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	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hall Nursing and Rehabilitation Center	312 Warren Avenue Kinston, NC 28501

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0693 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that feeding tubes are not used unless there is a medical reason and the resident agrees; and provide appropriate care for a resident with a feeding tube. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff interview the facility failed store a plastic tube feeding syringe with the plunger separate from the barrel which created a potential for bacterial growth. This deficiency was for 1 of 1 resident reviewed for enteral tube feeding management (Resident #2). Resident #2 was admitted to the facility on [DATE] with diagnoses that included dysphagia (trouble swallowing) following cerebral infarction (stroke). A quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #2 was severely cognitively impaired and was admitted with a gastrostomy tube (g-tube: a surgically placed tube that provided direct access to the stomach for nutrition, hydration and medication). The care plan for Resident #2 with the latest revision date of 1/24/25 indicated the use of a g-tube to assist Resident #2 with maintaining or improving nutritional status related to swallowing impairment. The goal was Resident #2 would be free from complication of g-tube feeding, i.e. aspiration formula intolerance or infection of stoma site through the next review. Interventions included to check the g-tube for patency by flushing with 30-60 cubic centimeters (cc) of water per facility policy, observe for signs or symptoms tube feeding complications such as infection and maintain gastrostomy tube for feeding purposes. An observation of Resident #2's plastic 60 cc syringe used for formula, medication and free water flushes was conducted on 7/7/25 at 10:20 AM. The syringe was observed to be stored in its open, original bag with what appeared to be water droplets inside. The syringe was stored with the piston inside the barrel. In an interview with Nurse #1 on 7/7/25 at 11:02 AM she stated she did not separate the 60 cc plunger from the barrel after use that morning. Nurse #1 further stated she had rinsed the 60 cc syringe after use and understood it should be stored with the barrel and plunger separated to avoid bacterial growth. Nurse #1 was unsure why she stored them together. In an interview with Nurse #3 on 7/7/25 at 11:45 AM she revealed she was the facility Infection Preventionist. Nurse #3 indicated Nurse #1 should have stored the barrel and piston of the 60 cc syringe separately to prevent potential disease-causing bacterial growth. In an interview with the Administrator on 7/7/25 at 12:01 PM she stated the 60 cc syringe should have been rinsed well after use and the two parts, the piston and the barrel, should be stored in the bag apart from each other to prevent bacterial growth.

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.

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

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	07/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Harmony Hall Nursing and Rehabilitation Center	312 Warren Avenue Kinston, NC 28501

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interview the facility failed to attempt alternative interventions, assess for entrapment risk, review the risks and benefits of the use of side rails, and/or obtain consent from the resident or resident representative before use of bilateral quarter length side rails. This deficient practice affected 1 of 1 resident (Resident #4) reviewed for side rails. Findings included:Resident #4 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease and non-Alzheimer's dementia. Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed she required partial to moderate assistance with bed mobility, and she had no impairment of upper or lower extremities. The MDS indicated Resident #4 was moderately cognitively impaired. Resident #4's comprehensive care plan dated 3/21/25 revealed she did not have a care plan that included the use of side rails. Resident #4 was observed lying in her bed on 7/8/25 at 4:20 PM with bilateral quarter length side rails in the raised position. A second observation of Resident #4 was conducted on 7/9/25 at 10:30 AM. Resident #4 was observed lying in her bed with bilateral quarter length side rails in the raised position. A review of Resident #4's electronic medical record (EMR) revealed no side rail assessments were completed to include: attempting alternatives, assess entrapment risk, review risks and benefits and obtain informed consent. In an interview with Nurse #1 on 7/7/25 at 11:00 AM she stated all nurses did admissions at the facility. She further stated she does not do side rail assessments and was not sure who was responsible for completing the side rail assessment. In an interview with the Director of Nursing (DON) on 7/8/25 at 3:55 PM she stated when a resident is admitted or readmitted there are no side rails on the bed. The DON further stated a side rail assessment is only completed if it appeared side rails would help a resident with positioning and mobility. The DON indicated the floor nurse was responsible for completing the assessment. The DON was not sure why Resident #4 did not have a side rail assessment completed. The DON was unaware alternatives to side rails needed to be attempted and documented before installing them. In an interview with the Administrator on 7/8/25 at 4:01 PM she stated the side rail assessment should be completed by the floor nurse on admission, if the resident needs side rails later in their stay, and quarterly. The Administrator indicated side rail assessments were not completed on admission or quarterly for Resident #4.