55 p.m. and signed by Licensed Practical Nurse (LPN) #1 documented, "...Lab tech here to draw blood. Resident took to room. When lab tech begin needle withdrawal, resident became combative

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and begin hitting and kicking lab tech. A CNA passing room went in and tried to assist lab tech with a pressure dressing on [left] arm. Two more CNAs walked in to assist. Resident continued to kick and hit and threw her arms up and everyone in room stated they heard what sounded like a knuckle pop loudly. Instantly a discolored area on [right] forearm appeared. A CNA informed me of the situation immediately. Ask resident if arm hurt. Stated, 'a little.' Could move fingers but could not move her hand laterally...

At 1715 [5:15 p.m.] Tylenol 325 mg [milligrams] [two] given. Still refused to allow a pressure [dressing] on hematoma. X-ray ordered for [right] forearm, wrist and hand...

At 1755 [5:55 p.m.] x-ray tech here. Resident allowed x-rays to be done [without] incident. Swelling around discolored area...

At 1905 [7:05 p.m.] Order from [Physician #1] to transport resident to [Hospital] ER for a fracture of distal ulna...

At 1915 [7:15 p.m.] Ambulance here for transport to [Hospital ER]...

Late Entry: At 2030 [8:30 p.m.], "...Called [Acting Administrator] and I was advised how to handle situation..."

b. An Incident/Accident (I&A) Reporting Form documented, "...Resident: [Resident #1]...Date: 12/9/12...Time: 1655 [4:55 p.m.]

(1) Where did incident/accident occur? Rsd [Resident's] Room [checked]...

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F 226	Continued From page 4 (2) What happened? Became combative during blood draw and began hitting and kicking lab tech. At one point while throwing arms around all four witnesses heard a loud pop. [Right] forearm began swelling immediately... (4) What did the resident or witness say about the incident? "That hurts some." according to witnesses in room...Name(s) of any witness(es): [Certified Nurse Assistant (CNA)] #1, [CNA #2], [CNA #3]... (5) Were there any injuries? Yes [checked]... (6) Did incident require any type of treatment? [checked yes] and documented "x-ray showed fractured [right] ulna. Sent to [Hospital]Emergency Room] per [Physician #1]... " (9) Notifications: Time Physician Notified: 1900 [7:00 p.m.]...Unable to reach family per numbers on face sheet...Time Administrator Notified: 2030 [8:30 p.m.]...Time [facility name] Police called: [not called]...Nurse Completing the I & A : [Licensed Practical Nurse (LPN) #1]...DON/ADON: [Director of Nurses/Assistant Director of Nursing]...Administrator: [Administrator] 12/10/12..." c. The DMS (Division of Medical Services)-7734 OLTC (Office of Long Term Care) Incident and Accident Report (I&A) (completed by the Acting Administrator) page 2 documented, "...This I and A dated 12/9/12 at 2040 was first reviewed by Resident Safe Handling Committee on 12/10/12 which meets Mon - Fri [Monday thru Friday]	F 226		

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revealed a report of a resident with a fractured right ulna. Resident became combative during a routine lab draw resulting in a fracture of the right arm. Phlebotomist and CNAs (2) were in the room at the time of the incident. Incident became known to the Acting Administrator at 2045 hours on 12/9/12. Reporting process begun..."

d. The DMS-762 Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long-Term Care Facilities (page 2) dated 12/9/12 at 2040 [8:40 p.m.] documented, "...Facility Staff Member Completing DMS-762: [Acting DON]...Type of Incident: Physical Abuse [checked]...Name of Involved Resident: [Resident #1]...Date and Time of Incident [if known]: 12/9/12 at 2040 PM...Date and Time of Discovery: 12/9/12 at 2040 PM...Date Incident Reported to OLTC: 12/10/12 1555 [3:55 p.m.]...Ambulatory? No [checked]...Oriented: Person [checked]...Physical Functional Level/Impairment: Propels self in wheelchair, Requires assist with all ADL's [Activities of Daily Living's] and transfers...Mental Functional Level: Alert to person only requires frequent reorientation to place and time...Primary Diagnosis: Dementia..."

Page 3 documented, "...During a routine lab draw resident became combative with lab staff and facility staff. She was swinging her arms and hitting and kicking the staff when they heard a popping noise. An x-ray was obtained which identified a fracture of the ulna. Resident was sent to the ER for evaluation and treatment. All notifications were made and report was filed. Resident is wheelchair bound and requires assist

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with ADL's and transfers..."

Page 4 documented, "...Witness statements were obtained and interviews conducted. After reviewing all findings and consulting with the physician it is believed that no abuse occurred and the fracture happened while the resident was being combative with staff [signed by the Acting DON and dated 12/17/12]..."

e. The Witness Statements:

1) The Witness Statement completed by Lab Tech #1 documented, "...Pt: [Resident #1]...Date: 12/6/12... Time: around 1700 [5:00 p.m.]...Started to draw blood of pt. [patient] when pt. became very abusive both physical and talkative. Pt. pulled needle out of her [left] arm. I tried to get her to let me tape her up but Pt. again started hitting me. Went to find a nurse or CNA. Got help from CNAs. Pt. still fighting and kicking us. All I was trying to do was get her arm cleaned up and bandage put on. As she was fighting us something made a popping sound...."

2) The Witness Statement completed by CNA #2 documented, "...As me and [CNA #3] were walking by to get the resident up for supper. The Phlebotomist ask if we can help. So me and [CNA #3] walked into the room. At that time [CNA #1] was already in the room. [Resident #1] were too. So, I was standing by 'A' bed. So [CNA #3] and [CNA #1] was verbally telling her [Resident #1] that it would be okay for the Phlebotomist to put a Band-Aid on her arm so she agreed and was calm. But, when the Phlebotomist put pressure to the hematoma, she started hitting and kicking at the Phlebotomist as [CNA #1] was

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bending over and she hit her on the shoulder. But, as she [resident] was bringing her [right] arm up that's when I heard a loud pop sound..."

3) The Witness Statement completed by [CNA #1] documented, "...When I was walking down the hall, I was called over by [Lab Tech #1] for assistance with [Resident #1]. [Lab Tech #1] told me she was very combative hitting and kicking her while she was drawing her blood and the resident had pulled out the needle from her left arm where she has drawn one tube of blood... [Resident #1] was in her wheelchair and I asked to see her arm. She complied. I then asked if we could go to her room so we could put a bandage on her she started that was fine. I wheeled her into the room and she became upset once again and that is when [CNA #3 and #2] walked by and [Lab Tech #1] asked if they could assist with talking with her about her bandage. While [CNA #3] was caressing her left arm and I was on her right side and was caressing her arm and shoulder trying to assure her it was going to be ok when [Lab Tech #1] put pressure with the cotton ball on her left arm, she became upset and started kicking the Lab Tech; at this time I bent over to get in the path of her kicking she had hit me and raised up her right arm and we all heard the pop and we went to find the charge nurse to report..."

4) The Witness Statement completed by [CNA #3] documented, "...[CNA #2] and I were walking by [Resident #1] room when the Phlebotomist yelled out at us to come help her with [Resident #1] The Phlebotomist said she was trying to put a dressing on her arm because she had a hematoma and [Resident #1] was not letting her

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do it. [CNA #2] and I went into the room. That is when I noticed that [CNA #1] was standing on the right side of [Resident #1] wheelchair. She said that her hematoma was really bad. As I got closer to [Resident #1], she smiled at me and said that she was glad I came. I then squatted down by her left side and started to explain to her that we are here to help and pointed out the hematoma to her and she agreed that we could put a dressing on it. The Phlebotomist began to apply pressure to the hematoma on her left arm when [Resident #1] began hitting at [CNA #1] when I heard the 'pop'. I am not sure if it was on the up swing or down swing. I was looking at the Phlebotomist because she was about to kick her in the head. [CNA #1] reacted a lot quicker to shield the Phlebotomist, but got hit in the process. Once we/I heard the popping noise I left the room immediately to go get [LPN #1], the LPN in charge. [CNA #1and #2] and the Phlebotomist stayed in the room with [Resident #1] while I left to go get [LPN #1], but I could not find her so I got the PRN [As Needed] LPN [LPN #2]..."

5) The Witness Statement completed by LPN [Licensed Practical Nurse] #2 documented, "...At approximately 1650 [4:50 p.m.] [CNA #3] reported that [Resident #1] [right] arm had made a large popping sound. I asked, did she hit it on anything. 'No' stated [CNA #3]; we were holding her right arm down when I heard a loud pop." Other nurse; [LPN #1] came down hall and I reported to her. Assessed Resident. Upon assessment [right] [forearm] swollen and purple [right] 2nd digit curved in. [Resident #1] c/o [complained of] pain. Other nurse medicated. I notified [Physician #1]; received x-ray order...Notified [Registered Nurse (RN) #1]..."

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6) The Witness Statement completed by [LPN #1] documented, "...At approx [approximately] 1655 [4:55 p.m.] I was notified by [left blank] that [Resident #1] became very combative while lab tech was doing a blood draw. While resident was throwing arms around everyone in room heard a loud pop. I entered room and an area on [right] forearm was turning blue and resident could not move her hand laterally. Swelling began. At 1715 [5:17 p.m.] given Tylenol because resident stated it 'hurt a little'. Ordered Xray for right forearm, wrist and hand. Results being a fractured right ulna. At 1915 transferred to [Hospital] ER per ambulance."

f. The Orthopedic Report dated 12/13/12 documented, "[Resident #1] is a 90 - year old nursing home patient who injured her right arm 12/9/12. Someone came in to draw her blood early in the morning and she did not want them to. She fought them and they restrained her physically to try and get that blood drawn and somehow she ended up with an ulnar shaft fracture. She splintered. She is reasonably comfortable. She certainly seems pleasantly confused today.
Physical Examination: She is in a short arm splint. She has normal range of motion of her fingers. Sensory exam is not terrible easy to get cooperation with.

X-Rays: AP[anterioposterial] and lateral x-rays of the right forearm from the emergency room reveal a minimally displaced fracture of the distal ulnar shaft. There is some mild angulation and about 50% translation ...

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Assessment: Minimally displaced right ulnar shaft night stick fracture.

Plan: We switched her over to a short arm cast. We will keep her in that cast for 5 more weeks. I will see her back in the office 5 weeks from now with AP and lateral x-rays of her right forearm out of plaster ...."

g. The Plan of Care dated 1/22/13 thru 4/22/13 documented,

"...Problem: Behavior...Problem Date: 2/18/13 Physically Abusive - slapping, hitting, and kicking staff and other residents..."

Approaches: Always have two Health Care Workers when providing personal care...Explain purpose of care or medication before giving...Intervene as needed to protect the rights & safety of others...Reapproach resident later, when she becomes agitated...If resident refuses care, provide time & space so that she does not escalate in her behavior. Re-approach using calm tone, alternate staff member. If resident becomes combative during lab draw, do not attempt to draw lab...

Problem: Osteoporosis...Problem Date: 3/23/10 Resident is at risk for Fracture R/T [related to] dx: osteoporosis...

Approaches: 12/10/12 Notify physician of any increase in combativeness because of increased potential for injury/fractures of her bones...Do not attempt to provide care when resident behaviors starts to escalate..."

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h. Staff who were in the resident's room at the time of the injury were interviewed:

1) On 3/25/13 at 4:40 p.m., CNA #1 stated she had been working the 3 - 11 shift on the 6th floor since August 2012. She stated that she had been taught (at time of Orientation but not since) that if a resident becomes too combative during care they are to leave alone and come back; but sometimes I'll try talking to them first to attempt to calm them down before I leave them alone.

When asked if she remembered the incident with [Resident #1] back in December 2012. She stated, "Yes, [Resident #1] wasn't being cooperative with the lab draw - kicking Phlebotomist. I was the first CNA to assist before [CNA #2 and #3] came in to help as well. I had already attempted to calm her down unsuccessfully before the other two CNAs were asked to come help by the Phlebotomist. [CNA #3] got her to agree to let Phlebotomist draw blood but when she knelt down and began trying to draw blood she started kicking at Phlebotomist and I knelt down trying to block the kicks and she hit me two times once on my left shoulder and once on the back of my head ... is when we heard snap then [Resident #1] looking up at [CNA #3] stated, 'Look what you did, you broke my arm,' then [CNA #3] told us, 'All I was doing was holding her shoulders trying to talk to her'."

On 3/26/13 at 4:23 p.m., CNA #1 was asked to verify the interview notes above (3/25/13 at 4:40 p.m.). She stated, "If Resident #1 is upset she will hit and kick. I'm not aware of any prior fractures due to her hitting and kicking at people/objects. The interview was stopped and

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the CNA left and returned at 5.50 p.m., she returned and stated, "I wrote my witness statement after the phlebotomist had told what had happened when she became combative. I'm not sure if [CNA #2 and #3] came in after Phlebotomist asked them to or not. I am not sure who was holding her down, I think it was [CNA #3]. I was on left side putting my back in front of Phlebotomist because Resident #1 was kicking at her. I didn't see how she was being held. I knew there would be a State Investigation. I did hear [CNA #3] say, "I'm holding as tight as I can." I could not see where she was held from the position I was in. [LPN #1] told us what had to be said in the Witness Statements in a room her, me, [CNA #2 and #3]. I told [LPN #1] what I just told you about what I saw and heard. At first [CNA #3] told [LPN #1] she was holding her arm down then she changed her story to she was holding her shoulders. I told [CNA #3], I thought she said that she was holding her arm down and she said, "No, you must have misunderstood me." After this meeting,[LPN #1] took [CNA #3] into the room by themselves for about 30 minutes, then [LPN #1] called us all back into a room, gave us all a blank Witness Statement and told us to fill out the statements and do not put down that she was being restrained. This is when [CNA #3] said I wasn't restraining her, I was holding her. I did not tell the Administrator or DON about what actually happened because after [LPN #1] talked to us, I was afraid for my job. I just didn't know what to do. I'm just proud this is out in the open now, it has been eating at me ever since."

2) On 3/26/13 at 3:20 p.m., CNA #2 was asked if she remembered the incident with Resident #1

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back in December 2012. She stated, "Yes, Me, [CNA #1and CNA #3] and the Phlebotomist were in her room when her arm was fractured. We went into her room due to the Lab needed to put band aid over hematoma, I call it a big bubble, on her left arm. Me and [CNA #3] was together, [CNA #1] was already in there. I stood by the door because there were already two CNAs and the Phlebotomist in there. [CNA #1], was standing in front of left leg and [CNA #3], was standing in front of her right leg, tried to calm her down by talking to her. Initially it worked, but when lab started putting on the band aid both of the CNAs squatted down in same location and she [resident] starting kicking and screaming. They all were in front of resident so I was unable to see what was going on but I did hear a very loud pop even from where I was standing because it was so loud." When asked what she had been instructed to do when a resident becomes combative during care, she stated, "You are suppose to leave room immediately and wait for them to calm down and let nurse know. She was probably already upset before me and [CNA #3] came in there. Should not have had that many people try to get her to do something when she was so agitated. Should have stepped back and see if she calmed down. I feel like it was abuse because she got hurt and from what I said from the beginning when she started swinging we maybe should have left the room. I know it wasn't done on purpose. I do think this could have been handled differently but it just happened so fast. After reading interview notes back to CNA #2 she said, "I don't agree with what I said about abuse, I believe it was an accident." She agreed to the above statement after making the last adjustment in the statement and she signed and dated the

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statement 3/26/13.

3) On 3/27/13 at 10:57 a.m., CNA #3 was asked if she remembered Resident #1 and the incident with her back in December 2012 when her arm was fractured during a blood draw? She stated, "Yes, I was present during that incident. From my memory the Phlebotomist; I don't remember her name asked [CNA #2] and I as we were walking by [Resident #1] room if we could come help. I said, ok. We go into the room and [CNA #1] was already in there. [Resident #1] was sitting in her wheel chair at the bottom of her bed [B - bed] facing the door and [CNA #1] was on her right side. She stayed on the right side; none of us switched around. [CNA #1] was on [Resident #1] right side. [CNA #2], I'm not sure she didn't come all the way in there. She stayed closer to the bottom of the A - bed. [CNA #1] still on right side and Phlebotomist was kneeled down on her left side. I'm right here, [CNA #3] demonstrated as standing to the left back side of the wheel chair. I take care of her all the time, I know how to handle her. She was upset with the Phlebotomist and started to kick at her. She was holding her left arm and pressed the band aid on it and [Resident #1] verbally said,' It hurts.' She goes to kick her again and I want to say at least 2 or 3 times in that hot second. Then [CNA #1], her reaction was a lot quicker than mine and she went down to block the hit and pushed the Phlebotomist out of the way. That's when [Resident #1] reached down and hit [CNA #1] with her right arm. Then we heard a pop; I'm going to say I heard a pop because I know what I heard and it was a loud pop. I don't know if it was the up swing or the down swing when she hit [CNA #1] that I heard the pop. I think it was when she went down and

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hit [CNA #1] and then swung arm up and that's when I heard the pop. This is the critical point, I don't really know it just happened so fast. We heard the pop and that's when [CNA #2] said, did you all hear that and we said, yeah we heard that...Like it was loud enough for [CNA #2] to hear it and she was still there at the bottom of A - bed. It was loud enough for her to say what was that. After hearing the pop, I left the room to get the nurse. I had trouble finding her initially. She wasn't on the floor. I don't remember who I told. I know I came back with a nurse. I want to say it was [LPN #1] that I brought back to the room. Did I bring [LPN #2], I don't know. Trying to think who it was. [LPN #1] wrote the report. It might have been [LPN #2], then [LPN #1] came later."

She was then asked what she told the nurse? She stated, "This is what I don't remember in detail because whatever I told them it had to be what I heard. Sounded like she broke her arm. Before doing our Witness Statements, we were called into a room with[LPN #1]. It was [CNA #2, CNA #1, LPN #1] and myself. I don't remember if [LPN #2] was in there. [LPN #1] didn't say much; said we could get into trouble and it would be reported to the State. She didn't say why we would be in trouble. I think we all understood why. If the xray had come back with her wrist then said arm fractured, we would be in bad trouble. That meant to me a mark on our license. The meeting in the room was to warn us how serious the situation was. I think we explained what happened before we went into the room; it might have been in the room, we weren't in there long. I want to say we did."

She was then asked if anyone told them what to

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write or not write on their Witness Statements. She said, "No, [LPN #1] basically said be careful what you say because this will be reported and the State will review it. That's basically what she said. I have never been through anything like this before. I have completed Witness Statements before but not anything like this. I was expecting to hear from State. I did not talk to the Administrator or DON. They didn't talk to me; they may have talked to [LPN #1, CNA #1 and CNA #2]. It's been awhile ago and I don't remember talking to them. We were all really scared. LPN #1 scared us but I haven't heard anything since the incident."

She was then asked to read her Witness Statement and after reading it she was asked if what was in her Witness Statement was an accurate account of the incident. After a long pause, she stated, "To say, I don't remember in particular her right arm held when after she swung to hit [CNA #1]. To say someone held her arm, that's not how I remember the incident. I don't remember. I'm trying to be as honest as I can. The Phlebotomist is knelt down to put the dressing on her left arm. She swings down and hits [CNA #1]. As far as [CNA #1] maybe grabbing her right arm then, I don't remember. I don't remember her continuing hitting after hearing the pop. From my memory, it's not like it happened yesterday. Knowing [Resident #1], she gets combative real quick. I can't know if [CNA #1] was holding her arm after she swung. I don't know if [CNA #2] held her arm after she swung. [CNA #2] could have been there, her and [CNA #1] were both there. [CNA #2] was on [Resident #1] right side with [CNA #1]. [CNA #2] could have come up before the pop, I don't remember."

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She was asked if there was anything she would change about her Witness Statement? She stated, "I can add to my statement, [LPN #1] did take us in a room. She did tell us not to say anything in the Witness Statements that could be viewed as Abuse"

She was then asked if she held Resident #1 arm down? After a very long pause she stated, "I want to say No, then I want to say Yes...I did not break her arm...she had already hit [CNA #1] and that's when we heard the pop when her arm was up in the air and she was coming down to hit [CNA #1] again and that's when I grabbed her arm. When we heard the pop, I think [Resident #1] was still focused on the Phlebotomist because she is still kicking at her and [CNA #1] knelt down trying to shield the Phlebotomist. [CNA #1] was looking down. When [Resident #1] was going down to hit her again is when I reached over her. I don't think I grabbed her. I think I just pushed her arm back up and [CNA #1] is on her right side now. [Resident #1] is trying to hit again and I'm trying to calm her down. I'm saying we were holding her arm down on the arm of the wheel chair. I was holding her arm and trying to get her to calm down. She did try to move her arm while I was holding it and she was mad at the Phlebotomist. This is what I reported to [LPN #1] and then she told us that we couldn't write that she was held down because that is Abuse and the State is going to be reviewing this and we could lose our license."

After another pause she said, "So when [LPN #1] told us this, what I should have done is reported that immediately to the Administrator and DON."

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4) On 3/26/13 at 4:35 p.m., Lab Tech #1 [Phlebotomist] was asked if she remembered the incident with Resident #1 in December 2012. She stated, "Yes, but I don't remember if she was in the hallway or in her room when she let me stick her after I had explained to her what I was going to do. I stuck her (in the arm opposite from the one that was broken) and she did ok for about a second after I stuck her. After that she bent her arm up and took the tourniquet off and became a little combative, ie: she was fighting me to stop, she was trying to push me away. I was just concerned about getting cotton ball on her arm because she was bleeding everywhere. There was no pressure applied and she had the hematoma but I can't remember the size of the hematoma. It is not common practice to have people help with combative residents until it gets done. I don't remember if I got band aid on or not. I did not hear a popping sound.

At this time she was shown her Witness Statement and after reading it, she stated, "Hmmm, I don't have very good memory." She was then asked if this is really what happened as documented in her Witness Statement? At this time she began crying and stated, "I'm so proud this is over, I couldn't even sleep that night. [CNA #3] was holding her right arm down while I was cleaning the blood off of left arm where I had drawn the blood. She was holding her right arm down during this time. I don't remember who told me but I was told not to put [CNA #3's] name in there that she was holding her down. It could have been [CNA #3] that told me this but I honestly don't remember who told me that. I was told the next day by [CNA #3] that they were all

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pulled into a room and got their butt chewed out. I do not know who did this." She was then asked if prior to her and the CNAs filling out their Witness Statements if anybody said, this is what we have to say? She stated, "The CNAs were at the medication cart discussing what had to be said on the Witness Statements. [CNA #3] told everyone that they should say they were just helping and she was flailing her arms around when they heard the pop."

She was asked after that night, did anyone from the facility ever question you about this incident? She stated, "No, I filled out the Witness Statement before I left that night."

She was then asked to demonstrate how (Resident #1) was held down. She stated, "[CNA #3] was standing at the resident's right side of her wheel chair where her arm was lying on the right arm rest of the wheel chair. She held with one hand at her elbow and the other hand across her wrist/hand. She said, "I'm holding her as tight as I can. At that time [Resident #1] tried to raise her right hand/arm when [CNA #3] beared down hard smashing her right hand/wrist down on top of the wheel chair's right arm rest. She did not flail her arm around when this happened. Immediately after she pushed her arm back down she stated, 'Oh ----, I think I broke her arm' !"

i. The nurses who received report of the resident injury were interviewed:

1) On 3/26/13 at 2:27 p.m. via phone, LPN #2 was asked if she remembered the incident with Resident #1 back in December 2012. She stated, "Yes, I was passing meds on "B" hall

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when I had a CNA come up and asked for [LPN #1] because she couldn't find her. This was my 1st night on the floor. After seeing her [CNA #3] the 3rd time still looking for [LPN #1] and appearing very panicky, I asked her if there was anything I could help with. She told me the lab was in the room and they were holding her [Resident #1] arm and they heard a snap. I then said, wait a minute, you heard a snap and asked her if she was sure she didn't hit her arm on something. She said no, she didn't hit her arm on anything. After assessing her, I determined at that point it was probably broken and I called the Doctor and he ordered an Xray. I pulled [LPN #1] to the side and told her the story they [CNAs] told me and this is a reportable; you can't hold people down...it's abuse. Before I got Xray results and before I got to tell [LPN #1] what I had been told; their stories had changed. I didn't know what to do since the stories had changed from it broke when they were holding her down to she hit it on wheel chair then to she did it when she was flailing her arms around. [LPN #1] then pulled all of the CNAs and myself into the office together and said, 'Get your stories straight; what happened?' No one at that point admitted to holding her arm down. I asked [CNA #3] why she told me that they were holding her down when her arm snapped. She told me that I must have misunderstood her because that's not what she told me. I do know the lab lady was talked to because she told me the next day, 'I don't want to get anybody in trouble but, I'm not going to hold anybody down anymore.' I talked to the Administrator the next morning and told her what they had originally told me what happened but now their stories had changed. I do not know how she could have fractured it like that just by

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flailing her arms around."

2) On 3/27/13 at 9:54 a.m., LPN #1 was interviewed via telephone and asked if she remembered the incident with (Resident #1) in December 2012 when her arm was fractured during a blood draw. The LPN stated, "Yes, I knew [Resident #1]. She was a resident on my hall. I was the nurse. I did not witness it but they came to get me when the resident became combative. I don't remember who came to get me... I remember [LPN #2] being there because she told me she had gotten another story from one of the CNAs, [#2 or #3]. She told me this after I shipped [Resident #1]... She told me [Resident #1] got combative when they were drawing blood. ... She thought they held her arm too hard when [Resident #1] became combative. I don't know if an aide told her this or what. I took [CNA #3] in the office to ask her what happened. It might have been after [Resident #1] was shipped out that I talked to her... I told her [CNA #3], that [LPN #2] had told me they were holding her down. [CNA #3] said 'no'. The Lab Tech told me the same thing. I didn't know at the time I was talking to the lab tech, there were conflicting statements... [LPN #2] was the only one that told me her arm broke because staff was holding down her arm... This is when I asked [CNA #3] what happened and she denied [LPN #2's] statement... I usually get all witnesses to come to nurses station to fill out witness statements. I don't remember what I did that night. I only talked to [CNA #3] in a room. I did not tell anyone what to write or what not to write on witness statements." LPN #1 was then asked what she does if she receives an allegation of abuse against a resident. She stated, "The first thing I

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usually do is talk to my supervisor, but as far as I remember no one came to me about an allegation of abuse until now. I did consider this an allegation of abuse, that is why I talked to my supervisor. I told [RN #1] that I had received an allegation of abuse around the same time I told her about the xray. I am not sure what time it was. I showed her mine and CNA #3's witness statements. I'm not sure if she did anything after that, I think she did. It's been too long ago, I don't remember. I have nothing else to say." She was then asked if she was still employed at the facility. She stated, "No, they fired me because I had been working so many hours and I was assisting a CNA with a resident when he hauled off and hit my boob so hard it hurt. I spatted his hand, and that's abuse." At 10:45 a.m. she was read her statement and attested to its accuracy verbally on the phone.

3) On 3/27/13 at 3:14 p.m., RN#1 was asked if she remembered the incident with Resident #1 back in December 2012 when her arm was fractured during a blood draw. She stated, "Not other than what [LPN #1] told me. The Lab Tech came during supper and they were very busy and they had difficulty drawing blood. All I remember of the conversation for sure is that they had trouble drawing [Resident #1's] blood. No one notified me of an allegation of abuse. The next time I saw [Resident #1] she had a cast on. I asked someone what happened and they said she broke her arm. I said 'oh, really' and no one offered an explanation as to how it happened or anything... If I had been told there was a fracture during care, I would immediately send that person or persons in the room home and immediately start an investigation. A resident has the right to

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refuse and if they are combative and kicking, the staff should leave. If they are demented you still can't force them."

j. Management Staff were interviewed regarding investigation of the incident:

1) On 3/26/13 at 9:55 a.m., the Acting DON (Current DON) stated that she first became aware of the incident with [Resident #1], " ... when one of the staff members [don't remember who actually called me; trying to remember the nurses involved] told me Lab lady was here and had drawn the blood and when she was getting ready to put the bandage on she [Resident #1] started fighting, became combative. The Lab Tech went out and found more staff to come in and help and when staff went back in her room she was kicking and swinging at herself. They heard a pop, they notified [Physician #1] and got an order to send her for an Xray. I had them , the nurse to get witness statements from all that were there even the lab girl. Then we, the next day I believe it was, me and the Administrator went through the witness statements and spoke to all the staff that was here to verify what happened. One of the witness statements, I believe it was the nurse who said they were holding her hand when they heard the pop, I called at home to question her why her witness statement was the only one that documented that she had been held down and she told me because that is what I was told by [CNA #3]. We did interview staff and residents to determine if any had problems with lab draws or the staff. I don't have the interviews with the residents documented and we did not do any body audits of residents with recent lab draws or who had been cared for by any of the staff

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present during the incident. I have read the Ortho consult on 12/13/12. The best I can figure is the transport person gave him the information that the break occurred when staff were holding her down during a lab draw but I have not called the Ortho doctor or the transport driver either to find out. I did talk with [CNA #3] about what the nurse had reported to me. She gave the same account of her being combative and she was throwing her arms up when they heard a pop. I don't have it documented where I talked to [CNA #3]. The only thing I remember doing was talking to Physician #1 and asking him if he thought the fracture was caused by being held down during a lab draw. I feel like it was thoroughly investigated because we spoke to [CNA #3] and [LPN #2]. We did not call Ortho doctor because we had no idea how he got that information because the transportation driver nor he was present during the lab draw. We should have talked to both of them to find out where they got their information." She also stated, "If a resident becomes combative, staff have been instructed to walk away and notify the charge nurse and then we try to teach them to use the individual approach with each resident. We try and train on that several times a year and also when we do abuse training. I feel like they were trying to assist and not really pressuring her into anything. [LPN #1] was terminated due to an Abuse situation that occurred with another resident."

2) On 3/26/13 at 11:17 a.m. the Acting Administrator (Current Administrator) stated after being asked if and when she was made aware of the incident with [Resident #1] back in December 2012, " I was told about the incident in December with [Resident #1], that initially she rejected

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having her blood drawn by the Phlebotomist. During procedure she became agitated, combative, pulling away leaving bleeding at the site. They had stepped back, then resident flailed her arms out at the staff and they all heard a pop. I know we initiated a reportable and it was submitted to OLTC [Office of Long Term Care]. We decided that there was no abuse alleged due to hearing a pop and reviewing the witness statements during our investigation and we also reviewed it with the Medical Director about this. I'm sure I reviewed the witness statements but I don't remember when I did it. I understand now there should have been audits/interviews of other residents. I didn't know before this happened. I understand that bleeding was a concern so I'm sure they were focused on that and that is the reason they did not back away."

After reviewing the witness statements the Administrator stated, "There is no mention of bleeding in these, just hematoma. When a person is combative the staff should have stepped away and stopped the procedure. The staff should not have proceeded with applying the bandaid or pressure to the hematoma."

She also stated, "I did review all of the witness statements. I really do not have a lot of recollection about this incident. I believe the DON questioned [CNA #3] about [LPN #2] witness statement about why she documented that she had told her initially that they had been holding her down to obtain the lab and thought they had broken her arm."

When asked if she had seen the Ortho Consult report; she stated, "I have not ever seen this

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F 226	Continued From page 26 report. I don't know how he would have known she was restrained during the blood draw. It would have been a productive conversation on why he said that or how he came to that conclusion." "I know now other residents should have been assessed, a conversation should have occurred with the Ortho Doctor, further staff education should occur and we've started this after the 2/8/13 incident. We should have done a better job investigating this." After reviewing the Nurses Note dated 12/9/12 and completed by [LPN #1], she [Administrator] stated, "I don't remember that phone call but I assume I told her to call the Doctor but I don't recall, so I don't know what she meant by 'Spoke to [Acting Administrator] and advised how to handle situation.' She was terminated in February due to an interaction she had with a resident that was unacceptable."	F 226		
F 323 SS=H	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, record review and interview, the facility failed to ensure thorough	F 323		

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investigation of a fracture that occurred during a lab draw and to ensure that staff did not attempt to restrain and continue to provide care for a resident who became agitated and combative to reduce the potential for injury for 1 (Resident #1) of 1 case mix residents who had a history of resisting care. The failed practice caused a pattern of actual harm for Resident #1 who sustained a wrist/hand fracture and had the potential to cause more than minimal harm to __ who had a history of resisting care as identified by the ___ dated ___. The findings are:

Resident #1 had diagnoses of Fracture Right Ulna-Closed, Osteoporosis and Senile Dementia with Depressive Features. The Annual Minimum Data Set with an Assessment Reference Date (ARD) of 1/22/13 documented the resident scored 6 (0 - 7 indicates severely impaired) on the Brief Interview for Mental Status, had inattention and disorganized thinking that comes and goes and changes in severity; exhibited no physical Behavioral Symptoms directed toward other during the last seven days of the ARD; required extensive assistance of one staff member with bed mobility, transfer, locomotion on and off the unit and with dressing and was totally dependent on one staff member for toilet use and personal care/bathing; and had no falls with major injuries since prior assessment.

a. A Nurses Notes dated 12/9/12 at 4:55 p.m. and signed by Licensed Practical Nurse (LPN) #1 documented, "...Lab tech here to draw blood. Resident took to room. When lab tech begin needle withdrawal, resident became combative and begin hitting and kicking lab tech. A CNA passing room went in and tried to assist lab tech

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with a pressure dressing on [left] arm. Two more CNAs walked in to assist. Resident continued to kick and hit and threw her arms up and everyone in room stated they heard what sounded like a knuckle pop loudly. Instantly a discolored area on [right] forearm appeared. A CNA informed me of the situation immediately. Ask resident if arm hurt. Stated, 'a little.' Could move fingers but could not move her hand laterally...

At 1715 [5:15 p.m.] Tylenol 325 mg [milligrams] [two] given. Still refused to allow a pressure [dressing] on hematoma. X-ray ordered for [right] forearm, wrist and hand...

At 1755 [5:55 p.m.] x-ray tech here. Resident allowed x-rays to be done [without] incident. Swelling around discolored area...

At 1905 [7:05 p.m.] Order from [Physician #1] to transport resident to [Hospital] ER for a fracture of distal ulna...

At 1915 [7:15 p.m.] Ambulance here for transport to [Hospital ER]...

Late Entry: At 2030 [8:30 p.m.], "...Called [Acting Administrator] and I was advised how to handle situation..."

b. An Incident/Accident (I&A) Reporting Form documented, "...Resident: [Resident #1]...Date: 12/9/12...Time: 1655 [4:55 p.m.]

(1) Where did incident/accident occur? Rsd [Resident's] Room [checked]...

(2) What happened? Became combative during

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blood draw and began hitting and kicking lab tech. At one point while throwing arms around all four witnesses heard a loud pop. [Right] forearm began swelling immediately...

(4) What did the resident or witness say about the incident? "That hurts some." according to witnesses in room...Name(s) of any witness(es): [Certified Nurse Assistant (CNA)] #1, [CNA #2], [CNA #3]...

(5) Were there any injuries? Yes [checked]...

(6) Did incident require any type of treatment? [checked yes] and documented "x-ray showed fractured [right] ulna. Sent to [Hospital]Emergency Room] per [Physician #1]... "

(9) Notifications: Time Physician Notified: 1900 [7:00 p.m.]...Unable to reach family per numbers on face sheet...Time Administrator Notified: 2030 [8:30 p.m.]...Time [facility name] Police called: [not called]...Nurse Completing the I & A : [Licensed Practical Nurse (LPN) #1]...DON/ADON: [Director of Nurses/Assistant Director of Nursing]...Administrator: [Administrator] 12/10/12..."

c. The DMS (Division of Medical Services)-7734 OLTC (Office of Long Term Care) Incident and Accident Report (I&A) (completed by the Acting Administrator) page 2 documented, "...This I and A dated 12/9/12 at 2040 was first reviewed by Resident Safe Handling Committee on 12/10/12 which meets Mon - Fri [Monday thru Friday] revealed a report of a resident with a fractured right ulna. Resident became combative during a

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routine lab draw resulting in a fracture of the right arm. Phlebotomist and CNAs (2) were in the room at the time of the incident. Incident became known to the Acting Administrator at 2045 hours on 12/9/12. Reporting process begun..."

d. The DMS-762 Facility Investigation Report for Resident Abuse, Neglect, Misappropriation of Property, & Exploitation of Residents in Long-Term Care Facilities (page 2) dated 12/9/12 at 2040 [8:40 p.m.] documented, "...Facility Staff Member Completing DMS-762: [Acting DON]...Type of Incident: Physical Abuse [checked]...Name of Involved Resident: [Resident #1]...Date and Time of Incident [if known]: 12/9/12 at 2040 PM...Date and Time of Discovery: 12/9/12 at 2040 PM...Date Incident Reported to OLTC: 12/10/12 1555 [3:55 p.m.]...Ambulatory? No [checked]...Oriented: Person [checked]...Physical Functional Level/Impairment: Propels self in wheelchair, Requires assist with all ADL's [Activities of Daily Living's] and transfers...Mental Functional Level: Alert to person only requires frequent reorientation to place and time...Primary Diagnosis: Dementia..."

Page 3 documented, "...During a routine lab draw resident became combative with lab staff and facility staff. She was swinging her arms and hitting and kicking the staff when they heard a popping noise. An x-ray was obtained which identified a fracture of the ulna. Resident was sent to the ER for evaluation and treatment. All notifications were made and report was filed. Resident is wheelchair bound and requires assist with ADL's and transfers..."

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Page 4 documented, "...Witness statements were obtained and interviews conducted. After reviewing all findings and consulting with the physician it is believed that no abuse occurred and the fracture happened while the resident was being combative with staff [signed by the Acting DON and dated 12/17/12]..."

e. The Witness Statements:

1) The Witness Statement completed by Lab Tech #1 documented, "...Pt: [Resident #1]...Date: 12/6/12... Time: around 1700 [5:00 p.m.]...Started to draw blood of pt. [patient] when pt. became very abusive both physical and talkative. Pt. pulled needle out of her [left] arm. I tried to get her to let me tape her up but Pt. again started hitting me. Went to find a nurse or CNA. Got help from CNAs. Pt. still fighting and kicking us. All I was trying to do was get her arm cleaned up and bandage put on. As she was fighting us something made a popping sound...."

2) The Witness Statement completed by CNA #2 documented, "...As me and [CNA #3] were walking by to get the resident up for supper. The Phlebotomist ask if we can help. So me and [CNA #3] walked into the room. At that time [CNA #1] was already in the room. [Resident #1] were too. So, I was standing by 'A' bed. So [CNA #3] and [CNA #1] was verbally telling her [Resident #1] that it would be okay for the Phlebotomist to put a Band-Aid on her arm so she agreed and was calm. But, when the Phlebotomist put pressure to the hematoma, she started hitting and kicking at the Phlebotomist as [CNA #1] was bending over and she hit her on the shoulder. But, as she [resident] was bringing her [right] arm

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up that's when I heard a loud pop sound..."

3) The Witness Statement completed by [CNA #1] documented, "...When I was walking down the hall, I was called over by [Lab Tech #1] for assistance with [Resident #1]. [Lab Tech #1] told me she was very combative hitting and kicking her while she was drawing her blood and the resident had pulled out the needle from her left arm where she has drawn one tube of blood... [Resident #1] was in her wheelchair and I asked to see her arm. She complied. I then asked if we could go to her room so we could put a bandage on her she started that was fine. I wheeled her into the room and she became upset once again and that is when [CNA #3 and #2] walked by and [Lab Tech #1] asked if they could assist with talking with her about her bandage. While [CNA #3] was caressing her left arm and I was on her right side and was caressing her arm and shoulder trying to assure her it was going to be ok when [Lab Tech #1] put pressure with the cotton ball on her left arm, she became upset and started kicking the Lab Tech; at this time I bent over to get in the path of her kicking she had hit me and raised up her right arm and we all heard the pop and we went to find the charge nurse to report..."

4) The Witness Statement completed by [CNA #3] documented, "...[CNA #2] and I were walking by [Resident #1] room when the Phlebotomist yelled out at us to come help her with [Resident #1] The Phlebotomist said she was trying to put a dressing on her arm because she had a hematoma and [Resident #1] was not letting her do it. [CNA #2] and I went into the room. That is when I noticed that [CNA #1] was standing on the

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right side of [Resident #1] wheelchair. She said that her hematoma was really bad. As I got closer to [Resident #1], she smiled at me and said that she was glad I came. I then squatted down by her left side and started to explain to her that we are here to help and pointed out the hematoma to her and she agreed that we could put a dressing on it. The Phlebotomist began to apply pressure to the hematoma on her left arm when [Resident #1] began hitting at [CNA #1] when I heard the 'pop'. I am not sure if it was on the up swing or down swing. I was looking at the Phlebotomist because she was about to kick her in the head. [CNA #1] reacted a lot quicker to shield the Phlebotomist, but got hit in the process. Once we/I heard the popping noise I left the room immediately to go get [LPN #1], the LPN in charge. [CNA #1and #2] and the Phlebotomist stayed in the room with [Resident #1] while I left to go get [LPN #1], but I could not find her so I got the PRN [As Needed] LPN [LPN #2]..."

5) The Witness Statement completed by LPN [Licensed Practical Nurse] #2 documented, "...At approximately 1650 [4:50 p.m.] [CNA #3] reported that [Resident #1] [right] arm had made a large popping sound. I asked, did she hit it on anything. 'No' stated [CNA #3]; we were holding her right arm down when I heard a loud pop." Other nurse; [LPN #1] came down hall and I reported to her. Assessed Resident. Upon assessment [right] [forearm] swollen and purple [right] 2nd digit curved in. [Resident #1] c/o [complained of] pain. Other nurse medicated. I notified [Physician #1]; received x-ray order...Notified [Registered Nurse (RN) #1]..."

6) The Witness Statement completed by [LPN #1]

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documented, "...At approx [approximately] 1655 [4:55 p.m.] I was notified by [left blank] that [Resident #1] became very combative while lab tech was doing a blood draw. While resident was throwing arms around everyone in room heard a loud pop. I entered room and an area on [right] forearm was turning blue and resident could not move her hand laterally. Swelling began. At 1715 [5:17 p.m.] given Tylenol because resident stated it 'hurt a little'. Ordered Xray for right forearm, wrist and hand. Results being a fractured right ulna. At 1915 transferred to [Hospital] ER per ambulance."

f. The Orthopedic Report dated 12/13/12 documented, "[Resident #1] is a 90 - year old nursing home patient who injured her right arm 12/9/12. Someone came in to draw her blood early in the morning and she did not want them to. She fought them and they restrained her physically to try and get that blood drawn and somehow she ended up with an ulnar shaft fracture. She splintered. She is reasonably comfortable. She certainly seems pleasantly confused today.
Physical Examination: She is in a short arm splint. She has normal range of motion of her fingers. Sensory exam is not terrible easy to get cooperation with.

X-Rays: AP[anterioposterial] and lateral x-rays of the right forearm from the emergency room reveal a minimally displaced fracture of the distal ulnar shaft. There is some mild angulation and about 50% translation ...

Assessment: Minimally displaced right ulnar shaft night stick fracture.

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Plan: We switched her over to a short arm cast. We will keep her in that cast for 5 more weeks. I will see her back in the office 5 weeks from now with AP and lateral x-rays of her right forearm out of plaster ...."

g. The Plan of Care dated 1/22/13 thru 4/22/13 documented,

"...Problem: Behavior...Problem Date: 2/18/13 Physically Abusive - slapping, hitting, and kicking staff and other residents..."

Approaches: Always have two Health Care Workers when providing personal care...Explain purpose of care or medication before giving...Intervene as needed to protect the rights & safety of others...Reapproach resident later, when she becomes agitated...If resident refuses care, provide time & space so that she does not escalate in her behavior. Re-approach using calm tone, alternate staff member. If resident becomes combative during lab draw, do not attempt to draw lab...

Problem: Osteoporosis...Problem Date: 3/23/10 Resident is at risk for Fracture R/T [related to] dx: osteoporosis...

Approaches: 12/10/12 Notify physician of any increase in combativeness because of increased potential for injury/fractures of her bones...Do not attempt to provide care when resident behaviors starts to escalate..."

h. Staff who were in the resident's room at the time of the injury were interviewed:

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1) On 3/25/13 at 4:40 p.m., CNA #1 stated she had been working the 3 - 11 shift on the 6th floor since August 2012. She stated that she had been taught (at time of Orientation but not since) that if a resident becomes too combative during care they are to leave alone and come back; but sometimes I'll try talking to them first to attempt to calm them down before I leave them alone.

When asked if she remembered the incident with [Resident #1] back in December 2012. She stated, "Yes, [Resident #1] wasn't being cooperative with the lab draw - kicking Phlebotomist. I was the first CNA to assist before [CNA #2 and #3] came in to help as well. I had already attempted to calm her down unsuccessfully before the other two CNAs were asked to come help by the Phlebotomist. [CNA #3] got her to agree to let Phlebotomist draw blood but when she knelt down and began trying to draw blood she started kicking at Phlebotomist and I knelt down trying to block the kicks and she hit me two times once on my left shoulder and once on the back of my head ... is when we heard snap then [Resident #1] looking up at [CNA #3] stated, 'Look what you did, you broke my arm,' then [CNA #3] told us, 'All I was doing was holding her shoulders trying to talk to her'."

On 3/26/13 at 4:23 p.m., CNA #1 was asked to verify the interview notes above (3/25/13 at 4:40 p.m.). She stated, "If Resident #1 is upset she will hit and kick. I'm not aware of any prior fractures due to her hitting and kicking at people/objects. The interview was stopped and the CNA left and returned at 5.50 p.m., she returned and stated, "I wrote my witness

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statement after the phlebotomist had told what had happened when she became combative. I'm not sure if [CNA #2 and #3] came in after Phlebotomist asked them to or not. I am not sure who was holding her down, I think it was [CNA #3]. I was on left side putting my back in front of Phlebotomist because Resident #1 was kicking at her. I didn't see how she was being held. I knew there would be a State Investigation. I did hear [CNA #3] say, "I'm holding as tight as I can." I could not see where she was held from the position I was in. [LPN #1] told us what had to be said in the Witness Statements in a room her, me, [CNA #2 and #3]. I told [LPN #1] what I just told you about what I saw and heard. At first [CNA #3] told [LPN #1] she was holding her arm down then she changed her story to she was holding her shoulders. I told [CNA #3], I thought she said that she was holding her arm down and she said, "No, you must have misunderstood me." After this meeting,[LPN #1] took [CNA #3] into the room by themselves for about 30 minutes, then [LPN #1] called us all back into a room, gave us all a blank Witness Statement and told us to fill out the statements and do not put down that she was being restrained. This is when [CNA #3] said I wasn't restraining her, I was holding her. I did not tell the Administrator or DON about what actually happened because after [LPN #1] talked to us, I was afraid for my job. I just didn't know what to do. I'm just proud this is out in the open now, it has been eating at me ever since."

2) On 3/26/13 at 3:20 p.m., CNA #2 was asked if she remembered the incident with Resident #1 back in December 2012. She stated, "Yes, Me, [CNA #1and CNA #3] and the Phlebotomist were

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in her room when her arm was fractured. We went into her room due to the Lab needed to put band aid over hematoma, I call it a big bubble, on her left arm. Me and [CNA #3] was together, [CNA #1] was already in there. I stood by the door because there were already two CNAs and the Phlebotomist in there. [CNA #1], was standing in front of left leg and [CNA #3], was standing in front of her right leg, tried to calm her down by talking to her. Initially it worked, but when lab started putting on the band aid both of the CNAs squatted down in same location and she [resident] starting kicking and screaming. They all were in front of resident so I was unable to see what was going on but I did hear a very loud pop even from where I was standing because it was so loud." When asked what she had been instructed to do when a resident becomes combative during care, she stated, "You are suppose to leave room immediately and wait for them to calm down and let nurse know. She was probably already upset before me and [CNA #3] came in there. Should not have had that many people try to get her to do something when she was so agitated. Should have stepped back and see if she calmed down. I feel like it was abuse because she got hurt and from what I said from the beginning when she started swinging we maybe should have left the room. I know it wasn't done on purpose. I do think this could have been handled differently but it just happened so fast. After reading interview notes back to CNA #2 she said, "I don't agree with what I said about abuse, I believe it was an accident." She agreed to the above statement after making the last adjustment in the statement and she signed and dated the statement 3/26/13.

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3) On 3/27/13 at 10:57 a.m., CNA #3 was asked if she remembered Resident #1 and the incident with her back in December 2012 when her arm was fractured during a blood draw? She stated, "Yes, I was present during that incident. From my memory the Phlebotomist; I don't remember her name asked [CNA #2] and I as we were walking by [Resident #1] room if we could come help. I said, ok. We go into the room and [CNA #1] was already in there. [Resident #1] was sitting in her wheel chair at the bottom of her bed [B - bed] facing the door and [CNA #1] was on her right side. She stayed on the right side; none of us switched around. [CNA #1] was on [Resident #1] right side. [CNA #2], I'm not sure she didn't come all the way in there. She stayed closer to the bottom of the A - bed. [CNA #1] still on right side and Phlebotomist was kneeled down on her left side. I'm right here, [CNA #3] demonstrated as standing to the left back side of the wheel chair. I take care of her all the time, I know how to handle her. She was upset with the Phlebotomist and started to kick at her. She was holding her left arm and pressed the band aid on it and [Resident #1] verbally said,' It hurts.' She goes to kick her again and I want to say at least 2 or 3 times in that hot second. Then [CNA #1], her reaction was a lot quicker than mine and she went down to block the hit and pushed the Phlebotomist out of the way. That's when [Resident #1] reached down and hit [CNA #1] with her right arm. Then we heard a pop; I'm going to say I heard a pop because I know what I heard and it was a loud pop. I don't know if it was the up swing or the down swing when she hit [CNA #1] that I heard the pop. I think it was when she went down and hit [CNA #1] and then swung arm up and that's when I heard the pop. This is the critical point, I

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don't really know it just happened so fast. We heard the pop and that's when [CNA #2] said, did you all hear that and we said, yeah we heard that...Like it was loud enough for [CNA #2] to hear it and she was still there at the bottom of A - bed. It was loud enough for her to say what was that. After hearing the pop, I left the room to get the nurse. I had trouble finding her initially. She wasn't on the floor. I don't remember who I told. I know I came back with a nurse. I want to say it was [LPN #1] that I brought back to the room. Did I bring [LPN #2], I don't know. Trying to think who it was. [LPN #1] wrote the report. It might have been [LPN #2], then [LPN #1] came later."

She was then asked what she told the nurse? She stated, "This is what I don't remember in detail because whatever I told them it had to be what I heard. Sounded like she broke her arm. Before doing our Witness Statements, we were called into a room with[LPN #1]. It was [CNA #2, CNA #1, LPN #1] and myself. I don't remember if [LPN #2] was in there. [LPN #1] didn't say much; said we could get into trouble and it would be reported to the State. She didn't say why we would be in trouble. I think we all understood why. If the xray had come back with her wrist then said arm fractured, we would be in bad trouble. That meant to me a mark on our license. The meeting in the room was to warn us how serious the situation was. I think we explained what happened before we went into the room; it might have been in the room, we weren't in there long. I want to say we did."

She was then asked if anyone told them what to write or not write on their Witness Statements. She said, "No, [LPN #1] basically said be careful

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what you say because this will be reported and the State will review it. That's basically what she said. I have never been through anything like this before. I have completed Witness Statements before but not anything like this. I was expecting to hear from State. I did not talk to the Administrator or DON. They didn't talk to me; they may have talked to [LPN #1, CNA #1 and CNA #2]. It's been awhile ago and I don't remember talking to them. We were all really scared. LPN #1 scared us but I haven't heard anything since the incident."

She was then asked to read her Witness Statement and after reading it she was asked if what was in her Witness Statement was an accurate account of the incident. After a long pause, she stated, "To say, I don't remember in particular her right arm held when after she swung to hit [CNA #1]. To say someone held her arm, that's not how I remember the incident. I don't remember. I'm trying to be as honest as I can. The Phlebotomist is knelt down to put the dressing on her left arm. She swings down and hits [CNA #1]. As far as [CNA #1] maybe grabbing her right arm then, I don't remember. I don't remember her continuing hitting after hearing the pop. From my memory, it's not like it happened yesterday. Knowing [Resident #1], she gets combative real quick. I can't know if [CNA #1] was holding her arm after she swung. I don't know if [CNA #2] held her arm after she swung. [CNA #2] could have been there, her and [CNA #1] were both there. [CNA #2] was on [Resident #1] right side with [CNA #1]. [CNA #2] could have come up before the pop, I don't remember."

She was asked if there was anything she would

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change about her Witness Statement? She stated, "I can add to my statement, [LPN #1] did take us in a room. She did tell us not to say anything in the Witness Statements that could be viewed as Abuse"

She was then asked if she held Resident #1 arm down? After a very long pause she stated, "I want to say No, then I want to say Yes...I did not break her arm...she had already hit [CNA #1] and that's when we heard the pop when her arm was up in the air and she was coming down to hit [CNA #1] again and that's when I grabbed her arm. When we heard the pop, I think [Resident #1] was still focused on the Phlebotomist because she is still kicking at her and [CNA #1] knelt down trying to shield the Phlebotomist. [CNA #1] was looking down. When [Resident #1] was going down to hit her again is when I reached over her. I don't think I grabbed her. I think I just pushed her arm back up and [CNA #1] is on her right side now. [Resident #1] is trying to hit again and I'm trying to calm her down. I'm saying we were holding her arm down on the arm of the wheel chair. I was holding her arm and trying to get her to calm down. She did try to move her arm while I was holding it and she was mad at the Phlebotomist. This is what I reported to [LPN #1] and then she told us that we couldn't write that she was held down because that is Abuse and the State is going to be reviewing this and we could lose our license."

After another pause she said, "So when [LPN #1] told us this, what I should have done is reported that immediately to the Administrator and DON."

4) On 3/26/13 at 4:35 p.m., Lab Tech #1

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[Phlebotomist] was asked if she remembered the incident with Resident #1 in December 2012. She stated, "Yes, but I don't remember if she was in the hallway or in her room when she let me stick her after I had explained to her what I was going to do. I stuck her (in the arm opposite from the one that was broken) and she did ok for about a second after I stuck her. After that she bent her arm up and took the tourniquet off and became a little combative, ie: she was fighting me to stop, she was trying to push me away. I was just concerned about getting cotton ball on her arm because she was bleeding everywhere. There was no pressure applied and she had the hematoma but I can't remember the size of the hematoma. It is not common practice to have people help with combative residents until it gets done. I don't remember if I got band aid on or not. I did not hear a popping sound.

At this time she was shown her Witness Statement and after reading it, she stated, "Hmmm, I don't have very good memory." She was then asked if this is really what happened as documented in her Witness Statement? At this time she began crying and stated, "I'm so proud this is over, I couldn't even sleep that night. [CNA #3] was holding her right arm down while I was cleaning the blood off of left arm where I had drawn the blood. She was holding her right arm down during this time. I don't remember who told me but I was told not to put [CNA #3's] name in there that she was holding her down. It could have been [CNA #3] that told me this but I honestly don't remember who told me that. I was told the next day by [CNA #3] that they were all pulled into a room and got their butt chewed out. I do not know who did this." She was then asked

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if prior to her and the CNAs filling out their Witness Statements if anybody said, this is what we have to say? She stated, "The CNAs were at the medication cart discussing what had to be said on the Witness Statements. [CNA #3] told everyone that they should say they were just helping and she was flailing her arms around when they heard the pop."

She was asked after that night, did anyone from the facility ever question you about this incident? She stated, "No, I filled out the Witness Statement before I left that night."

She was then asked to demonstrate how (Resident #1) was held down. She stated, "[CNA #3] was standing at the resident's right side of her wheel chair where her arm was lying on the right arm rest of the wheel chair. She held with one hand at her elbow and the other hand across her wrist/hand. She said, "I'm holding her as tight as I can. At that time [Resident #1] tried to raise her right hand/arm when [CNA #3] beared down hard smashing her right hand/wrist down on top of the wheel chair's right arm rest. She did not flail her arm around when this happened. Immediately after she pushed her arm back down she stated, 'Oh ----, I think I broke her arm' !"

i. The nurses who received report of the resident injury were interviewed:

1) On 3/26/13 at 2:27 p.m. via phone, LPN #2 was asked if she remembered the incident with Resident #1 back in December 2012. She stated, "Yes, I was passing meds on "B" hall when I had a CNA come up and asked for [LPN #1] because she couldn't find her. This was my

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1st night on the floor. After seeing her [CNA #3] the 3rd time still looking for [LPN #1] and appearing very panicky, I asked her if there was anything I could help with. She told me the lab was in the room and they were holding her [Resident #1] arm and they heard a snap. I then said, wait a minute, you heard a snap and asked her if she was sure she didn't hit her arm on something. She said no, she didn't hit her arm on anything. After assessing her, I determined at that point it was probably broken and I called the Doctor and he ordered an Xray. I pulled [LPN #1] to the side and told her the story they [CNAs] told me and this is a reportable; you can't hold people down...it's abuse. Before I got Xray results and before I got to tell [LPN #1] what I had been told; their stories had changed. I didn't know what to do since the stories had changed from it broke when they were holding her down to she hit it on wheel chair then to she did it when she was flailing her arms around. [LPN #1] then pulled all of the CNAs and myself into the office together and said, 'Get your stories straight; what happened?' No one at that point admitted to holding her arm down. I asked [CNA #3] why she told me that they were holding her down when her arm snapped. She told me that I must have misunderstood her because that's not what she told me. I do know the lab lady was talked to because she told me the next day, 'I don't want to get anybody in trouble but, I'm not going to hold anybody down anymore.' I talked to the Administrator the next morning and told her what they had originally told me what happened but now their stories had changed. I do not know how she could have fractured it like that just by flailing her arms around."

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2) On 3/27/13 at 9:54 a.m., LPN #1 was interviewed via telephone and asked if she remembered the incident with (Resident #1) in December 2012 when her arm was fractured during a blood draw. The LPN stated, "Yes, I knew [Resident #1]. She was a resident on my hall. I was the nurse. I did not witness it but they came to get me when the resident became combative. I don't remember who came to get me... I remember [LPN #2] being there because she told me she had gotten another story from one of the CNAs, [#2 or #3]. She told me this after I shipped [Resident #1]... She told me [Resident #1] got combative when they were drawing blood. ... She thought they held her arm too hard when [Resident #1] became combative. I don't know if an aide told her this or what. I took [CNA #3] in the office to ask her what happened. It might have been after [Resident #1] was shipped out that I talked to her... I told her [CNA #3], that [LPN #2] had told me they were holding her down. [CNA #3] said 'no'. The Lab Tech told me the same thing. I didn't know at the time I was talking to the lab tech, there were conflicting statements... [LPN #2] was the only one that told me her arm broke because staff was holding down her arm... This is when I asked [CNA #3] what happened and she denied [LPN #2's] statement... I usually get all witnesses to come to nurses station to fill out witness statements. I don't remember what I did that night. I only talked to [CNA #3] in a room. I did not tell anyone what to write or what not to write on witness statements." LPN #1 was then asked what she does if she receives an allegation of abuse against a resident. She stated, "The first thing I usually do is talk to my supervisor, but as far as I remember no one came to me about an

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allegation of abuse until now. I did consider this an allegation of abuse, that is why I talked to my supervisor. I told [RN #1] that I had received an allegation of abuse around the same time I told her about the xray. I am not sure what time it was. I showed her mine and CNA #3's witness statements. I'm not sure if she did anything after that, I think she did. It's been too long ago, I don't remember. I have nothing else to say." She was then asked if she was still employed at the facility. She stated, "No, they fired me because I had been working so many hours and I was assisting a CNA with a resident when he hauled off and hit my boob so hard it hurt. I spatted his hand, and that's abuse." At 10:45 a.m. she was read her statement and attested to its accuracy verbally on the phone.

3) On 3/27/13 at 3:14 p.m., RN#1 was asked if she remembered the incident with Resident #1 back in December 2012 when her arm was fractured during a blood draw. She stated, "Not other than what [LPN #1] told me. The Lab Tech came during supper and they were very busy and they had difficulty drawing blood. All I remember of the conversation for sure is that they had trouble drawing [Resident #1's] blood. No one notified me of an allegation of abuse. The next time I saw [Resident #1] she had a cast on. I asked someone what happened and they said she broke her arm. I said 'oh, really' and no one offered an explanation as to how it happened or anything... If I had been told there was a fracture during care, I would immediately send that person or persons in the room home and immediately start an investigation. A resident has the right to refuse and if they are combative and kicking, the staff should leave. If they are demented you still

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can't force them."

j. Management Staff were interviewed regarding investigation of the incident:

1) On 3/26/13 at 9:55 a.m., the Acting DON (Current DON) stated that she first became aware of the incident with [Resident #1], " ... when one of the staff members [don't remember who actually called me; trying to remember the nurses involved] told me Lab lady was here and had drawn the blood and when she was getting ready to put the bandage on she [Resident #1] started fighting, became combative. The Lab Tech went out and found more staff to come in and help and when staff went back in her room she was kicking and swinging at herself. They heard a pop, they notified [Physician #1] and got an order to send her for an Xray. I had them , the nurse to get witness statements from all that were there even the lab girl. Then we, the next day I believe it was, me and the Administrator went through the witness statements and spoke to all the staff that was here to verify what happened. One of the witness statements, I believe it was the nurse who said they were holding her hand when they heard the pop, I called at home to question her why her witness statement was the only one that documented that she had been held down and she told me because that is what I was told by [CNA #3]. We did interview staff and residents to determine if any had problems with lab draws or the staff. I don't have the interviews with the residents documented and we did not do any body audits of residents with recent lab draws or who had been cared for by any of the staff present during the incident. I have read the Ortho consult on 12/13/12. The best I can figure is the

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transport person gave him the information that the break occurred when staff were holding her down during a lab draw but I have not called the Ortho doctor or the transport driver either to find out. I did talk with [CNA #3] about what the nurse had reported to me. She gave the same account of her being combative and she was throwing her arms up when they heard a pop. I don't have it documented where I talked to [CNA #3]. The only thing I remember doing was talking to Physician #1 and asking him if he thought the fracture was caused by being held down during a lab draw. I feel like it was thoroughly investigated because we spoke to [CNA #3] and [LPN #2]. We did not call Ortho doctor because we had no idea how he got that information because the transportation driver nor he was present during the lab draw. We should have talked to both of them to find out where they got their information." She also stated, "If a resident becomes combative, staff have been instructed to walk away and notify the charge nurse and then we try to teach them to use the individual approach with each resident. We try and train on that several times a year and also when we do abuse training. I feel like they were trying to assist and not really pressuring her into anything. [LPN #1] was terminated due to an Abuse situation that occurred with another resident."

2) On 3/26/13 at 11:17 a.m. the Acting Administrator (Current Administrator) stated after being asked if and when she was made aware of the incident with [Resident #1] back in December 2012, " I was told about the incident in December with [Resident #1], that initially she rejected having her blood drawn by the Phlebotomist. During procedure she became agitated,

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combative, pulling away leaving bleeding at the site. They had stepped back, then resident flailed her arms out at the staff and they all heard a pop. I know we initiated a reportable and it was submitted to OLTC [Office of Long Term Care]. We decided that there was no abuse alleged due to hearing a pop and reviewing the witness statements during our investigation and we also reviewed it with the Medical Director about this. I'm sure I reviewed the witness statements but I don't remember when I did it. I understand now there should have been audits/interviews of other residents. I didn't know before this happened. I understand that bleeding was a concern so I'm sure they were focused on that and that is the reason they did not back away."

After reviewing the witness statements the Administrator stated, "There is no mention of bleeding in these, just hematoma. When a person is combative the staff should have stepped away and stopped the procedure. The staff should not have proceeded with applying the bandaid or pressure to the hematoma."

She also stated, "I did review all of the witness statements. I really do not have a lot of recollection about this incident. I believe the DON questioned [CNA #3] about [LPN #2] witness statement about why she documented that she had told her initially that they had been holding her down to obtain the lab and thought they had broken her arm."

When asked if she had seen the Ortho Consult report; she stated, "I have not ever seen this report. I don't know how he would have known she was restrained during the blood draw. It

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would have been a productive conversation on why he said that or how he came to that conclusion."

"I know now other residents should have been assessed, a conversation should have occurred with the Ortho Doctor, further staff education should occur and we've started this after the 2/8/13 incident. We should have done a better job investigating this."

After reviewing the Nurses Note dated 12/9/12 and completed by [LPN #1], she [Administrator] stated, "I don't remember that phone call but I assume I told her to call the Doctor but I don't recall, so I don't know what she meant by 'Spoke to [Acting Administrator] and advised how to handle situation.' She was terminated in February due to an interaction she had with a resident that was unacceptable."