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 02/02/2018

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 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the	F 550		2/9/18

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

Electronically Signed | 02/09/2018

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F 550	Continued From page 1 exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, staff and resident interview, the facility failed to provide care in a manner to maintain the dignity of one of four residents reviewed for dignity (Resident #13) by failing to provide Activity of Daily Living care when the Resident was left incontinent before and during breakfast. Findings included: A review of medical records revealed Resident # 13 was admitted 1/10/2013 with diagnoses of cerebral palsy, epilepsy, anxiety and depression. The Annual Minimum Data Set (MDS) dated 5/10/2017 noted Resident #13 to be cognitively intact and needed extensive assistance for all Activities of Daily Living (ADLs) with the physical assistance of one to two persons. On 1/30/2018 at 9:38 AM Resident #13 was observed in his room in a wheel chair finishing his breakfast. Resident #13 stated he had turned on his call bell earlier that morning to be changed because he was wet. Resident #13 indicated he was told that the Nursing Assistant (NA) assigned to him was giving someone a bath and would be in when she finished. Resident #13 also stated a nurse from the 500 station came in and turned the call bell off and left the room. Resident #13 stated when the NA assigned to him finished with the bath, she came into Resident #13's room and told him breakfast trays were on the hall and she could not change him because of that. Resident #13 stated he ate breakfast in his wet brief. When asked if he was still wet, the Resident stated he	F 550	F-550 The process that led to this deficiency was the facility failed to provide care to maintain dignity for resident #13 by failing to provide activity of daily living during meal. On 1/29/18 resident #13 was immediately provided incontinent care by Nursing Assistant #1. On 1/29/18 100% audit of all residents was completed by Administrative Nurses to assure all residents had been provided incontinent care timely to include during meal time. No concerns were noted. On 1/29/18, an 100% in-service with all licensed nurses and nursing assistants was initiated by the Director of Nursing (DON) in regards to Incontinent Care to include providing incontinent care during meal times. In-service was completed on 2/8/18. In-service included: 1. Incontinent care will be provided following each incontinent episode to include during meal times 2. Steps to provide incontinent care during meal time for a resident in a private room 3. Steps to provide incontinent care during meal time for a resident in a semi-private room All newly hired licensed nurses and NAs will be in-serviced in regards to Incontinent Care to include providing incontinent care during meal times during orientation by the Staff Facilitator. In-service to included:	

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F 550	Continued From page 2 was. Resident #13 stated he felt bad when he was not changed and had to sit and eat while wet. On 2/1/2018 at 9:00 AM, in an interview, the Director of Nursing stated her expectation was the nurse who came in and turned the call bell off should have assisted Resident #13, and a resident would be changed no matter if it was mealtime or not. On 2/1/2018 at 9:45 AM, in an interview, the facility Administrator stated his expectation was residents would be changed whether meals were on the hall or not. The Administrator also indicated nurses should help with cares when needed.	F 550	1. Incontinent care will be provided following each incontinent episode to include during meal times 2. Steps to provide incontinent care during meal time for a resident in a private room 3. Steps to provide incontinent care during meal time for a resident in a semi-private room On 2/7/18, a 100% in-service was initiated by the Staff Facilitator with all licensed nurses, NAs, dietary staff, Dietary Manager, Therapy Manager, Therapy staff, Accounts Receivable, Accounts Payable, Social Worker, Housekeeping Supervisor, Housekeeping staff, Medical Records, Admissions Coordinator, Minimum Data Set Nurse, Quality Improvement nurse (QI), and Treatment nurse on Dignity to include providing incontinent care. In-service was completed on 2/8/18. All newly hired licensed nurses, NAs, dietary staff, Dietary Manager, Therapy Manager, Therapy staff, Accounts Receivable, Accounts Payable, Social Worker, Housekeeping Supervisor, Housekeeping staff, Medical Records, Admissions Coordinator, Minimum Data Set Nurse, Quality Improvement nurse (QI), and Treatment nurse will be in-serviced on the Dignity to include providing incontinent care during orientation by the Staff Facilitator. 25 % of all residents to include resident #13 will be observed by the Staff Facilitator and the QI Nurse for incontinent care to include meal times utilizing the Incontinent Care Audit Tool 5	

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F 550	Continued From page 3	F 550	x a week for 4 weeks, weekly x 4 weeks then monthly x 1 month to ensure all residents to include resident #13 are offered incontinent prior to and/or during meals per facility protocol. Any staff who fail to provide incontinent care prior to and/or during meal time will be immediately in-serviced by the Staff Facilitator on procedure for providing incontinent care to include incontinent care during meal time. The Director of Nursing will review and initial the Incontinent Care Audit Tool 5 x a week for 4 weeks, weekly x 4 weeks then monthly x 1 month for completion and to ensure all areas of concern are addressed. The Administrator will forward the results of Incontinent Care Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Incontinent Care Audit Tool 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. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	
F 585 SS=D	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity	F 585		2/9/18

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F 585	Continued From page 4	F 585		

that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may

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F 585	Continued From page 5	F 585		

be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation

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F 585	Continued From page 6 of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review the facility failed to provide a written grievance summary for 1 of 1 residents (Resident #260). Findings include: Review of the Minimum Data Set (MDS) dated 10/23/17 revealed Resident 260 was admitted to the facility on 10/6/17 with a diagnosis of Diabetes, Chronic Respiratory Failure, Sepsis, and Congestive Heart Failure (CHF). Resident #260 was cognitively intact, and needed supervision to limited assistance for all activities of daily living (ADLs). The plan of care for Resident #260 dated 10/19/17 was reviewed with no concerns. Review of the Grievance Log for the three months revealed one grievance had been recorded for Resident #260's family member. In an interview with the facility Administrator on 02/1/18 at 10:25 AM revealed that the grievance received from Resident #260's family member was resolved verbally. He also said that the facility never provided a written resolution and	F 585	F585 The process that led to this deficiency was the facility failed to provide resident #260 or resident representative (RR) a written grievance summary per the Resident Grievance Policy and per Resident Concern and Grievance guidelines. On 2/7/18 a 100% audit of all grievances x 90 days was completed by the Director of Nursing to ensure all residents to include resident #260 or resident representative was provided a written grievance summary per the Resident Grievance Policy and per Resident Concern and Grievance guidelines. Any grievance that does not have a written grievance summary will be immediately addressed by the Administrator and a written grievance summary completed and mailed to the resident or resident representative. On 2/9/18 the Administrator sent a written grievance summary to Resident Representative of resident #260 via certified mail for grievance dated 10/23/17. No other concerns were noted. On 2/9/18, the Administrator, Director of	

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F 585	Continued From page 7 summary for the grievance to the resident's family member, and should have. In an interview with the Director of Nursing (DON) on 01/31/18 at 10:20 AM she reported that she resolved the resident's family grievance verbally and never provided her with a written resolution and summary to the grievance. She acknowledged the family should have been provided a written resolution and summary, and did not.	F 585	Nursing and the Social Worker was in-serviced by the Facility Consultant on the Resident Grievance Policy and guidelines to include the Administrator □s responsibility to assure the resident or resident representative is provided with a written grievance summary results upon completion of the grievance investigation. 10% of resident grievances to be reviewed weekly for 8 weeks, then monthly for one month by the Administrator to ensure written notification of grievance results and decisions were provided to the resident and/or resident representative, utilizing the Grievance Summary Audit Tool. Any areas of identified concern will be immediately addressed by the Administrator during the audit to include notification of the resident or resident representative and/or additional staff training. The Administrator will forward the results of the Grievance Summary Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Grievance Summary Audit Tool 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. The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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F 693	Continued From page 8	F 693		
F 693 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 record review, observations and staff interviews, the facility failed to elevate the head of the bed for tube fed residents who were continually fed which resulted in the increased risk of aspiration for 2 of 7 tube fed residents reviewed (Resident #91 and Resident #92). Findings included: 1: Record review revealed Resident #91 was admitted to the facility on 9/26/2017 with	F 693	F693 The process that led to this deficiency was the facility failed to elevate the head of the bed for tube fed residents to include resident #91 and resident #92 who are continually fed which resulted in the increase risk for aspiration. On 2/1/18 an 100% audit of all tube fed residents to include resident # 91 and resident #92 was completed by the Quality Improvement Nurse (QI) to ensure the head of the bed was elevated at least 30-45 degrees to prevent risk of	2/9/18

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F 693	Continued From page 9 diagnoses which included Respiratory Failure and Gastrostomy (surgically inserted tube for feeding) status. Review of the Quarterly Minimum Data Set (MDS) dated 1/12/2018 indicated Resident #91 was rarely/never understood and required total assistance of 1 person for all activities of daily living (ADLs). The MDS further revealed all the resident's nutritional and hydration needs were provided through the feeding tube. Review of Resident's care Plan updated 1/17/2018 indicated to monitor for signs and symptoms of aspiration. The Care Plan also included the Resident Care Guide which listed to keep the head of the bed elevated. Resident #91's Physician orders for January 2018 and February 2018 were reviewed. Orders for continual tube feedings with water flushes were noted in the Physician's orders. Observations of Resident #91 were conducted on: -1/30/2018 at 9:36 AM. The resident was observed lying in bed with the tube feeding infusing. The head of the bed was observed to be raised approximately 10 degrees. -1/30/2018 at 11:23 AM. The resident was observed in bed with the head of the bed in the same position and the tube feeding infusing. -1/31/2018 at 9:22 AM. The resident was observed in bed with the head of the bed in the same position and the tube feeding infusing. 1/31/2018 at 11:54 AM. The resident was observed in bed with the head of the bed in the same position and the tube feeding infusing.	F 693	aspiration. The head of the bed was raised to 45 degrees for resident #91 and resident #92 during the audit. Wedges were placed between the bed and the mattress of the bed for all tube fed residents to maintain the head of the bed between a 30-45 degrees. No other concerns were identified. On 2/1/18 an 100% audit of care plans for all tube fed residents was completed by the Minimum Data Set Nurse (MDS) to include resident #91 and resident #92 to ensure residents were care planned for risk of aspiration related to continuous tube feeding to include the intervention to keep the head of the bed elevated between 30-45 degrees. All areas of concern were immediately addressed by the MDS Nurse and the care plan updated. On 2/1/18 an 100% in-service with all licensed nurses and nursing assistants (NA) on Aspiration Precautions for tube fed residents in regards to keeping the head of the bed elevated 30-45 degrees to prevent risk of aspiration was initiated by the Nurse Supervisor. No licensed nurse or NAs will be allowed to work until in-servicing is completed. In-service was completed on 2/8/18. All newly hired licensed nurses and NAs will be in-serviced on Aspiration Precautions for tube fed residents in regards to keeping the head of the bed elevated 30-45 degrees to prevent risk of aspiration during orientation by the Staff Facilitator. 25% audit of all tube fed residents will be completed by the Nurse Supervisor	

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F 693	Continued From page 10 An interview was conducted with Nurse #4 on 2/1/2018 at 8:45 AM. Nurse #4 confirmed she worked with Resident #91 during the 7:00 AM to 3:00 PM on 1/30/2018 through 2/1/2018. The nurse indicated awareness of the need for the head of the bed of tube fed residents to be elevated at 45 degrees to avoid aspiration. The nurse reported there were times when she observed Resident #91 to be in bed with the tube feeding infusing and the head of the bed not raised to the required level. The nurse indicated if she observed the head of the bed lowered, she immediately raised it to 45 degrees. An interview was conducted with Nursing Assistant (NA) #4 on 2/1/2018 at 8:55 AM. NA #4 confirmed she worked with Resident #91 on the 7:00 AM to 3:00 PM shift daily. NA #4 indicated she made sure the resident's head of the bed was raised to 45 degrees so the resident would not aspirate. The NA reported she turned the feeding pump off prior to lowering the head of the bed to provide ADL care and raised the head of the bed to 45 degrees when the care was completed. An interview was conducted with the Director of Nursing (DON) on 2/01/18 at 10:26 AM. The DON stated the expectation was for all tube feeding residents who were continually fed to be positioned in bed with the head of the bed raised 30 to 45 degrees to prevent aspiration. The DON further indicated all direct care staff were aware of the expectation for required positioning of tube fed residents. 2: Record review revealed Resident #92 was	F 693	utilizing the Aspiration Risk Quality Improvement (QI) Audit Tool 3 x week for 4 weeks, weekly x 4 weeks then monthly x 1 month to ensure all tube fed residents are care planned/care guide for Risk for Aspiration to include keeping head of bed elevated 30-45 degrees to prevent aspiration. Any areas of concern will be immediately addressed by the Nurse Supervisor and staff re-training completed. The Director of Nursing will review the Aspiration Risk (QI) Audit Tool 3 x a week for 4 weeks, weekly x 4 weeks then monthly x 1 month to ensure all areas of concern are addressed. The Administrator will forward the results of the Aspiration Risk (QI) Audit Tool Audit Tool to the Executive QI Committee monthly x 3 months. The Executive QI Committee will meet monthly x 3 months and review the Aspiration Risk (QI) Audit Tool Audit Tool 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 The Administrator and Director of Nursing will be responsible for the implementation of corrective actions to include all 100% audits, in services, and monitoring related to the plan of correction.	

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originally admitted to the facility on 4/27/2012 and was hospitalized on 10/7/2017 for a gastrostomy tube (surgically inserted tube for feeding) placement procedure. The resident's diagnoses included diaphragmatic hernia and gastrostomy status.

Review of the Significant Change Minimum Data Set (MDS) dated 10/12/2017 indicated Resident #92 was severely cognitively impaired and required extensive to total assistance for all activities of daily living (ADLs). The MDS further revealed all the resident's nutritional and hydration needs were provided through the feeding tube.

Review of Resident's care Plan updated 10/12/2017 indicated to monitor for signs and symptoms of aspiration. The Care Plan also included the Resident Care Guide which listed to keep the head of the bed elevated.

Resident #92's Physician orders for January 2018 and February 2018 were reviewed. Orders for continual tube feedings with water flushes were noted in the Physician's orders.

Observations of Resident #92 were conducted on:
-1/30/2018 at 9:32 AM. The resident was observed lying in bed with the tube feeding infusing. The head of the bed was observed to be raised approximately 5 to 10 degrees.
-1/30/2018 at 10:54 AM. The resident was observed in bed with the head of the bed in the same position and the tube feeding infusing.
-2/1/2018 at 10:04 AM. The resident was observed in bed with the head of the bed in the same position and the tube feeding infusing.

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 02/02/2018

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 693	Continued From page 12 On 2/1/2018 at 10:08 AM, an observation was made of Resident # 92 by Nurse #5 while this surveyor was in the resident's room. Nurse #5 confirmed she worked with Resident #92 during the 7:00 AM to 3:00 PM on 1/30/2018 through 2/1/2018. Nurse #5 raised the resident's head of the bed to approximately 45 degrees. The nurse indicated awareness of the need for the head of the bed of tube fed residents to be elevated at 45 degrees to avoid aspiration. Nurse #5 reported she was unaware who left the resident's head of the bed lowered with the tube feedings infusing. An interview was conducted with Nursing Assistant (NA) #5 on 2/1/2018 at 10:19 AM. NA #5 confirmed she was the NA responsible for Resident #92 on the 7:00 AM to 3:00 PM shift. NA #5 reported she was aware of the need for tube fed resident's to be positioned with the head of the bed raised. She stated she was unsure how much the bed needed to be raised. NA #5 indicated she did not remember if the head of the bed was raised when she last checked on Resident #92. An interview was conducted with the Director of Nursing (DON) on 2/01/18 at 10:26 AM. The DON stated the expectation was for all tube feeding residents who were continually fed to be positioned in bed with the head of the bed raised 30 to 45 degrees to prevent aspiration. The DON further indicated all direct care staff were aware of the expectation for required positioning of tube fed residents.	F 693		