STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345156	A. BUILDING _____ B. WING _____	C 01/09/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HALL NURSING AND REHABILITATION CENTER	312 WARREN AVENUE KINSTON, NC 28502

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F 323 SS=G	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 observations, record review and staff interviews, the facility failed to ensure the safety of 1 of 2 residents who sustained a fracture above the right knee. (Resident # 1). Findings include: 1. Resident # 1 was admitted to the facility on 2/29/2000 with a diagnosis of Alzheimer's Disease. A review of the 5-Day / Quarterly Minimum Data Set (MDS) assessment of 10/19/12 revealed the resident had severe cognitive loss, no speech, and was dependent in all aspects of care. Resident # 1 required maximum assistance with bed mobility, and transferred with a mechanical lift and assistance of one. A review of the Care Area Assessment (CAA) for Falls dated 7/27/12 revealed the resident had no falls, was assessed as being at low risk for falls, and was no longer care planned for falls due to being dependent for all aspects of mobility. A review of the Care Plan dated 10/19/12 and Resident Care Guide (care plan for nursing assistants) revealed the resident was transferred with a mechanical lift with assistance of one until 12/28/12. From 12/28/12, the mechanical lift was	F 323	Past noncompliance: no plan of correction required.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Quinn Alan Chambers RN	DON	1-23-13

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 323	Continued From page 1 to be utilized with the assistance of two. A review of the Nurses Notes for 12/28/12 12:45 PM revealed, "called to room by cna (certified nursing assistant) regarding resident right lower leg. Res (resident) usually stiff and contracted but is moving more freely than usual. No bruising noted but edema noted at knee and thigh area. Does have some facial grimacing noted but does not seem to be severe pain." The physician was notified and Resident # 1 was sent to the Emergency Room (ER) for evaluation. During an interview on 1/8/13 at 3:01 PM, Nurse # 1 stated the NA # 1 reported the resident's leg was usually stiff and was not like that now and wanted her to check it. Nurse # 1 stated she assessed Resident # 1's right leg and found the right thigh swollen from above the knee. Nurse # 1 stated there was no bruising present. During an interview on 1/8/13 at 3:15 PM, Nursing Assistant (NA) # 1 stated she worked with the resident on 12/27/12 and 12/28/12. NA # 1 stated she bathed the resident on 12/27/12 and 12/28/12 and there was no bruising or swelling of the right leg. NA # 1 stated both the Resident # 1's legs were stiff. NA # 1 stated when she dressed Resident # 1 on 12/28/12, she noticed her right leg was not as stiff. NA # 1 stated she transferred Resident # 1 from the bed to the geri-chair using the mechanical lift after her bath on 12/28/12. NA # 1 stated the resident did not bump the side rails during care or the mechanical lift during transfer. NA # 1 stated she put Resident # 1 back to bed after lunch using the mechanical lift. NA # 1 stated the resident did not bump the side rails during care or the mechanical lift during transfer. NA # 1 stated when she changed the resident's clothes, she noticed the right leg moved more freely and there was	F 323		

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swelling above the knee. NA # 1 stated she reported to the nurse, "I don't know if this is anything or not, but there is something different about her right leg. It is more free moving and there is swelling." NA # 1 stated there was no bruising present on the right leg.

A review of the ER record dated 12/28/12 revealed the following: "Pt (patient) from (name of facility). Rt (right) knee swelling. Pt groins (sic) on arrival with palpation of rt knee nonambulatory." The musculoskeletal assessment comment revealed: "Rt knee pain and swelling since this AM. Pt nonambulatory and staff states not dropped." The integumentary (skin) assessment revealed: "WNL (within normal limits)."

A review of the x-ray report of the right leg dated 12/28/12 revealed a comminuted fracture (a fracture in which the bone is broken into several pieces) of the distal right femur. There was no documentation of demineralization or osteoporosis of the right femur. Resident # 1 was admitted to the surgical floor.

A review of the hospital History & Physical dated 12/28/12 revealed an examination of Resident # 1's extremities showed the following: "The patient has contractures of the bilateral lower extremities, no pitting edema, bilateral extremities are in foot drop prevention boots."

On 12/30/12, surgery was performed. During an interview on 1/9/13 at 3:48 PM, the orthopedic surgeon (OS) stated, "There was enough force to the knee to cause the lower bone to push up into the femur causing it to shatter. It was a very pretty straight transverse fracture where the knee snapped the femur up above the knee."

Resident # 1 had not returned to the facility from the hospital on 1/9/13.

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F 323	Continued From page 3 A review of the facility investigation revealed direct care staff and nursing staff who cared for the resident from 12/26/12 - 12/28/12 reported there was no bruising or swelling of the right leg until 12/28/12. During an interview on 12/8/13 at 3:50 PM, the Administrator stated during the investigation they learned that on 12/26/12, 11-7 NA # 2 gave Resident # 1 a shower. NA # 2 did not use the mechanical lift to transfer Resident # 1, but transferred Resident # 1 three times by lifting the resident in his arms. NA # 2 was suspended on 12/29/12 until the investigation was completed, and then terminated for improper transfers. During an interview on 1/9/13 at 3:06 PM, NA # 2 stated he knew Resident # 1 was supposed to be transferred with the mechanical lift, but forgot to use it when he gave the shower on 12/26/12. NA # 2 stated he gently lifted the Resident # 1 from the bed with one arm around the middle of the back, and one arm under the knees, and gently sat Resident # 1 in the geri-chair. NA # 2 stated he lifted the resident in the same way when transferring from the geri-chair to the shower chair, and back to the geri chair following the shower. NA # 2 stated Resident # 1's knee was not bumped during the transfers or the shower. During an interview on 1/9/13 at 3:58 PM, the Administrator stated they were unable to determine if an injury occurred due to improper transfers because there was no bruising, and swelling did not occur until 12/28/12. The Administrator stated they were not able to determine how or when the fracture occurred. The Administrator stated the fracture could have occurred after Resident # 1 left with EMS or at the hospital. Further review of the facility investigation on	F 323		

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1/9/13 revealed Resident # 1 ' s care plan and Resident Care Guide were updated to reflect transfers were to be performed using a mechanical lift with assistance of two staff on 12/28/12. A 24-Hour Report and a 5 Working Day report was sent to the appropriate state agency within the mandated timeframe. NA # 2 was suspended pending the outcome of the investigation, and terminated at the conclusion of the investigation on 1/4/13 due to improper transfers based on Resident # 1 ' s care guide.
Group and individual inservices were conducted beginning 12/29/12 and included all nursing and direct care staff on Safe Resident Handling & Movement Policy and use of the Resident Care Guide for the correct transfer technique. Quality Assurance (QA) interventions were integrated into the QA program by 1/4/13 utilizing audits during routine rounds to monitor one transfer per nursing station per week, including rotating shifts at random and was ongoing. The audits were to be reviewed at the next monthly QA meeting.
During an interview on 1/8/13 at 3:15 PM, NA # 1 stated she attended the inservice on Safe Resident Handling & Movement Policy. NA # 1 stated the information regarding resident transfers was on the Resident Care Guide after they were evaluated for the safest transfer. NA # 1 stated she checked the Resident Care Guide before each transfer.
During an interview on 1/9/13 at 2:06 PM, NA # 3 stated she had attended the inservice on Safe Resident Handling & Movement Policy. NA # 3 stated residents were evaluated to determine the safest mode of transfer, and the information was written on the Resident Care Guide. NA # 3 stated she checked the Resident Care Guide for her assigned residents daily because the

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F 323	Continued From page 5 information could change from day to day. On 1/9/13 at 2:06 PM, an observation of a transfer using the mechanical lift and assistance of one staff was conducted. NA # 3 checked the Resident Care Guide for the safest transfer technique for Resident # 4. NA # 3 prepared the mechanical lift and explained the procedure to Resident # 4. The transfer was completed correctly.	F 323		

Harmony Hall Nurs_g and Rehabilitation Cen_r

PO Box 3527
312 Warren Avenue
Kinston, NC 28502

Corrective Action Plan

1. All nursing staff were rein-serviced on the following:
   a. Review of the resident care guide prior to rendering care
   b. Proper use of lift equipment with return demonstration
   c. Handling residents carefully to avoid injury
   d. Maintaining the resident care area clear of hazards that could result in injury
   e. Reporting/evaluation of resident changes in condition
2. Nursing staff will be monitored on daily rounds by management personnel to assure compliance with care being administered by the resident care guide.
3. A QI plan was put in place to monitor staff with the use of lifts and following planned lift procedures. Staff performance with the lift will be reviewed each shift on three randomly selected employees weekly for four weeks, then once weekly each shift for four weeks to be followed by random checks as necessary. Staff retraining to take place as needed if issues with lift procedure are identified.
4. Results of the monitoring process will be review and discussed at the monthly CQI meeting with revisions to the corrective plan if warranted.