STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345156	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY HALL NURSING AND REHABILITATION CENTER	312 WARREN AVENUE , KINSTON, North Carolina, 28501

(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
F0000	INITIAL COMMENTS A Complaint investigation survey was conducted from 7/7/25 through 7/9/25. Event ID# 4EVW. The following intakes were investigated. Complaint 798233, 798241, 798234, 798236, 798238 and 798240. 12 of the 12 complaint allegations did not result in deficiency.	F0000		
F0693 SS = D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is NOT MET as evidenced by: Based on observation, record review and staff interview the facility failed store a plastic tube feeding syringe with the plunger separate from the barrel which created a potential for bacterial growth. This deficiency was for 1 of 1 resident reviewed for enteral tube feeding management (Resident #2).	F0693	F693 Tube Feeding Management/Restore Eating Skills On 7/7/25, the staff facilitator discarded the tube feeding syringe for resident #2 and a new tube feeding syringe placed at bedside. On 7/7/25, the nurse supervisor completed an audit of all residents who receive nutrition, hydration or medications via enteral feeding tubes. This audit is to ensure the tube feeding syringe is changed daily and dated with date opened and that the syringe and plunger are stored separately after use. There were no additional concerns identified during the audit. On 7/7/25, the staff facilitator initiated an in-service with all nurses to include nurse #1 regarding Tube Feeding Syringes with emphasis on changing syringes daily, dating syringes with open date and storing the syringe/plunger separately following use. The in-service will be completed by 7/30/25. After 7/30/25 any nurse who has not received the in-service or worked will complete the in-service upon the next scheduled work shift. All newly hired nurses will be educated during orientation. The nurse supervisor, staff facilitator and/or quality assurance nurse will audit all residents who receive nutrition, hydration or medications enteral feeding tubes 5 times a week x 4 weeks then weekly x 1 month utilizing the Tube Feeding Syringe Audit Tool to ensure the tube feeding syringe is changed daily, dated with an “open” and that the syringe and plunger are stored separately after use. The nurse supervisor, staff facilitator and/or quality assurance nurse will address all concerns identified during the audit to include replacing tube feeding syringe when indicated and re-education of staff. The Director of Nursing will	07/30/2025

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 reverse for further 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.

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

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F0693 SS = D	Continued from page 1 Resident #2 was admitted to the facility on 3/2/20 with diagnoses that included dysphagia (trouble swallowing) following cerebral infarction (stroke). A quarterly Minimum Data Set (MDS) dated 4/23/25 revealed Resident #2 was severely cognitively impaired and was admitted with a gastrostomy tube (g-tube: a surgically placed tube that provided direct access to the stomach for nutrition, hydration and medication). The care plan for Resident #2 with the latest revision date of 1/24/25 indicated the use of a g-tube to assist Resident #2 with maintaining or improving nutritional status related to swallowing impairment. The goal was Resident #2 would be free from complication of g-tube feeding, i.e. aspiration formula intolerance or infection of stoma site through the next review. Interventions included to check the g-tube for patency by flushing with 30-60 cubic centimeters (cc) of water per facility policy, observe for signs or symptoms tube feeding complications such as infection and maintain gastrostomy tube for feeding purposes. An observation of Resident #2's plastic 60 cc syringe used for formula, medication and free water flushes was conducted on 7/7/25 at 10:20 AM. The syringe was observed to be stored in its open, original bag with what appeared to be water droplets inside. The syringe was stored with the piston inside the barrel. In an interview with Nurse #1 on 7/7/25 at 11:02 AM she stated she did not separate the 60 cc plunger from the barrel after use that morning. Nurse #1 further stated she had rinsed the 60 cc syringe after use and understood it should be stored with the barrel and plunger separated to avoid bacterial growth. Nurse #1 was unsure why she stored them together. In an interview with Nurse #3 on 7/7/25 at 11:45 AM she revealed she was the facility Infection Preventionist. Nurse #3 indicated Nurse #1 should have stored the barrel and piston of the 60 cc syringe separately to prevent potential disease-causing bacterial growth. In an interview with the Administrator on 7/7/25 at 12:01 PM she stated the 60 cc syringe should have been rinsed well after use and the two parts, the piston and the barrel, should be stored in the bag apart from each	F0693	Continued from page 1 review the Tube Feeding Syringe Audit Tool 5 times weekly x 4 weeks then weekly x 1 month to ensure all concerns are addressed. The DON will forward the results of the Tube Feeding Syringe Audit Tool to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 2 months to review to determine trends and / or issues that may need further interventions put into place and to determine the need for further and / or frequency of monitoring.	

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F0693 SS = D	Continued from page 2 other to prevent bacterial growth.	F0693		
F0700 SS = D	Bedrails CFR(s): 483.25(n)(1)-(4) §483.25(n) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements. §483.25(n)(1) Assess the resident for risk of entrapment from bed rails prior to installation. §483.25(n)(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation. §483.25(n)(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight. §483.25(n)(4) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff interview the facility failed to attempt alternative interventions, assess for entrapment risk, review the risks and benefits of the use of side rails, and/or obtain consent from the resident or resident representative before use of bilateral quarter length side rails. This deficient practice affected 1 of 1 resident (Resident #4) reviewed for side rails. Findings included: Resident #4 was admitted to the facility on 9/20/21 with diagnoses that included Alzheimer's disease and non-Alzheimer's dementia. Resident #4's quarterly Minimum Data Set (MDS) dated 6/7/25 revealed she required partial to moderate	F0700	On 7/7/25, the Director of Nursing evaluated resident #4 for use of bed rails to enhance mobility and independence and the risk for entrapment. Resident #4 and resident representative were educated on the risks and benefits of use with verbal consent to utilize bed rails. On 7/7/25 the Director of Nursing, Staff Facilitator, Quality Improvement Nurse and Nursing Supervisor initiated an audit of all residents utilizing bed rails. This audit is to ensure the resident was assessed for risk of entrapment per facility protocol to include interventions attempted prior to installing bed rails, education of resident and/or resident representative on risk for entrapment, ensuring bed rails are installed per facility protocol and the care plan accurately reflects the use of bed rails. The DON and assign hall nurse will address all concerns identified during the audit to include assessment of resident for risk of entrapment, initiating appropriate interventions, therapy referral as indicated, education of the resident/resident representative on risk for entrapment and/or removal or bed rails, updating care plan for use of bed rails and education of staff. The audit will be completed by 7/30/25. On 7/7/25 the Staff Facilitator initiated an in-service with all nurses regarding Bed Rails with emphasis on assessment of resident for risk of entrapment, initiating appropriate interventions, therapy referral, appropriate installation of bed rails, education of the resident/resident representative on the risk for entrapment and updating the care plan. The in-service also includes quarterly monitoring of residents utilizing bed rails per facility protocol. The in-service will be completed by 7/30/25. After 7/30/25 any nurse who has not worked or received the in-service will complete it upon the next scheduled work shift. All newly hired nurses will be in-serviced during orientation regarding Bed Rails. The Staff Facilitator, Quality Assurance Nurse and Nursing Supervisor will review 10% of residents newly identified as utilizing bed rails utilizing the Bed Rail Audit Tool weekly x 4 weeks. This audit is to ensure that any resident utilizing bed rails has been assessed per facility protocol for the risk of entrapment. Appropriate interventions were initiated to include removal of bed rails if indicated, the resident/resident representative was educated on risk for entrapment, bed rails were installed per manufacturer guidelines and care plan/care guide	07/30/2025

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F0700 SS = D	Continued from page 3 assistance with bed mobility, and she had no impairment of upper or lower extremities. The MDS indicated Resident #4 was moderately cognitively impaired. Resident #4's comprehensive care plan dated 3/21/25 revealed she did not have a care plan that included the use of side rails. Resident #4 was observed lying in her bed on 7/8/25 at 4:20 PM with bilateral quarter length side rails in the raised position. A second observation of Resident #4 was conducted on 7/9/25 at 10:30 AM. Resident #4 was observed lying in her bed with bilateral quarter length side rails in the raised position. A review of Resident #4's electronic medical record (EMR) revealed no side rail assessments were completed to include: attempting alternatives, assess entrapment risk, review risks and benefits and obtain informed consent. In an interview with Nurse #1 on 7/7/25 at 11:00 AM she stated all nurses did admissions at the facility. She further stated she does not do side rail assessments and was not sure who was responsible for completing the side rail assessment. In an interview with the Director of Nursing (DON) on 7/8/25 at 3:55 PM she stated when a resident is admitted or readmitted there are no side rails on the bed. The DON further stated a side rail assessment is only completed if it appeared side rails would help a resident with positioning and mobility. The DON indicated the floor nurse was responsible for completing the assessment. The DON was not sure why Resident #4 did not have a side rail assessment completed. The DON was unaware alternatives to side rails needed to be attempted and documented before installing them. In an interview with the Administrator on 7/8/25 at 4:01 PM she stated the side rail assessment should be completed by the floor nurse on admission, if the resident needs side rails later in their stay, and quarterly. The Administrator indicated side rail assessments were not completed on admission or	F0700	Continued from page 3 updated for use of bed rails. The Director of Nursing or Administrator will address all areas of concern identified during the audit to include assessment of resident for risk of entrapment, initiating appropriate interventions, therapy referral as indicated, education of the resident/resident representative and/or removal or bed rails. DON will review the Bed Rail Audit Tool weekly x 4 weeks to ensure all areas of concern are addressed. The DON will present the findings of the Bed Rail Audit Tool to the Quality Assurance Performance Improvement (QAPI) committee monthly for 1 month for review and to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring	

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F0700 SS = D	Continued from page 4 quarterly for Resident #4.	F0700		