## SUMMARY STATEMENT OF DEFICIENCIES

### F 583

#### SS=D

**Personal Privacy/Confidentiality of Records**

**CFR(s): 483.10(h)(1)-(3)(i)(ii)**

- **§483.10(h) Privacy and Confidentiality.**
  - The resident has a right to personal privacy and confidentiality of his or her personal and medical records.
  
- **§483.10(h)(1) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

- **§483.10(h)(2) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.**

- **§483.10(h)(3) The resident has a right to secure and confidential personal and medical records.**
  
- **(i) The resident has the right to refuse the release**
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<tr>
<th>ID</th>
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<td>Continued From page 1 of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws. (ii) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's medical, social, and administrative records in accordance with State law. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to protect the private health information for 1 of 1 resident as evidenced by leaving the resident's personal and medical information exposed on an open and unattended computer screen in an area accessible to the public. (Resident #120) Findings included: Review of the medical record of resident #120 revealed the resident was admitted to the facility on 10/23/19 with cumulative diagnoses which included Atrial Fibrillation, Hypertension and Dementia. The resident's quarterly Minimum Data Set (MDS) dated 12/30/19 revealed the resident's cognition was moderately impaired. A continuous observation of the medication cart on the 2200 hall was conducted on 1/10/20 from 7:50 AM to 7:55 AM. At 7:50 AM on 1/10/29, the medication cart on the 2200 hall was observed unattended. The computer screen on the cart was open and showed Resident #120's face, name, age, date of birth, and medications the resident received. The cart was unattended with the computer screen open to Resident 120's confidential information until 7:55AM when the nurse returned. An interview was conducted with Nurse #1 at 7:56 AM on 1/20/20. The nurse stated the computer screen on the cart was open and showed Resident #120's face, name, age, date of birth, and medications the resident received. The cart was unattended with the computer screen open to Resident 120's confidential information until 7:55AM when the nurse returned.</td>
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<td>On 1/10/2020 Immediate retraining was conducted by the Staff Facilitator with the nurse #1 regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. 100% audit was completed on 01/10/2020 to ensure all electronic medical records are closed and not exposing resident's personal and medical information when left unattended in an area accessible to the public by Nurse Supervisor and Staff Facilitator. No identified areas of concerns identified during audit. 100% in service was initiated on 1/10/2020 by the Staff Facilitator with all nurses and Medication Aides regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public. This in-service was completed on 1/13/2020. All newly hired nurses and Medication Aides will receive in-service regarding protecting private health information by closing electronic medical record when left unattended in an area accessible to the public during orientation.</td>
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**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**HARMONY HALL NURSING AND REHABILITATION CENTER**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

312 WARREN AVENUE
KINSTON, NC  28502

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<td>Continued From page 2 screen should be turned off whenever the nurse has walked away. An interview was conducted with the administrator on 1/10/20 at 12:40 PM, and the administrator stated the nurses are supposed to protect the resident's health record.</td>
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<td>by the Staff Facilitator. 100% of Electronic Medical Records on the Medication Carts will be monitored using a Medication Cart Security /HIPPA QA Audit Tool to ensure all electronic medical records are closed to protect private health information when left unattended in an area accessible to the public. This audit will be completed by the Nurse Supervisor, Staff Facilitator, and Assisted Director Nursing weekly x 4 weeks and monthly x 1 month. Any identified area of concern will be immediately addressed by Nurse Supervisor, Staff Facilitator or Assistant Director of Nursing by re-educating the nurse or medication aide on closing the electronic medical record when left unattended in an area accessible to the public. The Director of Nursing will review and initial the Medication Cart Security/HIPPA QA Audit tool for completion and to ensure all areas of concerns were addressed weekly X’s 4 weeks and monthly x 1 month. The Administrator will forward the results of the Medication Cart Security /HIPPA QA Audit Tool to the Executive QA Committee monthly x 2 months. The Executive QA Committee will meet monthly x 2 months and review the Medication Cart Security /HIPPA QA 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.</td>
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