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 02/01/2019

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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E 000	Initial Comments An unannounced Recertification survey was conducted on 01/28/19 through 02/01/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # BVG211.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of the Complaint Investigation, Event ID BVG211 on 2/1/2019.	F 000		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable	F 623		2/18/19

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

Electronically Signed | 02/18/2019

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F 623	Continued From page 1	F 623		

before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with

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F 623	Continued From page 2 developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and (vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews the facility failed to provide written notification to the resident/resident representative of the reason for discharge to the hospital and failed to provide a copy of the notice to the Ombudsman for 1 of 2 sampled residents reviewed (resident #1) for hospitalization.	F 623	The Ombudsman and resident representative (RR) were notified by the Social Worker (SW) on 01/31/19 of resident # 1□s discharge to the hospital via letter. On 01/31/19 the Director of Nursing (DON) completed a 100% audit of all residents transferred or discharged to the	

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F 623	Continued From page 3 Findings included: Resident #1 was admitted to the facility on 09/24/18. Resident #1 ' s diagnosis included sepsis, gastroparesis, urinary tract infection (UTI), chronic obstructive pulmonary disease (COPD), disease of salivary glands, gastro esophageal reflux disease (GERD), Alzheimer ' s, contractures, fever, anus hemorrhage, pneumonitis, saddle embolus, sacral pressure ulcer stage 4, unstageable ischium ulcer, diabetes, malignant neoplasm, gastrostomy, and dementia. Review of Resident #1 ' s medical record revealed a hospital discharge on 01/05/19. The resident returned to the facility on 01/11/19. During an interview on 01/31/19 at 3:40 PM, the facility Social Worker revealed the resident/resident representative was usually notified by telephone call and documented in the resident ' s record. She revealed she was not aware that a letter was supposed to be sent to the resident/resident representative regarding the reason a resident was being discharged to the hospital. The Social Worker also revealed she did not know anything about sending a letter to the Ombudsman when a resident was discharged to the hospital. During an interview on 01/31/19 at 4:35 PM, the Administrator revealed she was not sure that a log of the discharges was being sent to the Ombudsman monthly. She revealed she was also not aware a letter had to be sent to the resident/resident representative when a resident was discharged to the hospital. She stated the residents ' family was called and information was	F 623	hospital within the past 30 days to ensure written notification was sent to RR/resident to ensure written notification was sent to the Regional Ombudsman via email by the Social Worker (SW). Written notification was sent to either the resident or RR via mail and via email to the Regional Ombudsman for any identified concerns noted on 02/01/19. The DON and Staff Facilitator initiated an in-service on 01/31/19 with all nurses in regards to when a resident is sent to the hospital the facility must provide a copy of the bed hold policy with the discharge packet and documentation must be placed in the progress notes. In-service to be completed on 02/14/19. All newly hired licensed nurses will be in-serviced by the Staff Facilitator during orientation in regards to when a resident is sent to the hospital the facility must provide a copy of the bed hold policy with the discharge packet and documentation must be placed in the progress notes. On 01/31/19 the facility administrator in-serviced the Social Workers in regards to: All residents that are transferred to the hospital must have written notification letter with bed hold policy sent to either RR or resident immediately upon SW notification of resident discharge from facility. The Regional Ombudsman must be notified at their time preference via email of all residents transferred to the hospital. The notification email to the regional ombudsman must be printed and placed in binder along with receipt of certified letter. All newly hired SW will be in-serviced during orientation by the Staff	

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F 623	Continued From page 4 documented in the record but written documentation wasn ' t sent.	F 623	Facilitator in regards to: All residents that are transferred to the hospital must have written notification letter with bed hold policy sent to either RR or resident immediately upon SW notification of resident discharge from facility. The Regional Ombudsman must be notified at their time preference via email of all residents transferred to the hospital. The notification email to the regional ombudsman must be printed and placed in binder along with receipt of certified letter. 100% of all residents transferred or discharge to the hospital will be monitored by the DON to ensure bed hold policy sent with resident with transfer paper work with documentation in the clinical record, notification by SW of resident transfer with reason and bed hold policy to resident or RR via mail, and notification of regional ombudsman monthly. This audit will be completed weekly timeseight weeks then monthly times 1 month using the Discharge Transfer Audit Tool. If areas of concerns are identified, the DON will immediately retrain the SW or Nurse. The Administrator will review and initial the Discharge Transfer Audit Tool weekly times eight weeks then monthly times 1 month for completion and to ensure all areas of concern have been addressed. The Administrator will present the findings of the Discharge Transfer Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Discharge Transfer Audit Tool to	

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F 623	Continued From page 5	F 623	determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the care plan for a resident with a	F 657	Resident # 105s□ care plan was reviewed and revised on 02/01/19 by the	2/18/19

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F 657	Continued From page 6 pressure ulcer was not revised and updated from a risk for pressure ulcer to an actual pressure ulcer for one of four residents reviewed for pressure ulcers (Resident #105). Findings included: A review of the medical record revealed Resident #105 was admitted 7/21/2011 with diagnoses of Coronary Artery Disease, Diabetes Mellitus and stroke. The Annual Minimum Data Set (MDS) dated 5/18/2018 noted Resident #105 to be cognitively intact and needed extensive to total assistance for all Activities of Daily Living, with the physical assistance of one to two persons. The Care Area Assessment focused on pressure ulcers and this area went to care plan. The care plan 7/30/2018 noted a focus of risk for pressure ulcers and a goal of resident will not develop a pressure ulcer through next review. The interventions were preventive. An observation of the pressure ulcer and the treatment was made on 2/1/2019 at 9:45 AM. In an interview on 2/1/2019 at 11:30 AM the MDS Coordinator stated assessments were checked for pressure ulcers and the treatment nurse would call and tell the MDS nurses when new pressure ulcers were found. The Coordinator noted when the MDS nurses did progress notes all of the information was reviewed. The Coordinator stated the pressure ulcer was found for Resident #105 on 12/14/2018. On 2/1/2019 at 11:40 AM, the nurse assigned to	F 657	Minimum Data Set (MDS) Nurse to reflect actual alteration in skin integrity. On 02/01/19 the Director of Nursing (DON) completed a 100% audit of all residents with wounds to ensure residents care plan reflects current alterations in skin integrity. Any areas of concern identified were immediately addressed by the DON and corrections were made. On 02/01/19 the DON completed an in-service with the facility treatment nurses in regards to the following: it is the responsibility of the wound care nurse to communicate daily during Cardinal Interdisciplinary Team meeting any newly acquired pressure ulcers from current or newly admitted residents to ensure entire team including, but not limited to, Minimum Date Set (MDS) Coordinator or Nurse is aware. All newly hired treatment nurses will be in-serviced by the Staff Facilitator during orientation in regards to the following: it is the responsibility of the wound care nurse to communicate daily during Cardinal Interdisciplinary Team meeting any newly acquired pressure ulcers from current or newly admitted residents to ensure entire team including, but not limited to, Minimum Date Set (MDS) Coordinator or Nurse is aware. On 02/04/19 the DON completed an in-service with the MDS Coordinator and MDS Nurse in regards to the following: MDS information should reflect a current accurate assessment of the residents condition including but not limited to pressure ulcers, surgical wounds, or other alterations in skin integrity. All newly hired MDS Nurses will be in-serviced during	

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F 657	Continued From page 7 Resident #105 for MDS was interviewed and indicated she missed putting the pressure ulcer in the care plan. The nurse stated "I just made a human error." On 2/1/2019 at 4:00 PM, the facility Administrator and the Director of Nursing were interviewed and stated their expectation was the MDS information would be current and correct.	F 657	orientation in regards to the following: MDS information should reflect a current accurate assessment of the residents condition including but not limited to pressure ulcers, surgical wounds, or other alterations in skin integrity. The DON will monitor weekly times 8 weeks then monthly times 1 month using the Pressure Ulcer Audit Tool 100% of all newly acquired pressure ulcers and newly admitted residents with pressure ulcers to ensure residents care plan is updated to reflect accurate MDS assessment of resident. Any areas of concern will be immediately corrected. The Administrator will review and initial the Pressure Ulcer Audit Tool weekly times 8 weeks then monthly times on month to ensure completion and all areas of concern addressed. The Administrator will present the findings of the Pressure Ulcer Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Pressure Ulcer Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring.	
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such	F 695		2/18/19

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F 695	Continued From page 8 care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to provide respiratory care by not changing the oxygen tubing weekly for two of two residents reviewed (Resident #102 and Resident #107). Findings included: 1. A review of the medical record revealed Resident #102 was admitted 12/2/2013 with diagnoses which included sepsis, pneumonia and stroke. The Quarterly Minimum Data Set (MDS) dated 1/10/2019 noted Resident #102 to be severely impaired for cognition and needed total assistance for all Activities of Daily Living with the physical help of one to two persons. The care plan dated 2/28/2018 noted a focus of potential for ineffective breathing pattern related to history of ineffective breathing. The goal was to maintain an airway. Interventions included: oxygen therapy as ordered. A review of the physician orders revealed Resident #102 was to receive oxygen at 2 liters per minute via nasal cannula. On 1/28/2019 at 4:30 PM an observation was made of Resident #102 wearing his oxygen. The tubing was dated with a marker indicating 1/15/19.	F 695	On 02/01/19 Resident # 102 and # 107 oxygen tubing was changed and dated by assigned hall nurse. On 02/01/19 the Director of Nursing (DON) completed an audit of all residents receiving any form of respiratory therapy/treatments to include oxygen supplies, tracheostomy care supplies, nebulizer supplies, and suctioning supplies to ensure changed timely. Any identified concerns were immediately addressed by the assigned hall nurse. On 02/01/19 an in-service was initiated by the DON and the Staff Facilitator with all nurses in regards to the following: it is the responsibility of all nurses to ensure all respiratory supplies to include oxygen supplies, tracheostomy care supplies, nebulizer supplies, and suctioning supplies is changed weekly by the medical supply clerk. If at any time the supplies is not changed, it is the responsibility of the nurse to change the supplies per facility policy, and to notify the DON/Administrator of supplies not being changed. Respiratory care supplies are kept in the medical supply rooms on each floor as well as the facility medical supply room. In-service will be completed by 02/14/19. All newly hired licensed nurses will be in-serviced during orientation by the Staff Facilitator in regards to the following: it is the	

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F 695	Continued From page 9 On 1/30/2019 a 10:30 AM, in an interview, Nurse #1 stated the Central Supply clerk changed oxygen tubing weekly. In an interview on 1/31/2019 at 3:30 PM, the Central Supply clerk stated she changed the oxygen tubing and humidifiers and it was to be done weekly. The clerk had a copy of the census and dates were written beside resident's names, with the latest date being 1/15/19. When asked if those dates were the last time the tubing was changed, the clerk stated that was the last time it was recorded. A review of the facility policy stated the tubing, humidifier bottle and catheter or mask must be changed weekly. On 2/1/2019 at 9:00 AM Nursing Assistant (NA) #1 stated she would take the oxygen tubing off to take a resident into the shower. NA #1 stated she had seen a tab with a date on the tubing. In an interview on 2/1/2019 at 9:05 AM, NA #2 stated she was aware of a tab with a date on the tubing. On 2/1/2019 at 2:18 PM, in an interview, NA #3 stated she had just begun to help the Central Supply clerk in changing the tubing for the oxygen for the residents. NA #3 indicated she uses the census list of residents and uses a marker to write the date on the tubing. NA #3 noted that she had not changed any tubing that particular week because she was doing 1:1 with a resident. On 2/1/2019 at 4:00 PM, in an interview, the facility Administrator stated her expectation was	F 695	responsibility of all nurses to ensure all respiratory supplies to include oxygen supplies, tracheostomy care supplies, nebulizer supplies, and suctioning supplies is changed weekly per facility policy by the medical supply clerk. If at any time the supplies is not changed, it is the responsibility of the nurse to change the supplies, and to notify the DON/Administrator of supplies not being changed. Respiratory care supplies are kept in the medical supply rooms on each floor as well as the facility medical supply room. On 02/01/19 the facility Administrator completed an in-service with the Medical Supply Clerk in regards to: the medical supply clerk is to order and keep on hand a sufficient amount of respiratory supplies including but not limited to: oxygen tubing, oxygen water bottles, nebulizer masks, tracheostomy supplies, suction canisters, suction tubing and catheters, etc. It is the responsibility of the Medical Supply Clerk to change all respiratory supplies every week per facility policy. If the Medical Supply Clerk is unable to change the supplies, then you are to notify the Administrator/DON, distribute the supplies needed to each station, and then the DON will assign the task to each floor nurse. All newly hired medical supply clerks will be in-serviced during orientation by the Staff Facilitator in regards to the following: it is the responsibility of all nurses to ensure all respiratory supplies to include oxygen supplies, tracheostomy care supplies, nebulizer supplies, and suctioning supplies is changed weekly per	

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F 695	Continued From page 10 the oxygen tubing would be changed weekly. 2. A review of the medical record revealed Resident #107 was admitted 5/4/2018 with diagnoses including pulmonary fibrosis, shortness of breath, acute bronchitis, cough and acute and chronic respiratory failure with hypoxia. The Significant Change Minimum Data Set (MDS) dated 9/6/2018 noted Resident #107 was cognitively intact and needed supervision to extensive assistance for all Activities of Daily Living with the physical help of one person. The care plan dated 10/31/2018 noted a focus of potential for ineffective breathing pattern related to Chronic Obstructive Pulmonary Disease, lung disease and pulmonary fibrosis. The goal was Resident #107 would have their airway maintained through the next review. Interventions included: Oxygen therapy as ordered. A review of orders by the physician noted an order for Resident #107 to have oxygen via nasal cannula at 6 liters per minute continuously. On 1/28/2019 at 4:15 PM, Resident #107 was observed in her room with the oxygen on and the tubing dated 1/15/19 with black marker. On 1/30/2019 a 10:30 AM, in an interview, Nurse #1 stated the Central Supply clerk changed oxygen tubing weekly. In an interview on 1/31/2019 at 3:30 PM, the Central Supply clerk stated she changed the oxygen tubing and humidifiers and it was to be done weekly. The clerk had a copy of the census and dates were written beside resident's names,	F 695	facility policy by the medical supply clerk. If at any time the supplies are not changed, it is the responsibility of the nurse to change the supplies, and to notify the DON/Administrator of supplies not being changed. Respiratory care supplies are kept in the medical supply rooms on each floor as well as the facility main medical supply room. 25% of all residents requiring respiratory supplies to include resident # 102 and # 107 will be monitored using the Resident Respiratory Supplies Audit Tool will be monitor weekly times 8 weeks then monthly times one month by the Unit Manager, Registered Nurse Supervisor, Assistant Director of Nursing, and Treatment Nurse to ensure respiratory supplies were changed and dated weekly. Any concerns will be immediately corrected by the Unit Manager, Registered Nurse Supervisor, Assistant Director of Nursing, and Treatment Nurse during audit. The DON will review and initial the Resident Respiratory Supplies Audit Tool weekly times eight weeks then monthly times one month for completion and to ensure all areas of concern have been addressed The DON will present the findings of the Resident Respiratory Supplies Audit Tool to the Executive Quality Assurance (QA) committee monthly for 3 months. The Executive QA Committee will meet monthly for 3 months and review the Resident Respiratory Supplies Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for	

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 02/01/2019

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 695	Continued From page 11 with the latest date being 1/15/19. When asked if those dates were the last time the tubing was changed, the clerk stated that was the last time it was recorded. A review of the facility policy stated the tubing, humidifier bottle and catheter or mask must be changed weekly. On 1/31/2019 at 4:00 PM, in an interview, Resident #107 stated someone in the facility had changed the bottle and the tubing, but it had been over a week ago. On 2/1/2019 at 9:00 AM Nursing Assistant (NA) #1 stated she would take the oxygen tubing off to take a resident into the shower. NA #1 stated she had seen a tab with a date on the tubing. In an interview on 2/1/2019 at 9:05 AM, NA #2 stated she was aware of a tab with a date on the tubing. On 2/1/2019 at 2:18 PM, in an interview, NA #3 stated she had just begun to help the Central Supply clerk in changing the tubing for the oxygen for the residents. NA #3 indicated she uses the census list of residents and uses a marker to write the date on the tubing. NA #3 noted that she had not changed any tubing that particular week because she was doing 1:1 with a resident. On 2/1/2019 at 4:00 PM, in an interview, the facility Administrator stated her expectation was the oxygen tubing would be changed weekly.	F 695	further frequency of monitoring.	