POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA /	MULTIPLE CONSTRUCTION		DATE OF REVISIT	
IDENTIFICATION NUMBER	A. Building			
345156 _{Y1}	B. Wing	Y2	11/20/2024	Y3
NAME OF FACILITY		STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMONY HALL NURSING AND REHABILITATION CENTER 3	312 WARREN AVENUE			
		KINSTON, NC 28501		

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction, that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

ITE	м	DATE	ITEM		DATE	ITEM		DATE
Y4		Y5	Y4		Y5	Y4		Y5
ID Prefix Reg. # LSC	F0554 483.10(c)(7)	Correction Completed 11/13/2024	ID Prefix Reg. # LSC	F0582 483.10(g)(17)(18)(i)-(v)	Correction Completed 11/13/2024	ID Prefix Reg. # LSC	F0689 483.25(d)(1)(2)	Correction Completed 11/13/2024
ID Prefix Reg. # LSC	F0690 483.25(e)(1)-(3)	Correction Completed 11/13/2024	ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
ID Prefix Reg. # LSC		Correction Completed	ID Prefix Reg. # LSC		Correction	ID Prefix Reg. # LSC		Correction Completed
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10/30/2024			UNC		S (CMS-2567) SEN	T TO THE FAC		YES NO