Complaint investigation #29307, #30277, #30359, and #30369 were completed at Life Care Center of Cleveland on October 24, 2012. No deficiencies were cited related to Complaint #30277, #30359, and #30369 under 42 CFR PART 482, Requirements for Long Term Care. Deficiencies were cited related to Complaint #29307.

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 medical record review, review of facility investigation, and interview, the facility failed to ensure a safety device was connected and functioning, to alert staff of unassisted transfers for one resident (#1) of six residents reviewed. The facility's failure to ensure the bed alarm was connected and functioning for resident #1 resulted in a fall and a frontal sinus fracture (fracture within the bones located above the eyes within the frontal bone of the skull), a C2 fracture (fracture involving the second vertebra, or second cervical vertebra, of the spinal column), a right radius fracture (wrist fracture, or fracture of one of the two large bones in the forearm) and a laceration on the right arm (Actual Harm).

This Plan of Correction constitutes our credible allegation of compliance.

1. What corrective action(s) will be accomplished for those residents found to have been affected by the practice;
   a. Resident #1 no longer resides in the facility.

2. How you will identify other residents having the potential to be affected by the same practice and what corrective action will be taken;
   a. A 100% audit of alarm devices was completed by the nursing staff on 10/24/2012 to ensure placement and functioning, and no other residents found to be affected.
**F 323 Continued From page 1**

The findings included:

Resident #1 was admitted to the facility on August 29, 2011, with diagnoses including Dementia, Psychosis, Rheumatoid Arthritis, Hypertension, Osteoporosis, Difficulty in Walking, and Protein S Deficiency (a congenital, or inherited disorder, that causes abnormal blood clotting).

Medical record review of a Fall Risk Evaluation form revealed a resident who scores ten or higher is at risk (of falls); the resident was evaluated on August 29, 2011, November 2, 2011, January 9, 2012, and scored nineteen on each evaluation.

Medical record review of a Physician’s Telephone Order dated August 29, 2011, at 2030 (8:30 p.m.) revealed, "...Bed chair pad alarm for safety..."  

Medical record review of the Physician’s Recapitulation Orders dated January 2012, revealed the order for the bed and chair pad alarm for safety continued.

Medical record review of a care plan dated August 29, 2011, revealed, "...Problem: Potential for injury r/t (related to) falls secondary to impaired mobility, impaired safety awareness...Approached:...MD (Medical Doctor) order 8/29/11 (August 29, 2011) bed/chair (bed and chair) alarm for safety..."

Medical record review of nurse’s notes dated October 19, 20, 21, 23, 24, and 26, 2011, revealed the resident was receiving skilled nursing services for Dementia, was confused and oriented to person only.

---

**F 323**

3. What measures will be put into place or what systematic changes you will make to ensure that the practice does not recur; and

a. Education was started on 10-24-12 by Unit Managers regarding alarm placement and functioning to nursing staff. An educational in-service was provided to nursing staff on alarm devices on 11/02/2012 and completed on 11-6-12 to ensure placement and functioning by the Director of Nursing, Assistant Director of Nursing, Unit Managers, Staff Development Coordinator, Executive Director and Regional Director of Clinical Services.

b. Alarm devices will be monitored to ensure placement and functioning daily for 4 weeks, then weekly for 4 weeks and then for one month by the Unit Managers, Weekend Managers on duty and/or nursing week end supervision to ensure effectiveness and compliance. All audits will be reported to the Director of Nursing as completed.
Continued From page 2

Medical record review of a nurse's note dated November 14, 2011, revealed the resident had a decline in tolerance and independence with ambulation.

Medical record review of a nurse's note dated January 19, 2012, at 1:30 p.m., revealed, "...heard someone screaming...yelling 'We need help down here!'...entered pt's (patient's) room...was observed lying face down in doorway of room...dark red blood noted around...face...911 (9-1-1) called at 1:32 p.m. Pt. left in position until EMS (emergency medical services) arrives (arrived)...1:40 p.m., (EMS) here to transport pt to ER (emergency room)...0 (no) chair alarm sounding at time of incident." 

Review of a facility investigation dated January 19, 2011, revealed "...resident was observed lying facedown (face-down) in the (resident's) room doorway...blood around face...EMS notified... (resident) remained in the position (resident) had been discovered until EMS placed in immobilization for transport to ER... (resident)...wasn't sure what occurred, but had lost a baby in the past & (and) (resident) saw this baby & was attempting to run to it. Management staff began...safety device audit...an emergency PI (performance improvement) meeting was conducted...to include checks of alarm orders, functioning, & placement. Suspension of CNA (certified nursing assistant) occurred...Associate (suspended CNA) was terminated." 

Review of written statements dated January 19, 2012, revealed:

4. How the corrective actions(s) will be monitored to ensure the practice will not recur, i.e., what quality assurance program will be put into place.

a. The Performance Improvement Committee met with The Medical Director, Executive Director, Director of Nursing, Assistant Director of Nursing, MDS Coordinator and reviewed F323 and our Plan of Correction on 10/31/2012.

b. The Director of Nursing will report results of the alarm audits to the the Performance Improvement Committee monthly. The PI Committee will review these results and if deemed necessary additional education may be provided; the process evaluated/revised and/or the audits reviewed, for three months or until 100% compliance is achieved.
F 323: Continued From page 3
Licensed Practical Nurse (LPN) #1 heard screaming and responded to observe the resident lying face-down, with blood around the (resident's) head. "...(Resident) was looking for (resident's) baby..."

CNA #1 was across the hall with another resident when a scream was heard. CNA #1 responded to resident #1's room. "(The) bed (pad) alarm was on with (alarm) box intact (connected). Chair pad (alarm) was in place to chair, but was not hooked up (connected) to (alarm) box...(resident) more confused today talking about (resident's) baby..."

Unit Manager #1 heard someone screaming, the resident was in the floor. LPN #2 observed the resident face-down in the doorway with blood around the resident's head.

Medical record review of a hospital Physician's Trauma History and Physical Form dated January 19, 2012, revealed the resident had a "fall from wheelchair on to face."

Diagnostics completed at the hospital on January 19, 2012, with positive findings included an x-ray of the right upper extremity, with a fracture of the right radius (wrist). CT Scans (Computed Tomography, a radiologic imaging that uses computer processing to generate an image of tissue density in slices through the patient's body) were completed on the head and spine; the head confirmed a nondisplaced frontal sinus fracture, (with no acute intracranial hemorrhage), and of the spine confirmed a C2 fracture.

Plastic Surgery was consulted on January 20,
F 323: Continued From page 4
2012, for the frontal sinus fracture. Mild facial
tenderness was evidenced, and the consult
revealed the resident could be treated on a
nonoperative basis.

Neurology was consulted on January 20, 2012,
for the cervical fracture, which was being treated
and supported with a cervical collar. The consult
revealed the resident was demented and
confused, and was unable to fully cooperate with
neurological testing. The physical examination
revealed the resident was "in no apparent
distress." Continued review revealed the cervical
fracture would "ideally be treated with a
stabilization procedure; however, in light of the
patient's...Dementia, Coagulopathy, age, etc., (et
cetera, "and so on"), this may not be well
tolerated. Will discuss further with the patient's
family when available..."

Medical record review of Trauma Services
Progress Notes dated January 20, 21, and 22,
2012, revealed the resident remained confused
dented, and stable.

Continued review of the progress notes dated
January 23, 2012, revealed the following:

6:15 a.m., "...Family wants hospice eval
(evaluation);"

(No time), "...Multiple concurrent med (medical)
issues...C-collar (cervical collar) 24/7 (24-hours
per day, seven days per week)."

10:10 a.m., "...Family notes h/o (history of)
compression fx (fracture)...."
Summary Statement of Deficiencies

F 323 Continued From page 5

Medical record review of a hospital Physician's Order Sheet dated January 23, 2012, at 10:56 a.m., revealed, "...Consult Hospice..."

Medical record review of a Hospice Patient Information Sheet revealed the resident was admitted to hospice services with Senile Dementia, on January 24, 2012.

Medical record review of a Hospice Physician's Progress Note dated January 25, 2012, revealed the resident had a Dementia FAST score of 7C (a seven-stage functional scale designed to evaluate patients at the more moderate to severe stages of Dementia, with stage seven being severe Dementia).

Medical record review of a progress note completed by the Hospice Medical Director on January 30, 2012, revealed the resident passed away on January 27, 2012, at 4:00 a.m., from Senile Dementia.

Review of a Termination Form dated January 24, 2012, revealed on January 19, 2012, CNA #1 failed to place a safety alarm on resident after transferring to the wheelchair. "Due to no alarm being placed in chair, resident arose from chair & sustained a fall....no alarm sounded to alarm staff...Due to severity of incident & resident outcome, Associate (CNA) is being terminated...I did fail to place an alarm on a patient. This is my fault..."

The surveyor made multiple, unsuccessful telephone attempts to reach CNA #1 for an interview, on October 23, 2012, at 11:30 a.m., and 6:15 p.m.; and on October 24, 2012, at 1:09
Continued From page 6

p.m. Each attempt resulted in no answer, and a recording which confirmed the voicemail service had not been set-up.

Interview with LPN #1 on October 23, 2012, at 5:00 p.m., in the Admission's Office, revealed the resident was confused, looking for (resident's) baby, and fell from the wheelchair. Continued interview confirmed the chair pad alarm was in the seat of the wheelchair, but LPN #1 was "unsure where the alarm box was that connects to the chair pad alarm; but it wasn't connected and the alarm was not sounding."

Interview with Unit Manager #1 on October 23, 2012, at 6:20 p.m., in the Admission's Office, confirmed on January 19, 2012, the resident attempted to get out of the wheelchair, unattended, and fell face-forward onto the floor. The resident had physician orders for a bed and chair alarm. At the time of the resident's unattended fall from the wheelchair, the chair alarm pad was in the seat of the wheelchair, but was not connected to the alarm box, and was not sounding as a result. Unit Manager #1 confirmed when CNA #1 transferred the resident from the bed to the wheelchair on January 19, 2012, CNA #1 failed to connect the chair alarm pad to the alarm box. Continued interview with Unit Manager #1 confirmed the facility failed to ensure the chair alarm pad and alarm box were connected.

Interview with the Administrator on October 23, 2012, at 6:53 p.m., in the Admission's Office, confirmed the facility failed to ensure the chair alarm pad was connected and functioning, to alert staff of the unassisted transfer. Continued
<table>
<thead>
<tr>
<th>F 323 Continued From page 7</th>
<th>F 323</th>
</tr>
</thead>
<tbody>
<tr>
<td>interview confirmed the fall resulted in multiple fractures and a laceration with sutures.</td>
<td></td>
</tr>
<tr>
<td>C/O 29307</td>
<td></td>
</tr>
</tbody>
</table>