DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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NAME OF PROVIDER OR SUPPLIER HARMONY HALL NURSING AND REHABILITATION CENTER PAGE 12 PORT 12 PROVIDER OR SUBMARY STATEMENT OF DEPOSITORS OF THE PROVIDERS OF THE APPROPRIATE DEPOSITOR OF THE PROVIDER OF THE APPROPRIATE DEPOSITOR OF THE APPROPRIATE	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED
NAME OF PROVIDER OR SUPPLIER HARMONY HALL NURSING AND REHABILITATION CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 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) F 000 INITIAL COMMENTS A complaint investigation survey was conducted from 12/05/22 through 12/06/22. Event ID# OC6011. The following intake was investigated, NC00195418. F our of the four complaint allegations were not substantiated. Survey Type: Complaint Investig.; Highest s/s: in			345156				
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Electronically Signed

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 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.