

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345156	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/27/2026
NAME OF PROVIDER OR SUPPLIER Harmony Hall Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and staff, Nurse Practitioner, and Pharmacy Consultant interviews, the facility failed to administer insulin prior to the manufacturer's recommended expiration date for 1 of 1 resident reviewed for professional standards (Resident #4). Resident #4 was admitted to the facility on [DATE] with diagnoses which included type 2 diabetes mellitus. Review of Resident #4's quarterly Minimum Data Set (MDS) dated [DATE] revealed he was cognitively intact and coded for the use of insulin. Review of Resident #4's care plan dated 1/12/26 revealed a focus for diabetes mellitus with interventions which included finger stick blood sugars as ordered by physician, medication as ordered by physician, and monitoring for signs and symptoms of hypoglycemia. The manufacturer's instructions 3/2026 for glargine insulin injector pen stated it should be discarded 28 days after opening. Review of Resident #4's February 2026 Medication Administration Record (MAR) revealed he received a glargine insulin injection on 2/25/26 at 8:00 pm by Nurse #2. Observation of Station 2 medication cart #1 on 2/26/26 at 10:14 am revealed one (1) open glargine insulin injector pen with an opened date of 1/20/26 and an expiration date of 2/17/26 which belonged to Resident #4. The observation further revealed a second glargine insulin injector pen for Resident #4 that remained unopened and was not dated. An interview was conducted with Nurse #2 on 2/26/26 at 3:30 p.m. Nurse #2 stated she was unaware that the glargine insulin pen she used to administer insulin on 2/25/26 to Resident #4 had expired on 2/17/26 because she did not check the expiration date prior to administration. Nurse #2 acknowledged she failed to check the expiration date and should have discarded the expired insulin pen. During a phone interview conducted on 2/26/26 at 12:30 p.m., the Pharmacy Consultant stated the insulin pen should have been discarded 28 days after opening due to decreased potency after the expiration date but indicated there was no harm to Resident #4 from receiving the expired insulin. In an interview conducted on 2/27/26 at 9:34 a.m., the Nurse Practitioner (NP) stated she was unaware Resident #4 had received expired glargine insulin. The NP stated nursing staff were expected to check their medication carts daily for expired medications. The NP reviewed Resident #4's blood sugars and further stated there was no harm to Resident #4 from receiving expired glargine insulin. During an interview conducted on 2/26/26 at 10:26 a.m., the Director of Nursing (DON) stated the floor nurses were responsible for checking the medication carts daily for expired medications and discarding any expired medications identified. The DON further stated her expectation was that nursing staff check the medication carts daily and not administer expired medications. During an interview with the Administrator on 2/26/26 at 3:30 pm, she stated her expectation was the nursing staff would check the medication carts daily and have no expired medications in the medication carts.</p>		

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
FORM CMS-2567 (02/99) Previous Versions Obsolete	Event ID: Facility ID: 345156	If continuation sheet Page 1 of 4

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, resident and staff interviews, the facility failed to secure smoking materials (cigarettes/lighters) for 1 of 9 residents sampled for smoking (Resident #57). Findings included: Review of the facility's revised smoking policy dated 3/27/2019 revealed all resident smoking materials are maintained in a secure area (medication cart) and are accessible only through the assistance of the facility's staff. Resident #57 was admitted to the facility on [DATE]. His diagnoses included hemiplegia (a form of paralysis that affects one side of the body), hemiparesis (weakness or the inability to move on one side of the body), cerebral infarction (occurs as a result of disrupted blood flow to the brain due to problems with the blood vessels that supply it) affecting the right dominant side, and tobacco use. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #57 was cognitively intact. The MDS further indicated he was coded for tobacco use. Review of the smoking assessment dated [DATE] revealed Resident #57 was a safe/independent smoker. Resident #57's revised care plan dated 11/26/25 indicated he was an independent, safe smoker, and his preference to smoke independently at the times of his choice was honored. On 2/24/26 at 11:43 AM an observation and interview were conducted with Resident #57. When asked if he smoked, he indicated yes. When asked where he kept his smoking materials, he lifted his shirt and was observed to have a pack of cigarettes and a lighter against his stomach. An interview was conducted on 2/24/26 at 12:28 PM with Nurse #3. She stated Resident #57 was supposed to turn his smoking materials in after each time after he went to the designated smoking area. Nurse #3 stated he may have tried to turn them in, but a staff member was not at the medication cart. Nurse #3 was observed to immediately remove Resident #57's smoking materials and locked them in the medication cart. On 2/25/26 at 8:14 AM a follow up observation of Resident #57 was conducted. Resident #57 was observed resting in bed. No smoking materials were noted. A follow up interview was conducted on 2/25/26 at 12:10 PM with Resident #57. He indicated his smoking materials were with the nurses. When asked why he had them in his possession while in his room on 2/24/26 he indicated he intended to go to the smoking area again in a few hours. An interview was conducted on 2/25/26 12:12 PM with Nurse Aide #1. She stated Resident #57 never kept his smoking materials with him. She further stated that when he got ready to go to the smoking area, he obtained his smoking materials from staff, went to the designated smoking area, and returned his smoking material to a staff member. On 2/25/26 at 12:36 PM a follow up interview was conducted with Nurse #3. She stated the Medication Aide or Nurse who was assigned to a medication cart containing smoking materials was responsible for making sure smoking materials were returned to the medication cart. In an interview with Medication Aide #1 on 2/25/26 at 2:08 PM she stated Resident #57 was aware he could not keep his smoking materials with him. She further stated Resident #57 may have been looking for a staff member to lock them in the medication cart but did not see anyone when he returned from the designated smoking area. An observation of Resident #57 was conducted on 2/25/26 at 3:45 PM in the designated smoking area; no concerns were noted. On 2/26/26 at 2:03 PM an interview was conducted with the Director of Nursing (DON). She stated residents who were deemed safe independent smokers did not have a designated smoking time and they may go to the designated smoking area whenever they want. She stated she did not know why Resident #57 had his smoking materials with him when he was in his room. The DON speculated that he may have gone out to smoke and when he came back, he did not see the Medication Aide near the medication cart, and he held on to the smoking materials until she returned. The DON further stated her expectation was when staff gave residents their smoking materials, that staff member ensured the smoking materials were returned to the designated medication cart. In an interview</p> <p>(continued on next page)</p>		

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<p>F 0689</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>on 2/26/26 at 2:17 PM with the Administrator she stated Resident #57 never held on to his smoking materials, and he probably would have returned them if there was a staff member near the medication cart. The Administrator stated her expectation was that residents returned their smoking materials to the Nurse or Medication Aide once they returned from the smoking area. She further stated she expected staff ensured the residents indeed returned them.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>Based on observations, manufacturer's instructions, staff and Pharmacy Consultant interviews, the facility failed to remove one (1) multi-dose insulin injector pen that was expired in 1 of 5 medication carts reviewed for medication storage and labeling (Station 2 medication cart #1).The manufacturer's instructions dated 3/2026 for insulin glargine injector pen stated it should be discarded 28 days after opening. Observation of Station 2 medication cart #1 on 2/26/26 at 10:14 am revealed one (1) open insulin glargine injector pen with a handwritten opened date of 1/20/26 and a handwritten expiration date of 2/17/26. During an interview and observation conducted on 2/26/26 at 10:14 a.m. the Medication Aide #1 who was assigned to Station 2 medication cart #1 stated she did not administer insulin injections; however, she acknowledged the insulin glargine pen should have been discarded after 28 days after opening. In an interview conducted on 2/26/26 at 10:20 a.m., Nurse #1, who was assigned to cover the Medication Aide #1 on Station 2 medication cart #1, stated the expired insulin glargine pen should have been removed from the medication cart and discarded. Nurse #1 further stated nursing staff, including medication aides, were expected to check their medication carts daily for expired medications. During a phone interview with the Pharmacy Consultant on 2/26/26 at 12:30 pm, she stated the insulin glargine pen should have been discarded 28 days after opening. During an interview conducted on 2/26/26 at 10:26 a.m., the Director of Nursing (DON) stated the floor nurses were responsible for checking the medication carts daily for expired medications and discarding any expired medications identified. The DON further stated her expectation was that nursing staff, including medication aides, check the medication carts daily and remove any expired medications. During an interview with the Administrator on 2/26/26 at 3:30 pm, she stated her expectations were the nursing staff would check the medication carts daily and have no expired medications in the medication carts.</p>		