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	10/30/2024

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 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Allow residents to self-administer drugs if determined clinically appropriate. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on record review, observations, and resident interview and staff interviews, the facility failed to assess the ability of a resident to self-administer medications prior to leaving the resident's medications on the bedside table in the resident's room for 2 of 2 residents observed with medications at bedside (Resident #25 and Resident #62). Findings included: 1. Resident #25 was admitted to the facility on [DATE]. Resident #25's quarterly Minimum Data Set Assessment (MDS) dated [DATE] indicated Resident #25 was cognitively intact. Physician orders included the following medication orders for Resident #25 that were active on 10/28/24: - Atorvastatin Calcium Tablet 40 milligram (mg) tablet give one tablet one time a day for supplement - Gabapentin Oral Capsule 100 mg tablet give one tablet one time a day for pain - Metoprolol Succinate ER 50 mg tablet give one tablet one time a day for hypertension - Sertraline HCL oral 150 mg tablet give one tablet one time a day for depression - Amoxicillin-Pot Clavulanate 875-125 mg tablet give one tablet every 12 hours for bacterial infection -Doxycycline Hyclate Oral 100 mg capsule give one capsule two times a day for infection There was no documentation in the Electronic Medical Record (EMR) that Resident #25 had been assessed to self-administer his medications. There was no physician's order for self-administration, and there was no care plan that addressed self-administration of medication. (continued on next page)

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

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 10/28/24 at 9:00 am, one medication cup was observed on Resident #25's bedside table located on the right side of Resident #25's bed. There were several pills in the medication cup. Resident #25 was sitting up in his bed. An observation and interview were conducted on 10/28/24 at 9:15 am with Nurse #3. She was observed at the medication cart in the hallway outside Resident #25's room. Nurse #3 walked into Resident #25's room and reached for the medication cup with his medications on the bedside table and asked Resident #25 if he was ready to take his medications. Resident #25 started yelling at Nurse #3 and asked why she was in his room. Resident #25 told her to leave his medications alone. Nurse #3 then walked out of Resident #25's room into the hallway without the cup of medications and Resident #25 still had not taken his medications. Nurse #3 stated she should not have left the medication cup with his medications on the bedside table. Nurse #3 further stated she should have stayed in Resident #25's room and watched him swallow the medications. An interview was conducted with Resident #25 on 10/28/24 at 9:21 am, during which he stated he did not need anyone to watch him take his medications. Resident #25 further stated the nurses left his medication cup with medications on his bedside table for him to take but did not state how often the nurses left his medication on his bedside table. A follow-up interview was conducted on 10/28/24 at 2:28 pm with Nurse #3 who indicated she had not usually left the medication cups with medications on the bedside table. Nurse #3 further indicated that Resident #25 got upset when someone watched him take his medications as evidenced earlier that morning. During an interview with the Director of Nursing (DON) on 10/28/24at 3:30 pm, she explained that Resident #25 had not been assessed to perform self-administration of his medication. She further stated Resident #25's medications should not have been left on the bedside table and Nurse #3 should have watched Resident #25 take his medications before she left his room. 2. Resident #62 was admitted to the facility on [DATE]. Resident #62's quarterly MDS assessment dated [DATE] revealed Resident #62 was cognitively intact. Physician orders included the following medication orders for Resident #62 that were active on 10/28/24: -Amlodipine Besylate 10 mg tablet give one tablet one time a day for hypertension -Aspirin 81 mg tablet give one tablet one time a day for anticoagulant -Oxybutynin Chloride 10 mg tablet give one tablet one time a day for bladder spasms -Empagliflozin 25 mg tablet give one tablet one time a day for diabetes mellitus -Meloxicam 15 mg tablet give one tablet in the morning for right knee pain with food -Multiple Vitamin-Mineral tablet give one tablet one time a day for supplement (continued on next page)

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F 0554 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	-Omega-3 500 mg oral capsule give one capsule in the morning for low lipoprotein level give with meal -Metformin HCl 500 mg tablet give one tablet two times a day for diabetes mellitus There was no documentation in the EMR that Resident #62 had been assessed to self-administer her medications. There was no physician's order for self-administration, and there was no care plan that addressed self-administration of medication. During an observation on 10/28/24 at 8:30 am, a medication cup was observed on Resident #62's bedside table located on the left side Resident #62's bed. There were several medications in the medication cup. Resident #62 was lying in her bed. During an interview with Nurse #3 on 10/28/24 at 9:15 am, she stated she was the assigned nurse for Resident #62. Nurse #3 further stated she should not have left Resident #62's medication cup with her medications on the bedside table. Nurse #3 indicated she should have stayed in Resident #62's room and watched her swallow the medications. In an interview with Resident #62 on 10/28/24 at 2:16 pm, she stated she liked to take her medications with milk. Resident #62 further stated the nurses left her medication cup with medications on her bedside table to take with breakfast. Resident #62 indicated this happened more than once during the week. In a follow-up interview with Nurse #3 on 10/28/24 at 2:26 pm, she stated she should not have left the resident's medication cup with medications on the bedside table. Nurse #3 indicated she had been called to another resident's room for a situation and without thinking she left Resident #62's medication cup with her medications on the bedside table. Nurse #3 stated she should have taken the medication cup with the medications back to the medication cart and returned with Resident #62's medications after evaluating the situation with another resident. During an interview with the DON on 10/28/24 at 3:30 pm, she explained that Resident #62 had not been assessed to perform self-administration of her medication. She further stated Resident #62's medications should not have been left on the bedside table. Nurse #3 should have watched Resident #62 take her medications before she left her room.

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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and staff interviews, the facility failed to provide a complete Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) prior to discharge from Medicare Part A skilled services by omitting the options checked section indicating a resident's decision to continue part A Medicare services and by omitting the resident's signature on the form for 2 of 3 residents (Resident#170 and Resident #7) reviewed for beneficiary protection review. The findings included: 1. Resident 170 was admitted to the facility 8/21/24 and admitted to Medicare Part A services. Resident #170's Medicare Part A skilled services ended on 9/6/24 and he remained in the facility. The SNF ABN review revealed Resident 170's name, the date services were to end, the estimated cost of the services and Resident #170's signature. There were no options checked for the decision made about continuing Medicare Part A services. An interview was conducted with the facility Social Worker on 10/29/24 at 9:46 AM who stated Resident #170 did not choose an option for the decision made regarding continuing Medicare Part A skilled services. She stated that she did not document his refusal to choose an option. Attempts to contact Resident #170 were unsuccessful. An interview was conducted with the facility Administrator on 10/30/24 at 10:56 AM who stated the SNF ABN should have been completed with Resident #170's decision regarding continued Medicare Part A skilled services. She stated if Resident #170 refused to choose an option it should have been documented on the form. 2. Resident #7 was admitted to the facility on [DATE]. She was admitted to Medicare Part A services on 9/6/24. Resident #7's Part A services ended on 10/14/24 and she remained in the facility. The SNF ABN review revealed Resident 170's name, the date services were to end, and the estimated cost of the services. There were no options checked for the decision made about continuing Medicare Part A services and there was no signature on the form. An interview was conducted with the facility Social Worker on 10/29/24 at 9:46 AM who stated it was an oversight Resident #7 did not choose an option or sign the SNF ABN. She stated it was normal procedure for the form to be signed at the same time as the Notice of Medicare Non-Coverage (Form CMS 10123). (continued on next page)

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was completed with Resident #7 on 10/30/24 at 9:00 AM who stated she did not recall being presented with the ABN form. An interview was conducted with the facility Administrator on 10/30/24 at 10:56 AM who stated the SNF ABN should have been completed with Resident #7's decision regarding continued Medicare Part A skilled services and signed.

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49159 Based on observations, record review, and resident and staff interviews, the facility failed to secure smoking materials (cigarettes/lighters) for 2 of 4 residents sampled for smoking (Resident #23, Resident #106). Findings included: Review of the facility's revised smoking policy dated 3/27/2019 revealed all resident smoking materials are kept in a secure area and are accessible by facility staff only. 1. Resident #23 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE], revealed Resident #23 was cognitively intact. Review of the smoking assessment dated [DATE] revealed Resident #23 was a safe/ independent smoker. Resident #23's revised care plan dated 10/16/2024 indicated he was an independent and safe smoker. On 10/28/2024 at 8:45 am Resident #23 was observed to have a pack of cigarettes and 2 lighters on his bedside table in his room. An oxygen concentrator was also observed in Resident #23's room on the left side of the bed and was currently turned off. An interview was conducted on 10/28/2024 at 8:47 am with Medication Aide #1. She stated when a resident comes back from smoking, they are supposed to bring smoking materials to the staff so they can lock them on the medication cart. The Medication Aide #1 was observed to immediately remove Resident #23's smoking materials and locked them in the medication cart. An interview was conducted with Resident #23 on 10/28/24 at 8:52 am. Resident #23 stated he usually keeps his lighters at his bedside. An interview with Nurse Aide (NA) #1 was conducted on 10/29/2024 at 4:49 am. She stated she has never seen Resident #23 smoke in his room or have cigarettes/lighters at his bedside. In an interview with Nurse #1 conducted on 10/29/2024 at 6:03 am, she stated Resident #23 has never smoked in his room. An observation of Resident #23 was conducted on 10/29/24 at 12:01 pm in the designated smoking area; no concerns were noted. 2. Resident #106 was admitted to the facility on [DATE]. The annual Minimum Data Set (MDS) dated [DATE], revealed Resident #106 was cognitively intact. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Review of the smoking assessment dated [DATE]revealed Resident #106 was a safe/ independent smoker. Resident #106's revised care plan dated 4/2/2024 indicated he was an independent and safe smoker. On 10/29/2024 at 11:45 am Resident #106 was observed in a Resident Council meeting with a cigarette lighter attached to a flap of a crossbody type bag. An observation of Resident #106 was conducted on 10/29/24 at 12:01 pm in the designated smoking area; no concerns were noted. An interview was conducted with Resident #106 on 10/29/2024 at 12:01 pm. He stated he always keeps his lighter with him, but the staff keep his cigarettes. An interview with Nurse #2 was conducted on 10/29/2024 at 12:14 pm. She stated she was not aware of a lighter attached to Resident #106's bag. She further stated residents who smoke were expected to return all cigarette packs and lighters after smoking. An interview was conducted with NA #2 on 10/29/2024 at 12:17 pm. She stated she never saw Resident #106 with a lighter. She added residents who smoke asked for their cigarettes and lighters from staff before they went to the smoking area. During an interview with NA #3 conducted on 10/29/2024 at 12:22 pm, NA#3 stated she was not aware Resident #106 had a lighter. She further stated if she found cigarettes or lighters in a resident's room, she would go directly to the nurse. An interview was conducted with the Administrator on 10/29/2024 at 10:24 am. She stated some residents can be very resourceful. Regarding Resident #23, she further stated Resident #23 does not allow staff to search his room. An interview was conducted with the Director of Nursing on 10/29/2024 at 1:20 pm. She stated per the facility's smoking policy, residents are not supposed to keep lighters with them. Staff have explained the smoking policy many times to residents.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49502 Based on observations, staff interviews, and facility record reviews, the facility failed to keep a urinary catheter bag from touching the floor to reduce the risk of infection for 2 of 4 residents (Resident #87 and Resident #91) reviewed with urinary catheters. The findings included: 1. Resident #87 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, benign prostatic hyperplasia, and urinary retention. Resident #87's care plan dated 9/6/24 revealed focus areas for urinary retention and at risk for infection. Interventions were to monitor for signs/symptoms of urinary retention and urinary tract infections (UTI's). An annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #87 had severely impaired cognition. The assessment indicated Resident #87 was dependent upon staff for all of his activities of daily living (ADL). Resident #87 was coded for an indwelling catheter. An initial observation was conducted on 10/27/24 at 10:45 am of Resident #87 as he was lying in his bed. A urinary catheter bag was observed to be hanging off the bedframe on the resident's right side of the bed (with a solid, blue-colored side of the bag facing the doorway). The entire bottom of the urinary catheter bag was resting on the floor. The bag did not have a detachable cover. An additional observation was conducted on 10/28/24 at 2:34 pm Resident #87's urinary catheter bag was observed to be hanging off the bedframe on the resident's right side of the bed. The entire bottom of the urinary catheter bag was resting on the floor. The urinary catheter bag did not have a detachable cover. On 10/28/24 at 2:45 pm, Resident #87 was observed to be in his bed with his urinary catheter bag hanging from the right side of the bed and again the entire bottom of the urinary catheter bag was touching the floor. In an interview with Nurse #3 on 10/28/24 at 2:45 pm, she stated was the hall nurse assigned to care for Resident #87. Nurse #3 was asked what her thoughts were about the position of the resident's urinary catheter bag. She replied, It shouldn't touch the floor. The nurse stated she thought the urinary catheter bag ended up touching the floor due to the low position of Resident #87's bed. During a subsequent observation on 10/30/24 at 8:22 am, Resident #87 was observed in his bed with his urinary catheter bag hanging from the right side of the bed and again touching the floor. During an interview with the Director of Nursing (DON) on 10/29/24 at 3:51 pm, she expected the nursing staff to attach a urinary catheter bag to a resident's bed frame or geri chair and position the bag so it would not touch the floor to reduce the risk of infection. (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2. Resident #91 was admitted to the facility on [DATE] with diagnoses which included chronic kidney disease, urinary tract infection (UTI), and urinary retention. A review of Resident #91's quarterly Minimum Data Assessment (MDS) dated [DATE] revealed Resident #91 was moderately cognitively impaired. Resident #91 was coded for indwelling catheter. Resident #91's care plan dated 9/25/24 revealed focus areas for urinary retention and at risk for infection. Interventions were to monitor for signs/symptoms of urinary retention and urinary tract infections (UTI's). An initial observation was conducted on 10/27/24 at 11:00 am of Resident #91 as she was lying in her bed. A urinary catheter bag was observed to be hanging off the bedframe on the resident's left side of the bed (with a solid, blue-colored side of the bag facing the doorway). The entire bottom of the urinary catheter bag was resting on the floor. The bag did not have a detachable cover. During an interview on 10/28/24 at 2:45 pm, Nurse #3 was identified as the hall nurse assigned to care for Resident #91. Nurse #3 stated the resident's urinary catheter bag should not touch the floor. The nurse stated she thought the urinary catheter bag ended up touching the floor due to the low position of Resident #91's bed. During an interview with the Director of Nursing (DON) on 10/29/24 at 3:51 pm, she expected the nursing staff to attach a urinary catheter bag to a resident's bed frame and position the bag so it would not touch the floor to reduce the risk of infection.