	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE S	
7.11.0 1 27.11 1	or dorate of the transfer of t	IDENTIFICATION TO MIDEN.	A. BUILDING: _			
		HAL011361	B. WING		04/0	4/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL ASHEVILL	ERS WAY E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department of an annual and follow	sure Section and Buncombe of Social Services conducted of-up survey and a complaint 2/24 through 04/04/24 with a 04/24.				
D 125	10A NCAC 13F .0403 Medication Staff	3(a) Qualifications Of	D 125			
	10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021.					
	facility failed to ensur aides (Staff A, B, and medications to reside approved medication checklist and 1 of 3 s (Staff B) completed th	as evidenced by: and record reviews, the e 3 of 3 sampled medication C) who administered ents completed the state clinical skills validation ampled medication aides ne state approved 5-hour our medication training as				
	The findings are:					
	-She was hired 08/09 (MA).	personnel record revealed: 1/23 as a medication aide tation Staff A completed the				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	TIPLE CONSTRUCTION () NG:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		04	R 4/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY LLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 125	15-hour medication of There was document medication aide writt - There was no docur the medication clinic Review of a Resider April 2024 electronic Record (eMAR) reve documentation that semedications. Telephone interview 4:12pm revealed: - She was hired on 0 in the facility administ residents She did not compleivalidation checklist at Refer to the interview Coordinator on 04/03 Refer to the interview Manager (BOM) on 0 Refer to the interview Director (ED) on 04/03 Refer to	training on 01/23/24. Intation Staff A passed the ten exam on 12/21/23. Imentation Staff A completed all skills validation checklist. It's February, March, and It Medication Administration realed there was Staff A administered With Staff A on 04/03/24 at 8/09/23 and worked as a MA extering medications to the a medication clinical skills and knew nothing about it. It with the Resident Care 3/24 at 2:25pm. It with the Business Office 04/03/24 at 2:20pm. It with the Interim Executive	D 125				

Division of Health Service Regulation

STATE FORM 8899 3L7611 If continuation sheet 2 of 58

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUNT	TAIN	LERS WAY		
		ASHEVILI	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 125	Continued From page	2	D 125		
	(eMAR) revealed ther Staff B administered r	e was documentation that medications.			
	4:45pm revealed:	vith Staff B on 04/03/24 at			
	administered medicat	in the facility as a MA and ions to residents. Leted the medication clinical to hours of medication			
	training in 2022 by a I gave the documentati	Registered Nurse (RN) and			
	Refer to the interview Coordinator on 04/03,	with the Resident Care /24 at 2:25pm.			
	Refer to the interview Manager (BOM) on 0	with the Business Office 4/03/24 at 2:20pm.			
	Refer to the interview Director (ED) on 04/0	with the Interim Executive 3/24 at 1:48pm.			
	-Staff C was hired on aide (MA).	personnel record revealed: 01/03/24 as a medication			
	15-hours of medication	tation Staff C passed the			
		nentation Staff C completed			
		/24 at 11:23am revealed medications to a resident.			
	Telephone interview v 2:42pm revealed: -She worked in the fa	vith Staff C on 04/03/24 at			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			7.1. 20.23.110.			R
		HAL011361	B. WING		04	1/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVII	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 125	medications to reside -She knew she comp skills validation chece 15-hours of medicati what happened to the Refer to the interview Coordinator on 04/03/24 at 1:25pm in the Manager (BOM) on 04/03/24 at 2:25pm in the James of the Manager (BOM) on 04/03/24 at 2:25pm in the James of the Manager (BOM) on 04/03/24 at 1:48p in the Manager (BOM) in the	ents. Deted the medication clinical klist when she completed the on training but did not know e documentation. If with the Resident Care 3/24 at 2:25pm. If with the Business Office 04/03/24 at 2:20pm. If with the Interim Executive 03/24 at 1:48pm. It with the Interim Executive 03/24 at 1:48pm. It with the MAs did not have e required training as he was for ensuring the MAs ded training. If we with the Interime Executive 03/24 at 1:48pm. It with the Interime Executive	D 125			
	-She was new to the	position of BOM.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL011361	B. WING		04/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBLE				
			E, NC 28804		T	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLET	E
D 125	Continued From page	e 4	D 125			
	-She did not know wh ensuring the MAs cor	o was responsible for npleted their training.				
D 137	10A NCAC 13F .0407 Qualifications	(a)(5) Other Staff	D 137			
	(a) Each staff person shall:(5) have no findings li	Other Staff Qualifications at an adult care home sted on the North Carolina el Registry according to G.S.				
	facility failed to ensure A) had no substantiat	as evidenced by: and record reviews, the e 1 of 3 sampled staff (Staff ed findings on the North Personnel Registry (HCPR)				
	The findings are:					
	Review of Staff A's, m personnel record reve -Staff A was hired on -There was no docum completed upon hire.	ealed:				
		on 04/03/24 at 4:12pm ed on 08/09/23 and worked				
	on 04/03/24 at 1:48pr -The Business Office responsible for ensuri documentation was in	Manager (BOM) was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL	ERS WAY E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 137	-He hired a BOM 3 da Interview with the BO revealed: -She was new to the -She did not know wh ensuring HCPR check Review of Staff A's He revealed there were re 10A NCAC 13F .0702	was "supporting" the facility. ays ago. M on 04/03/24 at 2:20pm position of BOM. to was responsible for the was were completed. CPR check dated 04/03/24 at 0 substantiated findings.	D 137		
	(b) The discharge of a facility at the direction designee shall be bas reasons: (1) the discharge is nowlefare of the resident meet the needs of the by the resident's physicianty so that the need of the services procumented by the resident's record; (3) the safety of the resident safety of the resident's record; (4) the discharge is not safety and the resident safety as the	esident has improved resident is no longer in provided by the facility, as esident's physician, r nurse practitioner in the resident or other individuals gered as determined by the profit of the administrator or their ion with the resident's			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		i i		(X3) DATE SURVEY COMPLETED	
AND FLAN	SI CONNECTION	IDENTIFICATION NOWDER.	A. BUILDING: _		
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUN	TAIN	ERS WAY E, NC 28804		
	OLIMANA DV. OT		<u>, </u>	DDO//DEDIO DI ANI OF CODDECTIO	N
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 224	Continued From page	e 6	D 224		
	in the facility is endar physician, physician a practitioner in the res (5) the resident has fa services and accomm due date according to	ngered as documented by a assistant, or nurse			
	This Rule is not met A1 VIOLATION	as evidenced by:			
	Based on interviews and record reviews the facility failed to initiate the discharge of 1 of 5 sampled residents (#3) who was having aggressive behaviors and was documented as being a harm to self and others.				
	The findings are:				
	09/15/22 revealed: -Diagnoses included	3's current FL2 dated dementia and depression. cumented as ambulatory priented.			
	revealed: -The date of admission	3's Resident Register on was not documented. sident #3's Responsible 22.			
	Review of Resident # revealed: -She punched anothe	3's incident reports			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL011361	B. WING		04	R I/04/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 224	Continued From page 12/28/23She was in another raised, making the ot 01/24/24She hit another reside of the head on 0 -She hit another reside on 03/15/24Aggressive behavior staff and other reside -She was sent to the mental evaluations of but was never admitted. Review of Resident # (MHP) visit note date -Staff reported the reaggression and slapp -There was also "sus struck another resident were	residents room with her fist her resident scream on lent on 02/02/24. Ident in the face and on the 2/09/24. Ident on the side of the head is were documented toward ints. Ident on the six occasions ed. 3 Mental Health Provider's d 01/24/24 revealed: sident had worsening and multiple staff members. picion" Resident #3 had	D 224	CROSS-REFERENCED IC DEFICIEN		DATE
	#3 dated 02/08/24 red-Staff reported Resident Staff were told that F self and others on 02 -The danger was door aggression with staff -Resident #3 might no she could not be stable-Resident #3 required own safety and the staff staff safety and the staff safety safety and the staff safety safety and the staff safety s	ent #3 was "hitting" and its. Resident #3 was a danger to //08/24. umented as physical and other residents. eed a higher level of care if				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C	ONSTRUCTION		E SURVEY PLETED	
		HAL011361	B. WING		۰,	R I/04/2024
		TIALUTI301			04	1/04/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
	T		LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 224	Continued From page	e 8	D 224			
	revealed the Health a	and 03/15/24 at 3:30pm and Wellness Director ble for communicating with nitiating discharges or				
	revealed: -She was aware Res aggressive towards of She and the medical notifying Resident #3 #3's aggressionThe facility sent the ER kept sending her treatmentShe was responsible manage resident behalischargesShe had not conside because she had not She, the MHP and the meeting on 02/08/2 Resident #3's aggrestive -They were currently locked because of Resident was no other	tion aides (MAs) were I's MHP and PCP of Resident resident to the ER, but the back to the facility without e for deciding how to haviors or initiating ered initiating a discharge yet thought about it. he resident's RP were having 44 about what to do about				
	at 5:15pm and 03/15. -He had not been ma aggressive behaviorsHe had only recently facility and could not had not been taken raggression in the pas-Resident #3's RP was	began working at this comment on why actions egarding Resident #3's				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		04	R 4/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΓAIN	BLERS WAY			
	T	ASHEVI	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 224	Resident #3The Clinical Director actions had been tak declined. Interview with Reside 12:15pm and 04/04/2-He was part of a me Resident #3's RP and The meeting was to Resident #3's aggres attacking staff, other point become aggres-It was determined the one-on-one sitter to swhile her medications When he left the me impression the reside sitter. Interview with the Interview with the Interview with the six declarations of the reside sitter.	was unsure why no other en after the sitter was ant #3's MHP on 03/29/24 at 44 at 9:55am revealed: eting on 02/08/24 with discuss how to manage sion since the resident was residents, and had at one sive with the MHP. e resident needed a rafely remain in the facility is were being adjusted. eting, he was under the ent would have a one-on-one erim Executive Director (ED)	D 224			
	had a sitter during the -He only recently four have a sitter because oneIt was an oversight traction had been take sitterIf a resident became be sent to the ER and the MA should contact.	revealed: rstanding that Resident #3 e month of February 2024. and out Resident #3 did not e the RP declined to procure that no other protective a fler the RP declined the aggressive and needed to d a resident's RP refused, et the ED or Clinical Director. the facility nurse would and send the resident to the				
		acility as of 02/20/24 and n why no action had been				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
AND PLAN	JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		1141 044004	B. WING		R
		HAL011361			04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY		
	T	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
D 224	Continued From page 10		D 224		
	taken in the past to address Resident #3's behaviors.				
	4:30pm and 03/27/24 -She was the Administ another state, so she operations to the EDIt was the ED and HV manage issues regarinitiate discharges if reshe was in contact where informed about A second telephone in Administrator on 04/00-She had not been on 08/28/23When she found out aggression through the (AHS) on 03/19/24 she Regional Director and Protection had been protections to the ED.	with the facility since about Resident #3's ne Adult Home Specialist ne reached out to her d was informed a Plan of			
	A third telephone inte on 04/04/24 at 2:19pr -She did not know wh considered when Res demonstrating aggres provider identified the and othersShe became the Adr the previous Administ January 2024Since she was locate had assigned an inter	ay a discharge was not sident #3 began sive behaviors and the resident as a harm to self ministrator of the facility after trator abruptly resigned in ed out of state, the facility from ED to the facility from the current			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			ATE SURVEY DMPLETED	
		HAL011361	B. WING		04	R I/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY				
(VA) ID	SLIMMARY ST	TATEMENT OF DEFICIENCIES	LLE, NC 28804	PROVIDER'S PLAN OF CO	RRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 224	Continued From page	e 11	D 224				
	was having any prob contacted her on 03/ -Corporate policy red be informed when Refor mental evaluation identified to be a hard-The Regional Direct were not told Reside danger to self and ot behaviors, or was se	ssive behaviors. as made aware Resident #3 lems was when the AHS 19/24. quired the Regional Directors esidents were sent to the ER as, or when residents were m to self or others. or informed her that they nt #3 was identified as a hers, was having aggressive nt to the ER.					
	Resident #3 who was harm to self and other subjected residents at that included slapping. These assaults occur 12/28/23 through 03/4 a one-on-one sitter sprotected from her againitiate a discharge resident in the subject of the sub	nitiate the discharge of a documented as being a sers in February 2024 and and staff to physical assaults g, hitting and punching. The five times from 15/24 and she was ordered so others residents were ggressions. This failure to esulted in serious abuse and es a Type A1 Violation.					
		provide an acceptable plan of nce with G.S. 131D-34 by					
		E FOR THIS TYPE A1 NOT EXCEED MAY 4, 2024.					
D 254	10A NCAC 13F .080	1(b) Resident Assessment	D 254				

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ווטופועום	i Health Service Negu	iation			т	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	=1ED
			1		R	,
		HAI 044364	B. WING		1	
		HAL011361	1		1 04/0	4/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
		41 COBBL	FRS WAY			
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	E, NC 28804			
			12, 140 20004	T		
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG	•	LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
		•		DEFICIENCY)		
D 254	Continued From page	e 12	D 254			
		ssessment instrument				
	established by the De	epartment or an instrument				
	approved by the Depa	artment based on it				
	containing at least the	e same information as				
	required on the estab	lished instrument. The				
		mpleted within 30 days				
		ind annually thereafter shall				
	be a functional assessment to determine a					
resident's level of functioning to include						
psychosocial well-being, cognitive status and						
physical functioning in activities of daily living.						
	Activities of daily living are bathing, dressing,					
	_	bulation or locomotion,				
	transferring, toileting					
		icate if the resident requires				
	referral to the residen					
		professional, provider of				
		pmental disabilities or				
	substance abuse serv					
	resource.	vices of community				
	resource.					
	This Dula is not not	as syldeneed by				
	This Rule is not met	-				
		ews and interviews the				
	•	e an annual assessment				
	and updated FL2 was	•				
	sampled residents (#	1 & #3).				
	The findings are:					
	The findings are:					
	1. Review of Residen	t #1's current FL2 dated				
	02/28/23 revealed dia	agnoses included dementia,				
	osteoporosis and hyp					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R
		HAL011361	B. WING		04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUNT	ΓΑΙΝ	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 254		1's record revealed no more	D 254		
	Refer to interview with Director (ED) on 04/0	n the interim Executive 2/24 at 1:50pm.			
		t #3's current FL2 dated agnoses included dementia			
	Review of Resident # recent FL2 was availa	3's record revealed no more able for review.			
		erim Executive Director (ED) n revealed Resident #3 did FL2.			
	Refer to interview with Director (ED) on 04/0	n the interim Executive 2/24 at 1:50pm.			
	on 04/02/24 at 1:50pr -The Health Care Dire for ensuring FL2s wel -The HCD position wa	ector (HCD) was responsible re updated. as currently vacant. up-to-date had been a long			
D 259	10A NCAC 13F .0802	2(a) Resident Care Plan	D 259		
	developed for each re the resident assessm 30 days following adn .0801 of this Section.	ne shall assure a care plan is esident in conjunction with ent to be completed within nission according to Rule			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or dortheories	IDENTIFICATION NOMBER.	A. BUILDING: _		
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	ΓAIN	ERS WAY		
			_E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 259	Continued From page	e 14	D 259		
	for each resident.				
	facility failed to ensurannually on 2 of 5 said annually on 2 of 5 said The findings are: 1. Review of Resident 02/28/23 revealed dia osteoporosis and hyper Review of Resident #-lt was dated 03/23/2-There was document supervision with eating Observation of Resid 12:05pm revealed: -She used a walker wambulate to the dining-She required staff as her walker to the dining-While eating lunch staff and assistance wanter the meal she refamily member and stousing her walker. Interview with the interior 04/02/24 at 1:50pm annually member as the interior of the started of	ews and interviews the e a care plan was updated impled residents (#1 & #3). It #1's current FL2 dated agnoses included dementia, perlipidemia. It's care plan revealed: 2. Itation she needed ag, ambulation and transfers. In the first assistance to ag room. It is saff assistance to ag room. It is taff assistance to ag room chair. It is the required prompting from It is the required prompting from It is the required prompting from It is the required assistance from a taff to transfer from the chair It is the recutive Director (ED) It is the revealed: It is the revealed to the revealed to the revealed: It is the revealed to the revealed			
	-He could not find a cResident #1.	urrent care plan for			
	-The Health Care Dire	ector (HCD) was responsible ns were updated but that / vacant.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
			A. BOILDING			R
		HAL011361	B. WING		l l	04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUN	41 COBE	BLERS WAY			
HARMON	TAI RETNOLDS MOUN	ASHEVII	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHI CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 259	Continued From page	e 15	D 259			
	-Keeping paperwork term oversite problen	up-to-date had been a long n at the facility.				
		nt #3's current FL2 dated agnoses of dementia and				
	Review of Resident # -It was dated 02/28/2 -There was documen					
	assistance with bathi	ng.				
	on 04/03/24 at 1:43pi -Resident #3 did not	erim Executive Director (ED) m revealed: have an updated care plan. i Care Director (HCD)				
	care plans up to date -Keeping paperwork	as currently vacant. ately be responsible to keep				
	long-term oversight.					
D 270	10A NCAC 13F .090 ² Supervision	1(b) Personal Care and	D 270			
		e supervision of residents in n resident's assessed needs,				
	This Rule is not met TYPE A1 VIOLATION	1				
	Based on observation	ns, interviews and record				

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NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 41 COBBLERS WAY A SHEVILLE, NC 28804 (X4) ID PREFIX TAG CROSS-REFERENCED TO THE APPROPRIATE DATE DATE D 270 Continued From page 16 reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident and staff. The findings are: Review of Resident #3's current FL2 dated 09/15/22 revealed: - Diagnoses included dementia and depression The resident was documented as ambulatory with no assistive devices and intermittently disoriented. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed there was no care plan available to review for Resident #3's incident report dated Review of Resident #3's incident report dated	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER HARMONY AT REYNOLDS MOUNTAIN (A4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG TAG COMPLETE DATE D 270 Continued From page 16 reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3)'s current FL2 dated 09/15/22 revealed: - Diagnoses included dementia and depression The resident was documented as ambulatory with no assistive devices and intermittently disoriented. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed there was no care plan available to review for Resident #3's incident report dated	7.1.12 1 27.1.1		152.11.11.10.11.10.11.10	A. BUILDING: _		
HARMONY AT REYNOLDS MOUNTAIN 41 COBBLERS WAY ASHEVILLE, NC 28804 (X4) D			HAL011361	B. WING		•
CALCE CALC	NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) D 270 Continued From page 16 reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident having aggressive behaviors that included slapping, hitting, and punching other residents and staff. The findings are: Review of Resident #3's current FL2 dated 09/15/22 revealed: -Diagnoses included dementia and depressionThe resident was documented as ambulatory with no assistive devices and intermittently disoriented. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed there was no care plan available to review for Resident #3. Review of Resident #3's incident report dated	HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ			
reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident having aggressive behaviors that included slapping, hitting, and punching other residents and staff. The findings are: Review of Resident #3's current FL2 dated 09/15/22 revealed: -Diagnoses included dementia and depressionThe resident was documented as ambulatory with no assistive devices and intermittently disoriented. Interview with the interim Executive Director (ED) on 04/03/24 at 1:43pm revealed there was no care plan available to review for Resident #3. Review of Resident #3's incident report dated	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETE
-Resident #3 hit a medication aide (MA), with her fist, after the MA told resident #3 she could not put her pills in her cup of water. -The Primary Care Provider (PCP) and the responsible party (RP) were notified. -Resident #3 was sent to the local hospital for a mental evaluation. -The incident report was signed and dated by a MA. Review of Resident #3's hospital records dated 12/28/23 revealed: -Resident #3 presented in the ER for "punching another individual in the face". -Resident #3 was not admitted and was discharged back to the facility. Review of Resident #3's incident report dated	D 270	reviews, the facility fat to 1 of 5 sampled Res resident having aggre included slapping, hit residents and staff. The findings are: Review of Resident # 09/15/22 revealed: -Diagnoses included -The resident was do with no assistive devidisoriented. Interview with the inte on 04/03/24 at 1:43pr care plan available to Review of Resident # 12/28/23 revealed: -Resident #3 hit a me fist, after the MA told put her pills in her cup -The Primary Care Pr responsible party (RF-Resident #3 was ser mental evaluationThe incident report with MA. Review of Resident # 12/28/23 revealed: -Resident #3 present another individual in the resident #3 was not discharged back to the resident #4 was not discharged back to	sided to provide supervision sidents (#3) related to the essive behaviors that ting, and punching other (3's current FL2 dated) dementia and depression. Cumented as ambulatory ces and intermittently erim Executive Director (ED) on revealed there was no ereview for Resident #3. (3's incident report dated) edication aide (MA), with her resident #3 she could not provider (PCP) and the endited of water. Covider (PCP) and the endited of water and the local hospital for a was signed and dated by a endited ed in the ER for "punching the face". It admitted and was the facility.	D 270		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		(X3) DATE COMI	SURVEY PLETED	
		HAL011361	B. WING		04	R / 04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 270	room with her fist rais -The other resident whelpResident #3 was "ex- redirected by staff our roomUnder the "Follow U documentation staff v Resident #3's PCP. Review of Resident # 02/02/24 revealed: -Resident #3 got agg and told them to shut said no so Resident # the faceThe PCP and RP w -There was no docum- sent out for evaluation -The follow-up section -The incident report v MA. Review of Resident # 02/02/24 revealed: -Resident #3 present another residentResident #3 was not discharged back to the Review of Resident # 02/09/24 revealed:	and in another resident's seed. As screaming and yelling for a screen years and was at of the other resident's The other resident was would follow up with The other resident was another resident was punched the resident in the resident was another reside	D 270	DEFICIENCY		
	of his headThe "Follow Up" sec #3 needed a 24-hour	tion documented Resident sitter, she was sent to R), and staff would follow up				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY IPLETED	
		HAL011361	B. WING		0.	R 4/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From pag	e 18	D 270			
	02/09/24 revealed: -Resident #3 present outburst." -Resident #3 was no discharged back to the Review of Resident #3 02/12/24 revealed: -Resident #3 was four room at 5:55pmThe other resident be Resident #3, leaving	#3's incident report dated and in another resident's became agitated and grabbed fingerprint marks on while attempting to remove room.				
		was signed and dated by a				
	03/15/24 revealed: -Resident #3 hit anot -There was documer sending Resident #3 evaluation.	#3's incident report dated ther resident in the face. Intation the RP declined to the hospital for an was signed by a MA and the				
	(MHP) note dated 01 -Staff reported the re aggression and slapp -There was also "sus struck another reside -The provider docum another resident wer consider transferring facility."	sident had worsening bed multiple staff members. spicion" Resident #3 had				

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	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING			
		HAL011361	B. WING		R 04/04/202	24
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	HARMONY AT REYNOLDS MOUNTAIN 41 COBB					
	TAT RETROEDS MOORE	ASHEVILLE	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COM	(X5) MPLETE DATE
D 270	Continued From page	e 19	D 270			
	adjustments to Residence medications.	ent #3's psychiatric				
	Resident #3 dated 02 -Facility staff had report "hitting" and "biting" or -Staff were notified that to self and others on or -The danger was document aggression with staff and the staf	orted Resident #3 was ther residents. at the resident was a danger 02/08/24. umented as physical and other residents. eed a higher level of care if				
	Observation in the facility on 03/15/24 at 3:55pm revealed: -A resident was sitting in a chair being assessed by a personal care aid (PCA) when Resident #3 walked in front of them. -Resident #3 was standing near the resident being assessed and started arguing with another PCA and then hit the other resident. -The PCA alerted staff that Resident #3 hit a resident while encouraging Resident #3 to move away from the other resident, but Resident #3 was not cooperative. -Resident #3's RP entered the room at that moment and asked Resident #3 if she had hit someone. -Resident #3 stated she had hit someone and then agreed to go outside in the courtyard with the RP.					
	4:00pm revealed: -She observed Reside	on 03/15/24 at 3:20pm and ent #3 hit the other resident. broached the other resident unprovoked.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		_	
HAL011361		B. WING		04/04	4/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBBLE	ERS WAY			
HARWON	TAI RETNOLDS MOUNT	ASHEVILLI	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 270	Continued From page	2 20	D 270			
D 270	-When the other reside and walk away, Resideright side of the head -Resident #3 had also stab the other resider and took the pencilResident #3 was offeresidentsA couple months ago Resident #3 shove a pinned the resident to -In that instance, staff two residents, and att situationThe other resident will did not require medical staff watched a vide techniques as part of -De-escalation consis separating the resident #3 was not RP declined sending -If a resident #3 was not RP declined sending -If a resident became trained to "just do the medical providerStaff were also instructional providerStaff were also instructional providerStaff were also instructional providerThe MA was responsive resident's PCPResident #3 did not held the PCA did not known.	dent attempted to stand up dent #3 slapped her on the contract a pencil, as if to ent, but the PCA intervened an aggressive towards other on the PCA observed resident to the floor, then to the floor in the hallway. If intervened, separated the dempted to de-escalate the death of the escalation of the floor in the hallway of intervened, separated the dempted to de-escalation of the escalation of the escala	D 270			
	Interview with a secon 3:37pm revealed: -She had observed R residents aggressivel					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE A. BUILDING:	(X3) DATE SURVEY COMPLETED	
			7. BOILBING.		R
		HAL011361	B. WING		04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON'	HARMONY AT REYNOLDS MOUNTAIN 41 COBBI				
ASHEVILL		E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 270	Continued From page	21	D 270		
D 270	-This had happened "not recall specifically what the outcome wa -If residents became a another, staff were su separate the resident situationResident #3 did not had the situationResident #3 had hit, -Resident #3 had hit, -Resident #3 also hit few weeksResident #3 had bitte another residentShe observed Resident had on the armShe could not recall #3She did not think the needed emergency mand the sidentShe notified the MA or she did not know of takenResident #3 did not gaggression because had be sent to the ERThe facility was work to get her medications.	a few" times and she could which other residents or s. aggressive with one apposed to intervene, s, and de-escalate the nave a one-on-one sitter. I PCA on 02/07/24 at at 3:30pm revealed: slapped, and choked staff. ively grabbed another uary 2024. another resident in the last en a staff member and ent #3 bite another resident who was bitten by Resident resident who was bitten nedical attention. dent #3 when she bit the of the incident. any other action that was get sent to the ER for ner RP did not want her to sing with Resident #3's MHP is adjusted. In the swell as initiating	D 270		
	Interview with a MA o				

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NAME OF PROVIDER OR SUPPLIER HARMONY AT REYNOLDS MOUNTAIN STREET ADDRESS, CITY, STATE, ZIP CODE ### ARMONY AT REYNOLDS MOUNTAIN ASHEVILLE, NC 28904 ### ASHEVILLE, NC 28904 PROVIDER'S PLAN OF CORRECTION (PARTY TAGE) PREFIX TAGE PREFIX TAGE PREFIX TAGE PREFIX TAGE PROVIDER'S PLAN OF CORRECTION SHOULD BE (PARTY TAGE) CROSS-REFERENCED TO THE AMPROVINGITE DATE D 270 PROVIDER'S PLAN OF CORRECTION SHOULD BE (PARTY TAGE) CROSS-REFERENCED TO THE AMPROVINGITE DATE D 270 PROVIDER'S PLAN OF CORRECTION SHOULD BE (PARTY TAGE) CROSS-REFERENCED TO THE AMPROVINGITE DATE D 270 PROVIDER'S PLAN OF CORRECTION SHOULD BE (PARTY TAGE) CROSS-REFERENCED TO THE AMPROVINGITE DATE PARTY TAGE CROSS-REFERENCED TO THE AMPROVINGITE DATE D 270	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER HARMONY AT REYNOLDS MOUNTAIN **11 COBBLERS* WAY ASHEVILLE, NC 28804* **12 COMPLETE (REACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DEPICE (REACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DEPICE (REACH DEPICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DEPICE (REACH DEPICENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) **DEPICE TAGGET OR THE APPROPRIATE OF	ANDILAN	or connection	IDENTIFICATION NUMBER.	A. BUILDING: _		COMIL	LILD
ASHEVILLE, NC 28804 ASHEVILLE, NC 2804			HAL011361	B. WING		1	
CA3 ID PROVIDER'S PLAN OF CORRECTION CASHERING CACH DEFICIENCES ID PROVIDER'S PLAN OF CORRECTION CACH DEFICIENCY (MUST BE PRECEDED BY PLLL TAG PROPRIET CACH DEFICIENCY OR ISC DIENTIFYING INFORMATION) PREPIX TAG PROVIDER'S PLAN OF CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) D 270 Continued From page 22 D 270 The resident #3 was aggressive and choked, hit, and slapped staff. Resident #3 was also aggressive to other residents. The resident had recently been found in another resident's room and was pinning that resident to her bed. Earlier that week, Resident #3 had also aggressively grabbed another resident's shirt. The facility had sent Resident #3 to the hospital a couple of times, but the ER did not treat her and sent her back to the facility. Staff were keeping all residents' rooms locked as a safety measure against Resident #3's aggression. Residents could exit their rooms without assistance but would have to ask staff to unlock their doors if they wanted to enter their rooms. She was not aware of any other safety measures in place. Interview with another MA on 03/15/24 at 3:15pm and 4:00pm revealed: She was aware that Resident #3 had just hit another resident in the head. In these situations, the MA was supposed to separate the residents and attempt to de-escalate the situation. The MA should also send the aggressive resident to the ER so that resident could have a psychiatric evaluation. In this case, Resident #3's RP would not allow	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE		
EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR ISC IDENTIFYING INFORMATION) PREFIX TAG	HARMON	HARMONY AT REYNOLDS MOUNTAIN					
revealed: -Resident #3 was aggressive and choked, hit, and slapped staffResident #3 was also aggressive to other residentsThe resident had recently been found in another resident's room and was pinning that resident to her bedEarlier that week, Resident #3 had also aggressively grabbed another resident's shirtThe facility had sent Resident #3 to the hospital a couple of times, but the ER did not treat her and sent her back to the facilityStaff were keeping all residents' rooms locked as a safety measure against Resident #3's aggressionResidents could exit their rooms without assistance but would have to ask staff to unlock their doors if they wanted to enter their roomsShe was not aware of any other safety measures in place. Interview with another MA on 03/15/24 at 3:15pm and 4:00pm revealed: -She was aware that Resident #3 had just hit another resident in the headIn these situations, the MA was supposed to separate the residents and attempt to de-escalate the situationThe MA should also send the aggressive resident to the ER so that resident could have a psychiatric evaluationIn this case, Resident #3's RP would not allow	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPRO	_D BE	COMPLETE
-The MA would call her supervisor to get guidance on what to do in the situationResident #3 was often aggressive towards other residentsIn the last couple weeks, she observed Resident #3 get into a physical altercation with another	D 270	revealed: -Resident #3 was ag and slapped staffResident #3 was als residentsThe resident had reresident's room and wher bedEarlier that week, Raggressively grabbedThe facility had sent a couple of times, busent her back to the Staff were keeping as a safety measure agaggressionResidents could exit assistance but would their doors if they was she was not aware in place. Interview with another and 4:00pm revealed. She was aware that another resident in the In these situations, it separate the resident the situationThe MA should also resident to the ER so psychiatric evaluationThe MA should also resident #3 to be set on the situationThe MA would call his guidance on what to -Resident #3 was oft residentsIn the last couple we	gressive and choked, hit, o aggressive to other cently been found in another was pinning that resident to esident #3 had also d another resident's shirt. Resident #3 to the hospital t the ER did not treat her and facility. all residents' rooms locked as ainst Resident #3's their rooms without have to ask staff to unlock inted to enter their rooms. of any other safety measures ar MA on 03/15/24 at 3:15pm be head. the MA was supposed to ts and attempt to de-escalate send the aggressive that resident could have a the man and the m	D 270			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		D	
		HAL011361	B. WING		R 04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON'	HARMONY AT REYNOLDS MOUNTAIN 41 COBB					
		ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 270	Continued From page	e 23	D 270			
D 270	residentIn that situation, Resresident in the face we-The other resident hit two residents began se-Staff intervened and residentsThe MA did not recal injured or required me-Resident #3 did not be-She was not aware to recommended a sitter of the management was restored management was restored injured or required me-Resident #3 did not be-She was not aware to recommended a sitter of management was restored injured or state of the management was restored in the management was restored in the management was restored in the management with a fourth 2:51pm revealed: -He had been out of the month and returned in the management was restored in the management with a fourth 2:51pm revealed: -He had been out of the month and returned in the management was respectively.	ident #3 hit the other ithout provocation. it Resident #3 back, and the slapping each other. separated the two If if either resident was edical attention. have a sitter. hat Resident #3's PCP had r. sponsible for deciding how g residents and when to In PCA on 04/02/24 at the facility on leave for about It to work on 04/01/24.	D 270			
	 Over a month ago, R towards staff and other 	Resident #3 was aggressive er residents.				
	-She would push and shove other residentsWhen he returned to work, Resident #3 had a sitterHe has not seen any aggressive behavior in Resident #3 since coming back to work.					
	Interview with the HW revealed: -She was aware that aggressive towards o -She and the MAs we PCP of Resident #3's -The facility sent the received.	/D on 02/07/24 at 4:51pm Resident #3 was frequently ther residents. ere notifying the MHP and aggression. resident to the ER, but the back to the facility without				
	manage resident beh					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED	
			· · · · · · · · · · -			В
		HAL011361	B. WING	<u>-</u>	04	R 4 /04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	V 47 DEVAIOL DO MOUNT	41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUNT	ASHEVII	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From page	e 24	D 270			
	about Resident #3's a -They were currently locked because of Re -There was no other s	02/08/24 about what to do aggression. keeping resident rooms asident #3's aggression. safety measures in place to work with the MHP.				
	at 5:15pm and 03/15/He had not been mad aggressive behaviors -He had only recently facility and could not on had been taken regar aggression in the paster had been recomposite the had been recomposite the residentsThe RP had decided Resident #3.	begun working at this comment on why no action ding Resident #3's t. us informed that a 24-hour amended for the safety of not to procure a sitter for a no other actions had been				
	12:15pm and 04/04/2- He was working close Resident #3's medical monthsResident #3 had a sign aggression beginningThe increase in aggression the different medication. He was part of a medication resident #3's RP and aggression the different medication.	around December 2023. ession was likely due to her in addition to reactions to ons. eting on 02/08/24 with I the HWD. discuss how to manage sion since the resident was residents, and had at one sive with the MHP.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			7.1. 20.23.110.			R
		HAL011361	B. WING		04	1/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		41 COBE	BLERS WAY	•		
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIENCE)	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
	while her medication -When he left the me impression the resid sitterHe found out at his with Resident #3 tha sitter and the HWD h after the meeting on -He felt there had be facility which may ha #3 not having the sit Review of an email f Director (ED) dated	safely remain in the facility s were being adjusted. Letting, he was under the ent would have a one-on-one mext follow up appointment at the RP had declined the letting had left her position shortly 02/08/24. Let a lot of turnover at the letting to Resident the put in place. Tom the Interim Executive 02/28/24 revealed that letting in given a 24-hour sitter for				
	O4/03/24 at 3:30pm -She was originally to specialized in Alzhei -She was unhappy were received thereWhen a sitter was firefused it because so were medication independent of a sitter in place for Followship of the control of the	old in 2022 that the facility mer's disease. vith the care Resident #3 had rst brought up in 2/2024, she he thought her behaviors uced. a 03/15/24, she agreed to put lesident #3. ond Interim ED on 03/19/24 at erstanding that Resident #3				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:	ONSTRUCTION		E SURVEY IPLETED	
		HAL011361	B. WING		04	R 4/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 270	be sent to the ER an the MA should conta -The ED, HWD and the assess the resident at ER if neededHe was new to the fromment on why no past to address Resident and the adjusted as a sitter if she was be or residents while her adjustedLocking resident does a sitter if she was be or residents while her adjustedLocking resident does a sitter if she was be or residents while her adjustedLocking resident does a sitter if she was be or residents while her adjustedLocking resident does a sitter if she was be or residents while her adjustedLocking resident does a sitter if she was the Adminitant another state and was facility, so she entrustant another state and was facility and state and state and state and was facility and state and st	e aggressive and needed to d a resident's RP refused, of the ED or Clinical Director. The facility nurse would and send the resident to the facility and could not action had been taken in the dent #3's behaviors. Idministrator on 03/19/24 at 4 at 4:53pm revealed: have been required to have ing aggressive toward staff or medications were being for swas not an appropriate ase to resident aggression. Strator at a sister facility in as not currently working at the sted the operations to the ED. With the facility but had not the issues with Resident #3. The turnover in the ED and antly. IWD's responsibility to reding resident care and to needed.	D 270			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			P WING		R
		HAL011361	B. WING		04/04/2024
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL ASHEVILL	.ERS WAY .E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 270	at the facility prior to hard the FD and RCC shatter was put into pla recommended. Resident #3 should have had medication a sitter. Based on observation reviews, it was determine the reviewable. The facility failed to part of the resident #3 who had and dementia and was behaviors such as slate other residents and sitter was not implemine resulting in Resident aggressive towards of the facility failed to part of the resident and constitutes a Type The facility failed to part of the facility	nearing from the AHS. ould have made sure a oce when it was first have been sent out to the nat was going on and should adjustments, as well as had as, interviews, and record nined Resident #3 was not rovide supervision to a diagnoses of depression as demonstrating aggressive apping, hitting, punching taff, resulting in Resident #3 narm to self and others. commended a sitter but the ented for almost 6 weeks, #3 continuing to be ther residents and staff. In serious abuse and neglect the A1 Violation. rovide an appropriate plan of noce with G.S. 131D-34.	D 270		
D 338	all residents guarante	Resident Rights hall assure that the rights of ed under G.S. 131D-21, ents' Rights, are maintained	D 338		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•
		41 COBBI	ERS WAY	•	
HARMON	Y AT REYNOLDS MOUNT	ASHEVILI	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
D 338	Continued From page	28	D 338		
		ns, interviews, and record iled to ensure residents I, physical abuse and Itiple residents being			
	The findings are:				
		dementia and depression. cumented as ambulatory			
	Register dated 02/03/ -The date of admission				
	12/28/23 revealed: -Resident #3 hit a MA told resident #3 she cup of waterThe PCP and the far	3's incident report dated A, with her fist, after the MA could not put her pills in her mily were notified. It to the local hospital for a			
	12/28/23 revealed:	admitted and was			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		· /	E SURVEY PLETED	
		HAL011361	B. WING		04	R / /04/2024
NAME OF PI	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	, ,	
		41 COBBI	LERS WAY	,		
HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 338	Continued From page	2 9	D 338			
	O1/24/24 revealed: -Resident #3 was four room with her fist rais: -The other resident whelpResident #3 was "ex redirected by staff our roomUnder the "Follow Up documentation staff where we will be resident #3's Primary. Review of Resident # (MHP) note dated 01/2-Facility staff reported aggression and slappe-There was also "susy struck another resident were consider transferring facility." -There was no document adjustments to Resident #3 got aggression and slapper facility." -There was no document adjustments to Resident #3 got aggression and slapper facility." -There was no document facility.	as screaming and yelling for tremely combative" and was t of the other resident's o" section there was yould follow up with y Care Provider (PCP). 3's Mental Health Provider 24/24 revealed: I the resident had worsening yed multiple staff members. picion" Resident #3 had int. ented if reports of striking to true, "we may need to this resident to a different hentation of changes or yent #3's psychiatric 3's incident report dated ravated at another resident up and the other resident tag punched the resident in				
	-The follow-up section Review of Resident #	n was blank. 3's Hospital Record dated				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		04	R 4/ 04/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 338	02/02/24 revealed: -Resident #3 presen another residentResident #3 was not discharged back to to the resident #3 was not discharged back to to the resident #3 review of Resident #3 requires own safety and the series of Review of Resident #3 requires own safety and the series of Resident #3 requires own safety and the series of Resident #3 became another resident on of his headThe "Follow Up" series #3 needed a 24-hou Emergency Room (Ewith the PCP. Review Resident #3 presen outburst." -Resident #3 was not discharged back to the Review of Resident #3 was not discharged #4 was not discharged back to the Review of Resident #4 was not discharged #4 was n	ted in the ER for hitting It admitted and was he facility. #3's MHP note dated Forted Resident #3 was other residents. In at the resident was a danger 02/08/24. Cumented as physical It and other residents. In eed a higher level of care if bilized in the facility. It do a one-on-one sitter for her reafety of other residents. #3's incident report dated the agitated and began hitting the side of his face and back ction documented Resident or sitter, she was sent to or in the ER for a "violent the tadmitted and was	D 338			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
		HAL011361	B. WING		04	R 1/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	. ZIP CODE		
		41 COBB	LERS WAY	,		
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	31	D 338			
	Resident #3, leaving	hile attempting to remove room.				
	03/15/24 revealed: -Resident #3 hit anotl	3's incident report dated ner resident in the face. tation the RP declined to the hospital for an				
	O3/15/24 at 3:55pm re -A staff member yelle another residentA resident was sitting #3 walked in front of I -A personal care aid (another resident asse- Resident #3 was sta and arguing with anou- The PCA was encou away from the other re was not cooperativeResident #3's RP en Resident #3 if she ha -Resident #3 stated s	d that Resident #3 hit g in a chair when Resident her. (PCA) was standing next to essing the resident's head. Inding above the resident ther PCA. Itaraging Resident #3 to walk resident, but Resident #3 tered the room and asked				
	4:00pm revealed: -She observed Resid -Resident #3 had app and "got into her face -When the other resid and walk away, Resid right side of the head	lent attempted to stand up dent #3 slapped her on the				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		04/04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		41 COBB	LERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ASHEVIL	LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	
PRÉFIX TAG	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
D 338	Continued From page	e 32	D 338		
	took the pencilResident #3 was often	t the PCA intervened and en aggressive towards other			
	residents.	the DCA cheeried			
	-A couple months ago	resident to the floor, then			
		the floor in the hallway.			
	=	f intervened, separated the			
		tempted to de-escalate the			
	-Staff watched a vide	o on de-escalation			
	techniques as part of				
		sted of speaking calmly and			
	separating the reside				
		as not seriously injured and			
	did not require medic				
	-Resident #3 was not	sent to the ER because her			
	RP declined sending	her out.			
		aggressive, staff were best we can" and call the			
	medical provider.				
	-Staff were also instru	ucted to "keep their			
	distance."	504: 6 14 14 64			
	aggression.	PCA informed the MA of the			
	-The MA was respons	sible for notifying the PCP.			
		have a one-on-one sitter.			
		w why the resident was not			
	given a sitter after it v PCP on 02/08/24.	vas recommended by the			
	Interview with a secon	nd PCA on 03/15/24 at			
	3:37pm revealed:				
	•	esident #3 grab other			
	residents aggressivel				
	-This had happened '	'a few" times and she could			
		which other residents or			
	what the outcome wa				
	-If residents became				
	another, staff were su	upposed to intervene,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
		HAL011361	B. WING		04/0	4/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBBL	ERS WAY			
TIARMON	TAT KETHOLDS MOON	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 338	Continued From page 33		D 338			
	situationResident #3 did not h	s, and de-escalate the have a one-on-one sitter. I PCA on 02/07/24 at				
	Interviews with a third PCA on 02/07/24 at 4:33pm and 03/15/24 at 3:30pm revealed: -Resident #3 had hit, slapped, and choked staffResident #3 aggressively grabbed another resident in early February 2024Resident #3 also hit another resident in the last few weeksResident #3 had bitten a staff member and					
	another residentShe had observed R resident on the arm.	esident #3 bite another				
	Resident #3.	which resident was bitten by				
	needed emergency m	resident who was bitten nedical attention. dent #3 when she bit the				
	other ResidentShe notified the MA					
	taken.	any other action that was				
	be sent to the ER.	ner RP did not want her to				
	psychiatric provider to -The Healthcare Direct	cing with Resident #3's o get medications adjusted.				
	discharges or hospita	he MHP as well as initiating lizations.				
	Interview with a MA o revealed:					
	-Resident #3 was agg and slapped staff. -Resident #3 was also	gressive and choked, hit, o aggressive to other				

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-She had recently been found in another

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING		_
		HAL011361	B. WING		R 04/04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL			
		ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDERICENCY)	D BE COMPLETE
D 338	Continued From page	e 34	D 338		
	resident's room and wher bedEarlier that week, Reaggressively grabbedThe facility had sent a couple of times, but sent her back to the factorial staff were keeping a a safety measure aga aggressionResidents could exit assistance but would their doors if they war	vas pinning that resident to esident #3 had also another resident's shirt. Resident #3 to the hospital the ER did not treat her and acility. Il residents' rooms locked as ainst Resident #3's			
	Interviews with another MA on 03/15/24 at 3:15pm and 4:00pm revealed: -She was aware that Resident #3 had just hit another resident in the headIn these situations, the MA was supposed to separate the residents and attempt to de-escalate the situationThe MA should also send the aggressive resident to the ER so that resident could have a psychiatric evaluationResident #3's RP would not allow Resident #3 to be sent to the ERThe MA would call her supervisor to get guidance on what to do in the situationResident #3 was often aggressive towards other residentsIn the last couple weeks, she observed Resident #3 get into a physical altercation with another residentResident #3 hit the other resident in the face without provocationThe other resident hit Resident #3 back, and the two residents began slapping each other.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEF		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION		SURVEY PLETED
AND PLAN OF CORP	RECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COIVIE	LETED
		HAL011361	B. WING		04	R / 04/2024
NAME OF PROVIDER	R OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HADMONY AT DE	EYNOLDS MOUN	TAIN 41 COBBI	LERS WAY			
HARMONT AT RE	TNOLDS MOUN	ASHEVIL	_E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
reside -She requii -Resi -She provid -Mand to ma initiat Interv (HWE -She aggre -She Resid -The ER ke treatr -She mana disch -She, meeti Resid -They locke -Ther other provid Interv at 5:1 -He h aggre -He h	did not recall if ered medical attendent #3 did not I was not aware to der had recommagement was resurage challenging edischarges. View with the Head was aware that essive towards of and the MAs not dent #3's aggressifacility sent the rept sending herment. Was responsible age resident beharges. had not conside use she had not the PCP, and the properties of the proper	either resident was injured or ntion. have a sitter. hat Resident #3's medical lended a sitter. sponsible for deciding how ag residents and when to alth and Wellness Director at 4:51pm revealed: Resident #3 was frequently atter residents. tified the MHP and PCP of sion. resident to the ER, but the back to the facility without a for deciding how to aviors or initiating ared initiating a discharge yet thought about it. the resident's family had a about what to do about	D 338			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		0,	R 1/04/2024
			<u> </u>		1 0-	1/04/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
	ı	ASHEVI	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From pag	e 36	D 338			
D 338	aggression in the paragesident #3's RP with sitter had been record other residents. The RP had decided Resident #3. He was unsure why taken after the sitter. Interviews with Resident #3: The was working clost the Resident #3's memonths. Resident #3 had a saggression beginning. The increase in agging disease progression different medications. He was part of a memoral Resident #3's RP and The meeting was to Resident #3's aggresiattacking staff, other point become aggresitt was determined the one-on-one sitter to while her medication. When he left the memoral memoral with the RP had defined the resident was determined the impression one-on-one sitter. He found out at his #3 that the RP had defined the resident was determined the impression one-on-one sitter.	as informed that a 24-hour mmended for the safety of d not to procure a sitter for no other actions had been was declined. dent #3's MHP on 03/29/24 at 24 at 9:55am revealed: sely with the facility to adjust edications over the past few significant increase in g around December 2023. ression was likely due to in addition to reactions to the in addition to reactions to the discuss how to manage sesion since the resident was residents, and had at one serive with him. The resident needed a safely remain in the facility is were being adjusted. Seeting on 02/08/24, he was in the resident would have a mext follow up with Resident eclined the sitter and the sitton shortly after the	D 338			
	#3 not having the sit	er had been put into place				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CO			E SURVEY IPLETED
		HAL011361	B. WING		04	R 4/ 04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
0/0/15	STIMMADA ST	ASHEVII ATEMENT OF DEFICIENCIES	LE, NC 28804	PROVIDER'S PLAN OF C	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION OF COR	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From page	e 37	D 338			
	Director (ED) dated 0	om the Interim Executive 2/28/24 revealed that given a 24-hour sitter for justed to a recent				
	3:30pm revealed: -She was originally to specialized in Alzhein -She was unhappy wi received thereWhen a sitter was fir 2024, she refused it behaviors were medic	ith the care Resident #3 had st brought up in February because she thought her cation induced. 03/15/24, she agreed to put				
	on 04/03/24 at 2:16pr -He began working as -He found out about f the Department of So the facility around 03/ -A sitter was put into -His role was to make they agreed to get a s -He made sure the sit	s RCC around 03/12/24. Resident #3's incidents when ocial Services (DSS) came to /20/24. place that same day. e phone calls to the RP, and				
	2:15pm and 04/03/24 -It was his understand sitter during the mont -He only recently four have a sitter because one.	ding that Resident #3 had a				

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		04	R I/04/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE	•	
			BLERS WAY			
HARMON	IY AT REYNOLDS MOUN	ITAIN	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 338	Continued From pag	je 38	D 338			
	sitter. -If a resident became be sent to the ER are the MA should contare. He, the HWD, and the assess the resident ER if needed. -He was new to the could not comment of taken in the past to a behaviors. Interviews with the Advisor and 03/27/2-Resident #3 should a sitter if she was be or residents while he adjusted. -Locking resident do safety plan in resporshe worked at a sist North Carolina, so so of the facility to the E-She kept in contact been informed about. -The ED and the HW-It was the ED and He protect the resident, resident care and to A third telephone into on 04/03/24 at 3:09pt-She had not been con 08/28/23. -When she found out aggression from the Services on 03/19/24.	with the facility but had not the issues with Resident #3. VD were new to their roles. WD's responsibility to manage issues regarding initiate discharges if needed.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO	DNSTRUCTION		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		04	R I/04/2024
NAME OF PROV	/IDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
HARMONY A	T REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
-Sat -T si -F ho ha a ot Bare in —TI m #% re pl fa co Of Pl	the facility. The ED and RCC slatter was put into plates a should ospital to find out wave had medication sitter in order to prother residents. ased on observation eviews, it was determiter in was determiter in the facility failed to prothe facility failed to prothe facility failed to prothe facility and physical harm of the facility and physical sidents when no influe to stop it for monitace and the facility provided occordance with G.S 3/15/24 for this violation of Protection or ORRECTION DATI	of any concerns from anyone mould have made sure a face. have been sent out to the hat was going on and should hadjustments, as well as had betect Resident #3 and the ms, interviews, and record mined Resident #3 was not protect the residents from m and neglect when Resident hically assaulted other terventions were put into hore than two months. This rious abuse and neglect and 1 Violation. a plan of protection in had 131D-34 on 02/08/24 and hation and an unacceptable	D 338			
10 (a pr	a) An adult care ho reparation and adm	4 Medication Administration me shall assure that the inistration of medications, -prescription, and treatments	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		04	R J /04/2024
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
HARMON	IY AT REYNOLDS MOUI	ATAIN 41 COBE	BLERS WAY			
TIANWON	TI AT RETNOLDS MOOI	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	which are maintaine (2) rules in this Sec and procedures. This Rule is not me Based on observation reviews the facility for were administered at (#1 & #3) related to thinners (#1) and are the findings are: 1. Review of Reside (02/28/23 revealed to 03/28/23 revealed to 03/28/23 revealed to 03/28/23 revealed to 13/2 revealed 13/2 reveal	d in the resident's record; and tion and the facility's policies It as evidenced by: In, interviews and record alled to ensure medications as order for 2 of 5 residents 2 vitamins and 2 blood anti-psychotic (#3). Int #1's current FL2 dated itagnoses included dementia, perlipidemia. Int #1's record revealed: It o discontinue Vitamin C on deficiency) 500mg daily, mentation the order was acy. Int was faxed to the pharmacy permittion was faxed to the pharmacy permittion. #1's January 2024 electronic retation record (eMAR) If or Vitamin C, 500mg daily, entation Vitamin C 500mg was 24 through 01/31/24. #1's February 2024 eMAR If or Vitamin C, 500mg daily, entation Vitamin C, 500mg was 24 through 02/06/24, entation Vitamin C, 500mg was	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:				
			B. WING			R	
		HAL011361	B. WIIVO		04	/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY				
	T	ASHEVIL	LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358 Continued From page 41		e 41	D 358				
	Telephone interview with a pharmacist from the facility's contracted pharmacy on 04/03/24 at 9:20am revealed the first time the 01/05/24 order to discontinue Vitamin C 500mg was received at the pharmacy was on 02/05/24.						
	04/03/24 at 9:54am r -The order to discont have been missed go because the original documentation that it -The photocopy of th	terview with a medication aide (MA) on 4/03/24 at 9:54am revealed: The order to discontinue Vitamin C 500 mg must ave been missed getting faxed to the pharmacy ecause the original order did not have any ocumentation that it was faxed. The photocopy of the order documented the fax the pharmacy on 02/05/24.					
	nurse on 04/03/24 at -Non-essential media were routinely discor receiving hospice se -Taking Vitamin C for detrimental but she of	cations such as Vitamins ntinued with residents					
	-A physician's order (used to treat vitamir -There was no docur faxed to the pharmac -There was a photoc	opy of the 01/05/24 order it was faxed to the pharmacy					
	medication administr revealed: -There was an entry	#1's January 2024 electronic ration record (eMAR) for Vitamin D3, 50mcg daily.					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011361	B. WING		0/	R / /04/2024
		HALUTI301			1 04	104/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	was administered 01 Review of Resident a revealed: -There was an entry -There was documer was administered 02 -There was documer was discontinued 02 Telephone interview facility's contracted p 9:20am revealed the to discontinue Vitami the pharmacy was of Interview with a med 04/03/24 at 9:54am recorder to discontinust have been missipharmacy because the tany documentation to the pharmacy on 0 Telephone interview nurse on 04/03/24 at -Non-essential medic were routinely discorreceiving hospice se -Taking Vitamin D for detrimental but she contracts.	for Vitamin D3, 50mcg daily. Intation Vitamin D3, 50mcg daily. Intation Vitamin D3, 50mcg doi. Intation aide doi. Into doi	D 358			
	-A physician's order as a blood thinner) 2	mentation the order was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		04	R J/ 04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	•	
HARMON	Y AT REYNOLDS MOUNT	FAIN 41 COBE	BLERS WAY			
TIARWON	TAT KETHOEDS MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 43	D 358			
		opy of the 01/05/24 order t was faxed to the pharmacy m.				
	medication administra revealed: -There was an entry f	or Xarelto 20mg daily				
	administered 01/05/2	9				
	revealed: -There was an entry f	or Xarelto 20mg daily. Italian Xarelto 20mg was				
	administered 02/01/2	4 through 02/06/24. tation Xarelto 20mg was				
	facility's contracted pl 9:20am revealed the	with a pharmacist from the harmacy on 04/03/24 at first time the 01/05/24 order 20mg was received at the 05/24.				
		evealed: nue Xarelto 20mg must				
	because the original of documentation that it	order did not have any was faxed. e order documented the fax				
	to the pharmacy on 0	2/05/24.				
	nurse on 04/03/24 at -Xarelto 20mg was no	ot a medication hospice liked ents receiving services. extra month was not				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
			7.1. 20.125101			R
		HAL011361	B. WING		04	/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	V AT REVNOLDS MOUN	41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 44	D 358			
	discontinue administering medications when ordered to do so.					
	-A physician's order to blood thinner) 81mgThere was no documentated to the pharmaceThere was a photocomy with documentation on 02/05/24 at 7:17p. Review of Resident # medication administrative revealed there was not revealed: -There was an entry starting 02/05/24.	mentation the order was cy. opy of the 01/05/24 order it was faxed to the pharmacy m. #1's January 2024 electronic ation record (eMAR) o entry for aspirin 81mg daily #1's February 2024 eMAR for aspirin 81mg daily, mentation aspirin 81mg was				
	facility's contracted p	/05/24. ication aide (MA) on				
	-The order to discont have been missed go because the original documentation that it -The photocopy of the to the pharmacy on 0	inue aspirin 81mg must etting faxed to the pharmacy order did not have any was faxed. e order documented the fax 02/05/24.				
	nurse on 04/03/24 at	with Resident #1's hospice 10:13am revealed:				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7.1. 20.122		R
		HAL011361	B. WING	 	04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	= ZIP CODE	·
TVAME OF T	NOVIDER OR GOLF EIER		BLERS WAY	-,211 0052	
HARMON	Y AT REYNOLDS MOUNT	'AIN	LE, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	
D 358	Continued From page	: 45	D 358		
	prescribe for resident servicesTaking Xarelto rather for an extra month wa	blood thinner they liked to s receiving hospice than the prescribed aspirin as not detrimental but she administer medications as			
	Refer to interview with 04/03/24 at 9:25am.	n a medication aide (MA) on			
	Refer to interview with at 9:33am.	efer to interview with a second MA on 04/03/24 9:33am.			
	Refer to interview with 9:54am.	n a third MA on 04/03/24 at			
	Refer to interview with Coordinator (RCC) or 10:13am.	n the Resident Care n 04/03/24 at 9:43am and			
	Refer to interview with Director (ED) on 04/0	n the Interim Executive 3/24 at 1:43pm.			
		is, interviews and record ined Resident #1 was not			
	09/15/22 revealed: -Resident #3 had diag depression.	t #3's current FL2 dated gnoses of dementia and bulatory with no assistive disoriented.			
	(anti-psychotic) 25 mg	discontinue Seroquel			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUN	FAIN 41 COBE	BLERS WAY		
	Г	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETE
D 358	Continued From page	e 46	D 358		
	to the pharmacy.				
	administration record -There was an entry f	or Seroquel, 25mg daily. tation Seroquel 25 mg was			
	facility's contracted pl 11:18am revealed: -Resident #3 had and Seroquel, 25 mg, on a -Resident #3 had a di 25mg, on 02/23/24 th facility.	06/23/23. iscontinue date for Seroquel, at was faxed from the			
	discontinued on 02/08 -She was unaware the to be given even thou an order for it to be displayedIf the physician was	evealed: esident #3's Seroquel was 8/24. e medication had continued igh the physician had written iscontinued. not onsite and did not hand it was easy for it be get			
		nd MA on 04/03/24 at was unaware Resident #3's inued on 02/08/24.			
	Refer to interview with 04/03/24 at 9:25am.	h a medication aide (MA) on			
	Refer to interview with at 9:33am.	h a second MA on 04/03/24			

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		04	R 9 /04/2024
NAME OF B	ROVIDER OR SUPPLIER	CTDEET A	ADDRESS, CITY, STATE	ZID CODE	, -	
NAIVIE OF F	ROVIDER OR SUFFLIER		BLERS WAY	, ZIF CODE		
HARMON	Y AT REYNOLDS MOUN	NTAIN	LLE, NC 28804			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ION SHOULD BE	(X5) COMPLETE DATE
TAG	REGULATORY OF	(LOCIDENTIF TING INFORMATION)	TAG	DEFICIENC		5/112
D 358	Continued From pag	ge 47	D 358			
	Refer to interview wi 9:54am.	ith a third MA on 04/03/24 at				
	Refer to interview with the Resident Care Coordinator (RCC) on 04/03/24 at 9:43am and 10:13am. Refer to interview with the Interim Executive Director (ED) on 04/03/24 at 1:43pm. Interview with a medication aide (MA) on 04/03/24 at 9:25am revealed: -When a medication was discontinued, she faxed					
	-The order and med	ity's contracted pharmacy. ications from the cart were				
	pick up from the faci	-				
		s on site when the order was ed to the MA to process.				
		s off-site, the orders were				
	faxed to the facility or to the pharmacy.					
	Interview with a secons 9:33am revealed:	ond MA on 04/03/24 at				
		was discontinued, the				
		te the order and gave it to the				
	MA or faxed the orde	er to the pharmacy.				
		nsible for faxing the orders to				
	the facility's contract					
		oved the medications from ation administration record				
	(eMAR).	ation administration record				
	,	was no longer on the eMAR,				
		removed from the cart.				
		d a return to pharmacy sheet				
	-	and medication were placed in				
	a box for Pharmacy					
	-This could happen i	if the MA does not scan the				
	medications.					
	│ -If medications are s	canned, it will tell you if the				

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· ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED	
		HAL011361	B. WING		R 04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE	
D 358	Continued From page	e 48	D 358			
	medication has been	discontinued.				
	revealed: -When an order was either start or discont working at that time withe order to the pharriconce the order was of the day and time the placed the original coresident's recordCart audits were corrand any medication of be identified during the literal l	faxed, the MA made a note ne order was faxed and appy of the order in the nducted weekly on third shift order discrepancies should nat audit. sident Care Coordinator to 9:43am and 10:13am on 03/12/24. at the facility's process was are discontinued. should be responsible for				
	order or fax . -He was unaware of a	, ,				
	discontinued by phys through.	icians and not being followed				
	on 04/03/24 at 1:43pi -He started as the Int -When medication we medication aides (MA faxing the orders to p	erim ED on 02/20/24. ere discontinued, the As) were responsible for				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL011361	B. WING		04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	AIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 358	_	working. should manage orders and follow up on everything.	D 358			
D 366	(i) The recording of the medication administration administration at the resistant person who adminimediately following medication to the resistent actually taking to the administration of medication. Pre-charmant This Rule is not met at Based on observation reviews, the facility faraides observed 2 of 5 #5) take their medicate medications left on a stand a bottle of a laxate kitchenette bar (#5). The findings are: 1. Review of Resident 11/27/23 revealed: -Diagnoses included of Resident #4 was interest.	Medication Administration ne administration on the attion record shall be by the inisters the medication administration of the dent and observation of the g the medication and prior of another resident's ting is prohibited. as evidenced by: s, interviews, and record illed to ensure medication sampled residents (#4 and ions related to morning resident's coffee table (#4) ive left on a resident's it #4's current FL2 dated dementia and hypertension. rmittently disoriented. int Register for Resident #4	D 366			
	Review of physician's	orders for Resident #4				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		04	R I/04/2024	
NAME OF F	PROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
LIADMON	IV AT DEVNOI DO MOUN	41 COB	BLERS WAY				
HARMON	IY AT REYNOLDS MOUN	ASHEVI	LLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 366	revealed: -There was an order used to treat demen 11/27/23There was an order used to treat depres 01/11/24There was an order (supplement) 1 tableThere was an order (supplement) 1 tableThere was an order from resident's room medications dated 0 Observation during to 9:42am revealed the the coffee table in R 4 medication tablets Interview with Resid revealed: -He did not know ho thereHe did not know if the medications or notHe did not know if semedications. Review of Resident Administration Recoveraled: -There was an entry an administration time documentation the content of the semestration time administration time admi	for donepezil (medication tia) 10mg daily dated for sertraline (medication sion) 25mg daily dated for multivitamin et daily dated 01/29/24. for vitamin D (supplement) ed 01/29/24. for oremove all medications in and staff to administer all 1/26/23. the initial tour on 04/02/24 at ere was a medication cup on esident #4's living room with in the cup. ent #4 on 04/02/24 at 9:45am w long the medications were the had taken his morning staff observed him take his #4's electronic Medication rid (eMAR) for 04/02/24 for donepezil 10mg daily with the of 9:00am and lonepezil was administered at for sertraline 25mg daily with	D 366				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 04/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY		
TIARMON	TAT KETNOEDO MOON	ASHEVII	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 366	Continued From page	e 51	D 366		
	with an administration documentation the m at 9:00amThere was an entry the an administration time.	ultivitamin was administered for vitamin D 2000 units with			
	O4/02/24 at 10:08am -She administered the Resident #4 and obse medicationsThe 4 tablets in the re donepezil, sertraline, multivitaminShe did not know whe table, but it must have -She did not see the entered his room to a	e 9:00am medications to erved him take the medication cup were			
	04/03/24 at 10:00am. Refer to the interview	with a second MA on with the Resident Care on 04/02/24 at 3:45pm.			
	Director (ED) on 04/0 2. Review of Residen 07/07/23 revealed: -Diagnoses included	at #5's current FL2 dated			
	hypertension, and rig -She was ambulatory disoriented.	_			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
			7. BOILDING			R	
		HAL011361	B. WING			/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	ERS WAY				
	Т		E, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETE DATE	
D 366	Continued From page	e 52	D 366				
	Review of the Reside revealed an admissio	ent Register for Resident #5 en date of 07/14/23.					
		orders for Resident #5 led polyethylene glycol one ation.					
	Observation during the initial tour on 04/02/24 at 9:23am revealed there was a bottle of polyethylene glycol on Resident #5's kitchenette bar.						
	Interview with Resident #5 on 04/02/24 at 9:25am revealed: -Staff informed her she could keep the polyethylene glycol in her roomShe took the medication as neededShe did not always tell staff when she took the medicationShe did not take any of the polyethylene glycol the morning of 04/02/24.						
	dated 04/02/24 revea polyethylene glycol 1 administration time of	d (eMAR) for Resident #5 led there was an entry for					
	04/02/24 at 10:08am -She administered the Resident #5 and obse medicationsShe thought Resider brought the polyethyle	e 9:00am medications to erved her take the nt #5's family member ene glycol to the resident. ns should not be left in only to document the					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		7 BOILDING			R		
		HAL011361	B. WING		04	1/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY				
(V4) ID	SLIMMARY ST	ASHEVI	LLE, NC 28804	PROVIDER'S PLAN OF CO	NRRECTION	(VE)	
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE EAPPROPRIATE	(X5) COMPLETE DATE	
D 366	Continued From page	e 53	D 366				
	observation of admini	istration.					
	Refer to the interview 04/03/24 at 10:00am.	with a second MA on					
	Refer to the interview Coordinator (RCC) or	with the Resident Care n 04/02/24 at 3:45pm.					
	Refer to the interview Director (ED) on 04/0	with the Interim Executive 3/24 at 1:48pm.					
	10:00am revealed: -She knew medication residents' roomsShe would stand new observe the resident then document the ac-She found medication.	take the medication and diministration. Ins left in rooms in the past. Instruction reporate nurse about one econtinued to find					
	(RCC) on 04/02/24 at -MAs were trained to medicationsMedications should r	sident Care Coordinator t 3:45pm revealed: observe residents take their not be left in resident rooms why there were medications					
	on 04/03/24 at 1:48pr -He did not know that the past in residents' -The MAs were traine	medications were found in rooms. d to document the dications after they observed					

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STATE FORM 8899 3L7611 If continuation sheet 54 of 58

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL011361	B. WING		04	R 4/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D980	Continued From page	÷ 54	D980			
D980	G.S. § 131D-25 Impl	ementation	D980			
	G.S. 131D-25 Implem	nentation				
	this Article shall rest v facility. Each facility s	lementing the provisions of with the administrator of the shall provide appropriate lement the declaration of ded in G.S. 131D-21.				
	This Rule is not met and VIOLATION	as evidenced by:				
	reviews the Administr overall operations of t compliance with the re- care homes as related residents were protect supervision, maintain	ules and regulations of adult d to failing to ensure the ted by providing ing their resident rights, and ge a resident (#3) who was				
	The findings are:					
	Review of the facility's had a capacity of 99 r	s license revealed the facility residents.				
	Review of the facility's 04/02/24 was 75 resid					
	04/03/24 at 2:55pm re -There was an admini on the wallThe Administrator do was the same name a	istrator's certification posted cumented on the certificate as the Administrator 24 at 4:30pm, 03/27/24 at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
		HAL011361	B. WING		04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	ERS WAY			
			_E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D980	Continued From page	e 55	D980			
	-The certificate was is scheduled to expire o	ssued on 01/01/23 and was in 12/31/24.				
		rim Executive Director (ED) m and 04/03/24 at 1:45pm				
	-He was new to the fa -He was in constant of	-				
	Administrator.	A durinistant on the state of the				
	-He had informed the Administrator that the state survey team was on site and would be contacting her.					
	4:30pm and 03/27/24	dministrator on 03/19/24 at at 4:53pm revealed: North Carolina and did not				
	work at the facility, so operations of the facil	she entrusted the				
	-She kept in contact v	vith the facility but had not				
	been informed about	resident isssues. ne turnover in the ED and				
	Health and Wellness					
	==	e Health and Wellness				
	Director's responsibili regarding resident ca	· ·				
	A second telephone in					
		3/24 at 3:09pm revealed: nsite at the facility since				
		ersations with the interim ED 2/20/24.				
	survey team entered	mployee that the state the facility on 04/02/24 but				
		t inform her until 04/03/24. ept informed of any issues at				
	the facility from anyor	ne other than the Adult				
	Home Specialist from Social Services.	the local Department of				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		04	R //04/2024
NAME OF D	ROVIDER OR SUPPLIER	STDEET V	DDRESS, CITY, STATE	ZIP CODE	•	
NAME OF F	ROVIDER OR SUFFLIER		BLERS WAY	, ZIF CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	COMPLETE DATE
D980	Continued From page	e 56	D980			
	Non-compliance was the following rule are	identified at violation level in as:				
	facility failed to initiate sampled residents (# aggressive behaviors being a harm to self a	and was documented as and others. [Refer to Tag 0702(b) Discharge of				
	Based on observations, interviews and record reviews, the facility failed to provide supervision to 1 of 5 sampled Residents (#3) related to the resident having aggressive behaviors that included slapping, hitting, and punching other residents and staff. [Refer to Tag 0270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].					
	reviews, the facility fa were free from menta neglect related to mu physically assaulted	by one resident (#3). [Refer AC 13F .0909 Resident				
	for the operations of non-compliance with related to resident rig resident (#3) was not became physically agresidents on five occathrough 03/15/24. The discharged after the lareported she was a h	is resident was not Primary Care Provider arm to self and others.The to ensure responsibility for				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 04/04/2024
NAME OF PROV	/IDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMONY A	T REYNOLDS MOUNT	AIN 41 COBBL ASHEVILL	ERS WAY E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	NTEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
m re th — Ti pi 04	esulted in serious nemis failure constitutes he facility failed to protection in accordar 4/04/24. CORRECTION DATE	ervision of the facility glect of the residents and a Type A1 Violation. Tovide an acceptable plan of face with G.S. 131D-34 by FOR THIS TYPE A1 OT EXCEED MAY 4, 2024.	D980		

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