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 08/08/2018

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 580 SS=D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).	F 580		8/28/18

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

Electronically Signed | 08/28/2018

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 580	Continued From page 1 §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is not met as evidenced by: Based on record review, staff interviews, and physician interviews, the facility failed to notify the Responsible Party of a change in the pressure ulcer condition for 1 of 3 residents reviewed for pressure ulcers, Resident #1. The findings included: Resident #1 was originally admitted to the facility 08/13/2013 with diagnoses which included arthritis, hypertension, and Alzheimer's disease. The annual Minimum data Set (MDS) assessment dated 05/08/2018 revealed Resident #1's diagnoses included cancer, diabetes mellitus, arthritis, hypertension, dysphagia, Alzheimer's disease, and others. The same annual MDS indicated Resident #1 was severely cognitively impaired, and was totally dependent upon staff for bed mobility, transfers, dressing, personal hygiene, and bathing. Resident #1 had no pressure ulcers according to the annual MDS. A review of the Wound Ulcer Flowsheet dated 05/27/2018 revealed Resident #1 had a facility-acquired Stage II pressure ulcer on the sacrum which measured 4.5 centimeters (cm) in length, 3 cm in width, and 0.1 cm in depth. There	F 580	F 580 The process that led to the deficiency was that the facility failed to notify the Resident Representative (RR) of a change in the pressure ulcer condition for 1 of 3 residents reviewed for pressure ulcers. A 100% Audit using the MD/RR Audit Tool was initiated on August 10, 2018 and completed on August 10, 2018 of all residents receiving treatments as well as 100% of all progress notes including resident # 1 for the past 30 days by the DON and the Quality Assurance (QA) Nurse to ensure appropriate notification of Resident Representative and physician for changes in condition, Antibiotic treatment, incidents, changes in skin condition or worsening skin conditions, resident refusals, changes in medications, or other episodes or changes that require notification. There were no issues noted from audit A 100% In-service with all licensed nurses has been initiated by the Director of Nursing on August 10, 2018 and was	

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F 580	Continued From page 2 was no sign of infection. According to the Wound Ulcer Flowsheet of 05/27/2018, the physician was notified of the pressure ulcer on 05/27/2018, and a message was left for the Responsible Party (RP) on 05/27/2018. Review of a hospital discharge summary dated 06/11/2018 revealed Resident #1 was hospitalized on 06/05/2018 and was discharged back to the facility on 06/11/2018. The hospital discharge summary included instructions to cleanse the sacral pressure ulcer with normal saline, apply debriding ointment, then cover with a foam dressing. The Wound Ulcer Flowsheet dated 06/12/2018 indicated Resident #1's sacral pressure ulcer was present upon her readmission to the facility. The pressure ulcer measured 6.5 cm in length, 5.0 cm in width and it was unstageable. (Unstageable means the pressure ulcer cannot be measured in depth due to tissue slough in the wound bed.) The treatment for the sacral ulcer was to cleanse with normal saline, apply a debriding ointment, then a foam dressing daily. This Wound Ulcer Flowsheet indicated the physician was notified on 06/11/2018 and the RP was notified on 06/12/2018. The Wound Ulcer Flowsheet dated 06/19/2018 revealed Resident #1's treatment for her sacral pressure ulcer was to cleanse the area with normal saline, apply a debriding ointment, then moistened gauze, then foam daily. The measurements of the sacral pressure ulcer were 5.5 cm in length, 4.5 cm in width, and 0.2 cm in depth. The date when the RP was notified was 06/11/2018. The Wound Ulcer Flowsheet dated 07/03/2018	F 580	completed on August 27, 2018 concerning physician and Resident Representative education of the following: new or worsening skin conditions, changes in resident condition, resident refusals, medication changes, physician appointments, incidents such as falls, or other episodes that require notification as well as follow up with families through each contact until someone is reached. No licensed nurse will be allowed to work until in-service has been completed. All newly hired nurses will be educated as well as on facility protocol for Resident Representative Notification as well as physician notifications. An in-service was completed on 08/10/18 with both treatment nurses by the Director of Nursing on the following: the notification of physicians of new and worsening wounds as well as other skin conditions, notification of resident representative using the resident representative wound consult form of new and worsening wounds as well as other skin conditions, routine notification of ongoing treatments of wounds, PEG tube sites, Foley sites, as well as other skin conditions to assure communication with staff and resident representatives. The RN Supervisor, Staff Facilitator, and QA Nurse will monitor all reported skin conditions 3x/wk x 4 weeks, weekly x 4 weeks, then monthly times one month using the Skin/Wound Notification Audit Tool to ensure the following: MD/RR	

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F 580	Continued From page 3 indicated under the notification section that a message was left for the RP on 07/03/2018. Review of the Wound Ulcer Flowsheet dated 07/10/2018 revealed Resident #1's sacral pressure ulcer measured 10 cm in length, 9.5 cm in depth, and 1.5 cm in depth, and the treatment was to cleanse the area with normal saline, apply a debriding ointment, then calcium alginate and apply a foam dressing daily. The same Wound Ulcer Flowsheet indicated a message was left for the RP on 07/05/2018. Review of a hospital discharge summary dated 07/20/2018 revealed Resident #1 was hospitalized from 07/12/2018 through 07/20/2018 with severe sepsis and a Stage IV sacral decubitus (pressure) ulcer. In an interview with Treatment Nurse #1 on 08/08/2018 at 3:15 PM, she stated when Resident #1 returned to the facility after her hospitalization in June (06/05/2018 through 06/11/2018), her skin around the sacrum was leathery in appearance. Treatment Nurse #1 stated she had talked with Resident #1's physician about the wound status, and the physician was to inform the RP and family of the progression of the pressure ulcer and treatments. Treatment Nurse #1 further stated she could not remember the exact date when she spoke with the physician, but it was about the time when the pressure ulcer became unstageable (06/12/2018.) During a phone interview on 08/08/2018 at 4:12 PM, RP #2 stated he nor his wife (RP #1) were notified of the condition, treatments, or staging of Resident #1's sacral pressure ulcer at any time	F 580	notification, root cause of issue addressed, incident report completed, appropriate interventions were put in place. The RN Supervisor, Staff Facilitator, and QA Nurse will forward all results from the Skin/Wound Notification Audit tool to the DON for review. The RN Supervisor, Staff Facilitator, and QA Nurse will monitor all progress notes 5x/wk x 4 weeks, then weekly x 4 weeks, then monthly times 1 month using the MD/RR Notification Tool to ensure any acute changes, behaviors, refusals, medication changes, incidents, new or worsening skin issues, or other needs have been addressed and appropriate notification per facility protocol has been completed. The RN Supervisor, Staff Facilitator, and QA Nurse will forward all results from Notification tool to the DON for review. The DON will forward the results of both the MD/RR Notification Tool and the Skin Wound Notification Audit Tool to the Executive QI committee monthly times 3 months and review the audit tools and address any concerns, issues, and/or trends as well as make changes as needed to included continued monitoring.	

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F 580	Continued From page 4	F 580		

during the month of June 2018. RP #2 further stated the first time he and RP #1 were notified of the condition of the sacral pressure ulcer was during Resident #1's hospitalization between 07/12/2018 and 07/20/2018. RP #2 stated the sacral pressure ulcer was a Stage IV at the time when he and RP #1 was notified.

In a phone interview with Resident #1's physician on 08/08/2018 at 5:20 PM, she stated she had not discussed Resident #1's sacral pressure ulcer with RP #1 or RP #2 at all during the month of June 2018.

In a follow up interview with Treatment Nurse #1 on 08/08/2018 at 6:02 PM, she stated she thought Resident #1's physician was going to speak with RP #1 about the condition of the sacral pressure ulcer based upon a conversation she had with her. Treatment Nurse #1 also stated she entered the date of the RP notification as 06/11/2018 on the Wound Ulcer Flowsheet based upon the date when she thought the physician would speak with her. Treatment Nurse #1 stated she did not talk with RP #1 or RP #2 on 06/11/2018 herself.

The Director of Nursing (DON) stated in an interview on 08/08/2018 at 6:43 PM that she expected for the treatment nurses to communicate with the RP regarding the condition and treatments of the sacral pressure ulcer. The DON added that if the family or RP could not be reached upon the first attempt, a message may be left, but the treatment nurse should contact the RP again the next day until he or she is reached.