Division of	of Health Service Regu	lation				-
	T OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE S COMPL	
					F	2
		HAL011361	B. WING		1	`)4/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, ST	ATE. ZIP CODE		
		41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUN	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 000	Initial Comments		D 000			
	County Department of an annual and follow	sure Section and Buncombe f Social Services conducted -up survey and a complaint 2/24 through 04/04/24 with a 04/24.				
D 125	aides, and their direct training, clinical skills written examination a 131D-4.5B. Persons occupational licensur medications are exen Readopted Eff. July 1 This Rule is not met Based on interviews a facility failed to ensur aides (Staff A, B, and medications to reside approved medication checklist and 1 of 3 s (Staff B) completed th and 10-hour or 15-ho required. The findings are: 1. Review of Staff A's -She was hired 08/09 (MA).	B Qualifications Of staff who administer r referred to as medication t supervisors shall complete validation, and pass the s set forth in G.S. authorized by state e laws to administer npt from this requirement. , 2021.	D 125	On 4/14/24 the community engathe services of a nursing team to review all employee files and contraining and clinical skills validated all clinical staff. On 5/14/2024 the community entities service of a nursing team to provide the required 15-hour medication aide training for all medication aides that required in Moving forward the community engage a nursing team to composite clinical skills validation for all clinical skills valid	o pmplete tion for ngaged t. will blete nical prming will de the g to all ithin six will de six	05/14 /2024
	alth Service Regulation					
ABORATORY	DIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATUR	E	TITLE Regional Director of Operation	20	(X6) DATE
Shay	, Lingerfelt			Regional Director of Operation	15	5/15/2024

STATE FORM

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3L7611

If continuation sheet 1 of 58

Reviewed and acknowledged LSB 05/22/24

	F OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION (2	X3) DATE SUR COMPLETE	
					R	
		HAL011361	B. WING		04/04/2	2024
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STA	FE, ZIP CODE		
IARMON	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLE ⁻ DATE
D 125	Continued From pag	e 1	D 125			
	 15-hour medication training on 01/23/24. There was documentation Staff A passed the medication aide written exam on 12/21/23. There was no documentation Staff A completed the medication clinical skills validation checklist. Review of a Resident's February, March, and April 2024 electronic Medication Administration Record (eMAR) revealed there was documentation that Staff A administered medications. 			Moving forward Health Care Dir (HCD) or designee will schedule required medication aide trainin with the nursing team upon completion of new hire orientation	e gs	E 17 10
				The HCD or designee will ensur medication aide trainings are completed and filed in the emplo files.		5/7/2
	Telephone interview with Staff A on 04/03/24 4:12pm revealed: -She was hired on 08/09/23 and worked as a in the facility administering medications to residents. -She did not complete a medication clinical s validation checklist and knew nothing about i	8/09/23 and worked as a MA tering medications to e a medication clinical skills		Moving forward the Business Of Manager (BOM) or designee wil review all employee files to ensu- required trainings are completed required.	ll ure all	
	Refer to the interview Coordinator on 04/03	v with the Resident Care 3/24 at 2:25pm.				
	Refer to the interview Manager (BOM) on (v with the Business Office 04/03/24 at 2:20pm.				
	Refer to the interview Director (ED) on 04/0	v with the Interim Executive 03/24 at 1:48pm.				
	-She was hired 07/13 (MA).	s personnel record revealed: 3/22 as a medication aide				
	medication aide writt -There was no docur 15-hours of medication	ntation Staff B passed the en exam on 11/06/07. nentation Staff B completed on training or completed the cal skills validation checklist.				
		t's February and March 2024 Administration Record				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY	
			A. BUILDING:	A. BUILDING:			
		HAL011361	B. WING		04	R / 04/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	Y AT REYNOLDS MOUN	TAIN 41 COB	BLERS WAY				
		ASHEVI	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 C (EACH CORRECTIVE AU CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLE DATE	
D 125	Continued From pag	e 2	D 125				
	. ,	(eMAR) revealed there was documentation that Staff B administered medications.					
	4:45pm revealed: -She worked full time administered medica -She knew she comp skills checklist and the training in 2022 by a gave the documenta -She did not know whe missing. Refer to the interview Coordinator on 04/03	bleted the medication clinical ne 15 hours of medication Registered Nurse (RN) and tion to a manager. hy the documentation was with the Resident Care 8/24 at 2:25pm. with the Business Office					
	Refer to the interview Director (ED) on 04/0	v with the Interim Executive 03/24 at 1:48pm.					
	-Staff C was hired or aide (MA). -There was documer 15-hours of medicati -There was documer medication aide writt -There was no docur	s personnel record revealed: n 01/03/24 as a medication ntation Staff C completed the on training. ntation Staff C passed the en exam on 11/06/07. mentation Staff C completed clinical skills validation					
		2/24 at 11:23am revealed medications to a resident.					
	Telephone interview 2:42pm revealed: -She worked in the fa	with Staff C on 04/03/24 at acility administering					

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		04	R / /04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE	, ZIP CODE		
	AT REYNOLDS MOUN	A1 COBI	BLERS WAY			
		ASHEVI	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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLE ⁻ DATE
D 125	Continued From page	ge 3	D 125			
	medications to resid	ents				
		pleted the medication clinical				
		cklist when she completed the				
		ion training but did not know				
	what happened to th					
	Refer to the interview	w with the Resident Care				
	Coordinator on 04/0					
	Refer to the interview	w with the Business Office				
	Manager (BOM) on	04/03/24 at 2:20pm.				
	Refer to the interviev	w with the Interim Executive				
	Director (ED) on 04/	/03/24 at 1:48pm.				
		esident Care Coordinator on				
	04/03/24 at 2:25pm					
		ny the MAs did not have				
	newly hired.	e required training as he was				
	-He was responsible completed the requi	e for ensuring the MAs red training.				
	Interview with the In	terim Executive Director (ED)				
	on 04/03/24 at 1:48					
	•	MAs and they assured him				
	-	required training, but the				
		e training was not in the				
	personnel records.					
	-The Business Office	e Manager (BOM) was				
	responsible for ensu	2 , <i>j</i>				
		in the personnel records but				
		without a dedicated BOM for				
	6 months.					
	-The corporate BOM	I was "supporting" the facility.				
	-He hired a BOM 3 of	days ago.				
		OM on 04/03/24 at 2:20pm				
	revealed:					
	-She was new to the	e position of BOM.				

STATE FORM

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED R
	ROVIDER OR SUPPLIER	TAIN 41 COBE	B. WING DDRESS, CITY, STA BLERS WAY LLE, NC 28804	TE, ZIP CODE	04/04/2024
(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 CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPL
D 125		e 4 ho was responsible for mpleted their training.	D 125		
D 137	 (a) Each staff person shall: (5) have no findings Health Care Person 131E-256; This Rule is not met Based on interviews facility failed to ensure A) had no substantia Carolina Health Care upon hire. The findings are: Review of Staff A's, r personnel record rev -Staff A was hired on -There was no docur completed upon hire Interview with Staff A revealed she was hir as a MA in the facility Interview with the Int on 04/03/24 at 1:48p -The Business Office responsible for ensure documentation was i 	7 Other Staff Qualifications in at an adult care home listed on the North Carolina nel Registry according to G.S. as evidenced by: and record reviews, the re 1 of 3 sampled staff (Staff ted findings on the North e Personnel Registry (HCPR) medication aide (MA), ealed: 08/09/23. mentation of a HCPR check on 04/03/24 at 4:12pm ed on 08/09/23 and worked /. erim Executive Director (ED) m revealed: Manager (BOM) was	D 137	On 4/14/2024 the community engaged the services of a nu- team to review all employee On 4/16/24 the community of North Carolina Health Care F check on all employees and was filed in the employee file On 5/7/24 the Executive Dire provided education to the BO required documentation need to scheduling new hire orient Moving forward the BOM or will complete North Carolina Care Registry check prior to scheduling a new hire for orient Moving forward the BOM or will review all new employee ensure compliance.	ursing files. ompleted Registry a copy es. ector (ED) DM on all ded prior tation. designee Health entation. designee

	of Health Service Regu r of Deficiencies of Correction	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL011361		CONSTRUCTION	(X3) DATE SU COMPLE R 04/04	TED
	Rovider or supplier Y at reynolds mount	AI COBI	DDRESS, CITY, STA BLERS WAY LLE, NC 28804	TE, ZIP CODE		
(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	(X5) COMPLETE DATE
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 r 10A NCAC 13F .0702 10A NCAC 13F .0702 (b) The discharge of a facility at the direction designee shall be bas reasons: (1) the discharge is new welfare of the residen meet the needs of the by the resident's physical nurse practitioner in the coumented by the re- physician assistant, o resident's record; (3) the safety of the re- in the facility at the direction facility at the direction	 was "supporting" the facility. ays ago. M on 04/03/24 at 2:20pm position of BOM. to was responsible for ks were completed. CPR check dated 04/03/24 to substantiated findings. 2 (b) Discharge Of Residents a resident initiated by the to f the administrator or their sed on one of the following ecessary to protect the tand the facility cannot e resident, as documented sician, physician assistant, or he resident is no longer in porvided by the facility, as 	D 137	On 5/3/24 the Corporate Clinical Specialist trained all managers discharge process, including notification, documentation, and assistance with transition plann The HCD or designee will ensu the safety and rights of all resid protected. Where a resident jeopardizes the health, safety, of being of the resident or others a community, the community sha immediately initiate discharge in compliance with state regulation a violent resident awaiting disch the community will ensure one- supervision until discharge.	on the d ing. re that ents are or well- at the ll n s. For narge,	5/3/202 On going

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		R
		HAL011361	B. WING		04/04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	ATE, ZIP CODE	
	AT REYNOLDS MOUN	ΙΤΔΙΝ	LERS WAY		
	SUMMARY ST			PROVIDER'S PLAN OF CORRECTION	(725)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLE
D 224	Continued From pag	e 6	D 224		
	in the facility is enda	ngered as documented by a		On 4/20/2024 the Clinical Specia	alist
	physician, physician			educated the HCD on proper dis	scovery
	practitioner in the res			process during assessment to	-
	•	failed to pay the costs of		decrease the possibility of admit	tting
	services and accomr	nodations by the payment o the resident's contract after		residents with aggressive behav	-
	•	ice of warning of discharge		Going forward, the ED will revie	AA7
	for failure to pay.			assessment prior to admission.	
				Moving forward, residents that a	ire
				exhibiting aggressive behavior,	
				immediately sent to the hospital evaluation and treatment.	
	This Rule is not met	as evidenced by:			
	A1 VIOLATION	,		Moving forward, any resident ad	Imitted
				to the hospital will be evaluated	
		and record reviews the		HCD or designee prior to return	
	sampled residents (#	, .		the community.	
		s and was documented as		Moving forward community will r	pot
	being a harm to self	and others.		allow residents with aggressive	
	The findings are:			behavior to return the communit	v until
	The findings are:			the resident is assessed by the	
	Review of Resident # 09/15/22 revealed:	#3's current FL2 dated		designee.	
		dementia and depression.		Moving forward the ED and UC	
		ocumented as ambulatory		Moving forward the ED and HCI	
	and intermittently dis			review documentation of resider aggressive behavior to ensure the second	he
	Review of Resident #	#3's Resident Register		safety of the resident and others	
	revealed:	3		around them can be managed a	
	-The date of admissi	on was not documented.		decide if the resident is appropri	ate to
		sident #3's Responsible		return to the community.	
	Party (RP) on 02/03/	22.			
	Review of Resident #	#3's incident reports			
	revealed:	en needenst in the force and			
	-She punched anothe alth Service Regulation	er resident in the face on			

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED
			A. BUILDING:			Р
		HAL011361	B. WING		04	R 1/ 04/2024
AME OF PF	ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	, ZIP CODE		
	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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 224	Continued From pag	je 7	D 224			
	12/28/23.					
		residents room with her fist				
	raised, making the o	ther resident scream on				
	01/24/24.					
	-She hit another resi					
		dent in the face and on the				
	side of the head on (J2/09/24. dent on the side of the head				
	on 03/15/24.	dent of the side of the flead				
		rs were documented toward				
	staff and other reside					
	-She was sent to the	e emergency room (ER) for				
	mental evaluations o	on three of the six occasions				
	but was never admit	ted.				
	Review of Resident	#3 Mental Health Provider's				
	(MHP) visit note date	ed 01/24/24 revealed:				
	-Staff reported the re	esident had worsening				
		ped multiple staff members.				
		spicion" Resident #3 had				
	struck another reside					
		nented if reports of striking re true, "we may need to				
		this resident to a different				
	facility."					
	Review of a second	MHP visit note for Resident				
	#3 dated 02/08/24 re	evealed:				
		lent #3 was "hitting" and				
	"biting" other residen					
		Resident #3 was a danger to				
	self and others on 02					
		cumented as physical f and other residents .				
		need a higher level of care if				
	she could not be stal	-				
		d a one-on-one sitter for her				
	-	safety of other residents.				
	Interviews with a per	rsonal care aide (PCA) on				
ion of Her	alth Service Regulation					

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If continuation sheet 8 of 58

	of Health Service Regi TOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
						R	
		HAL011361	B. WING		04	/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	ITAIN					
	1		ILLE, 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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEI	CTION SHOULD BE D THE APPROPRIATE	(X5) COMPLET DATE	
D 224	Continued From pag	e 8	D 224				
	revealed the Health (HWD) was responsi	and 03/15/24 at 3:30pm and Wellness Director ible for communicating with nitiating discharges or					
	revealed: -She was aware Res aggressive towards of -She and the medica notifying Resident #3 #3's aggression. -The facility sent the ER kept sending her treatment. -She was responsible manage resident bel discharges. -She had not conside because she had no -She, the MHP and the a meeting on 02/08/2 Resident #3's aggrest -They were currently locked because of R -There was no other	tion aides (MAs) were d'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 t thought about it. he resident's RP were having 24 about what to do about					
	at 5:15pm and 03/15 -He had not been ma aggressive behavior -He had only recently facility and could not had not been taken r aggression in the pa	y began working at this comment on why actions regarding Resident #3's					

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 04/04/2024				
		HAL011361							
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE					
HARMONY AT REYNOLDS MOUNTAIN 41 COBBLERS WAY ASHEVILLE, NC 28804									
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	FCORRECTION	(X5)			
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETI			
D 224	Continued From page	9	D 224						
	Resident #3.	not to procure a sitter for was unsure why no other en after the sitter was							
	12:15pm and 04/04/2 -He was part of a mea Resident #3's RP and -The meeting was to Resident #3's aggres attacking staff, other point become aggres -It was determined th one-on-one sitter to s while her medications -When he left the mea	discuss how to manage sion since the resident was residents, and had at one sive with the MHP.							
	on 03/19/24 at 2:15pr -It had been his unde had a sitter during the -He only recently four have a sitter because one. -It was an oversight th action had been taken sitter. -If a resident became be sent to the ER and the MA should contact -The ED, HWD, and the	rstanding that Resident #3 e month of February 2024. Ind out Resident #3 did not e the RP declined to procure that no other protective in after the RP declined the aggressive and needed to d a resident's RP refused, et the ED or Clinical Director. the facility nurse would ind send the resident to the							

Division of Health Service Regulation STATE FORM

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
	Y AT REYNOLDS MOUN	NTAIN	BLERS WAY			
		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 224	Continued From page	ge 10	D 224			
	taken in the past to a behaviors.	address Resident #3's				
		Administrator on 03/19/24 at 4 at 4:53pm revealed:				
	-	istrator at a sister facility in				
	another state, so she entrusted the day to day operations to the ED.					
	•	HWD's responsibility to				
	• •	arding resident care and to				
	initiate discharges if -She was in contact	with the facility but had not				
		t the issues with Resident #3.				
	A second telephone	interview with the				
	Administrator on 04/ -She had not been of	/03/24 at 3:09pm revealed: onsite at the facility since				
	08/28/23. -When she found ou	it about Resident #3's				
	aggression through	the Adult Home Specialist				
		she reached out to her nd was informed a Plan of				
	Protection had been					
		any concerns from anyone at				
	A third telephone int on 04/04/24 at 2:19	erview with the Administrator				
	•	/hy a discharge was not				
	considered when Re	-				
		essive behaviors and the ne resident as a harm to self				
	and others.					
		Iministrator of the facility after strator abruptly resigned in				
	January 2024.					
		ted out of state, the facility				
		erim ED to the facility from 02/20/24 when the current				
	interim ED could sta					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
		HAL011361	B. WING		04/04/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
HARMONY	AT REYNOLDS MOUN	ITAIN	BLERS WAY ILLE, NC 28804			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET
D 224	Continued From pag	je 11	D 224			
	-Neither interim EDs	had informed her of				
	Resident #3's aggre					
		as made aware Resident #3				
		blems was when the AHS				
	contacted her on 03					
	-Corporate policy required the Regional Directors be informed when Residents were sent to the ER					
	for mental evaluations, or when residents were					
	identified to be a har					
	-The Regional Direc	tor informed her that they				
		ent #3 was identified as a				
		thers, was having aggressive				
	behaviors, or was se	ent to the ER.				
	The facility failed to i	initiate the discharge of				
	-	s documented as being a				
		ers in February 2024 and				
	subjected residents	and staff to physical assaults				
		ng, hitting and punching.				
		Irred five times from				
		/15/24 and she was ordered				
		so others residents were				
	· · · · · · · · · · · · · · · · · · ·	ggressions. This failure to esulted in serious abuse and				
	0	tes a Type A1 Violation.				
		provide an acceptable plan of				
	·	ance with G.S. 131D-34 by				
	04/04/24.					
	CORRECTION DAT	E FOR THIS TYPE A1				
		NOT EXCEED MAY 4, 2024.				
D 254	10A NCAC 13F .080	1(b) Resident Assessment	D 254			
	10A NCAC 13F .080	1Resident Assessment				
		assure an assessment of				
		pleted within 30 days				
	following admission	and at least annually				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPL	
					R	
		HAL011361	B. WING	04/0	4/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STA	TE, ZIP CODE		
IARMON	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 ACTI) CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 254	established by the D approved by the Dep containing at least the required on the estable assessment to be con following admission as be a functional assess resident's level of fur psychosocial well-be physical functioning Activities of daily living personal hygiene, and transferring, toileting assessment shall incon referral to the resident licensed health care	ssessment instrument epartment or an instrument partment based on it e same information as olished instrument. The mpleted within 30 days and annually thereafter shall essment to determine a notioning to include ing, cognitive status and in activities of daily living. ng are bathing, dressing, nbulation or locomotion, and eating. The licate if the resident requires nt's physician or other professional, provider of opmental disabilities or	D 254	On 4/16/2024 the comi engaged the services of review all assisted livin charts and complete Fl assessments. On 4/30/2024 the Clinic educated the HCD on the completing annual asso FL2s. The ED will ensure the completes annual asso FL2s as required.	of nursing to lg residents' L2 and cal Specialist requirement for essments and HCD	
	facility failed to ensu	iews and interviews the re an annual assessment s completed for 2 of 5				
	The findings are:					
0		nt #1's current FL2 dated agnoses included dementia, perlipidemia				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			B. WING		R	
		HAL011361			04	/04/2024
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE, BLERS WAY	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΤΔΙΝ	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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 254	Continued From pag	e 13	D 254			
	Review of Resident recent FL2 was avail	#1's record revealed no more able for review.				
	Refer to interview wit Director (ED) on 04/0	th the interim Executive 02/24 at 1:50pm.				
		nt #3's current FL2 dated agnoses included dementia				
	Review of Resident recent FL2 was avail	#3's record revealed no more able for review.				
		erim Executive Director (ED) m revealed Resident #3 did FL2.				
	Refer to interview wit Director (ED) on 04/0	th the interim Executive 02/24 at 1:50pm.				
	on 04/02/24 at 1:50p -The Health Care Dir for ensuring FL2s we -The HCD position w	rector (HCD) was responsible ere updated. as currently vacant. up-to-date had been a long				
D 259	10A NCAC 13F .080	2(a) Resident Care Plan	D 259			
	 (a) An adult care hor developed for each r the resident assessm 30 days following ad .0801 of this Section 	2 Resident Care Plan ne shall assure a care plan is esident in conjunction with nent to be completed within mission according to Rule . The care plan is an n program of personal care				

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUF COMPLET	
			A. BUILDING: _			
		HAL011361	B. WING		R 04/04/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
		ASHEVIL	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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	DBE	(X5) COMPLE DATE
D 259	Continued From page	e 14	D 259			
	for each resident.					
				On 4/16/2024 the community		
				engaged the services of nursi	ng to	
				review all assisted living resid	ents'	
	This Rule is not met	-		care-plans to ensure compliar	nce.	
	Based on record reviews and interviews the					
	facility failed to ensure a care plan was updated annually on 2 of 5 sampled residents (#1 & #3).			Moving forward the HCD will a		
	annually on 2 of 5 sa	mpled residents (#1 & #3).		and complete a care plan for a		
	The findings are:			residents within 30 days of mo	ove in.	
	1 Poviow of Posidor	nt #1's current FL2 dated		Moving forward the HCD will		
		agnoses included dementia,		complete a care-plan for each		
	osteoporosis and hyp			resident every six months and change of condition as require	with	
	Review of Resident # -It was dated 03/23/2	¢1's care plan revealed: 2.				
	-There was documer	itation she needed				
	supervision with eating	ng, ambulation and transfers.				
		lent #1 on 04/02/24 at				
	12:05pm revealed:	with staff assistance to				
	-Sne used a walker v ambulate to the dinin	vith staff assistance to				
		ssistance to transfer from				
	her walker to the dini					
		he required prompting from				
	staff and assistance					
		equired assistance from a				
	•	taff to transfer from the chair				
	to using her walker.					
		erim Executive Director (ED)				
	on 04/02/24 at 1:50p					
		erim ED on 02/20/24.				
	-He could not find a c Resident #1.	unent care plan lor				
		ector (HCD) was responsible				
		ns were updated but that				
	position was currently					

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E SURVEY PLETED	
		HAL011361	B. WING	O	R 04/04/2024	
	ROVIDER OR SUPPLIER	STREET. 41 COB	ADDRESS, CITY, STA BLERS WAY ILLE, NC 28804	· · · · ·	104/2024	
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
D 259 D 270	term oversite proble 2. Review of Reside 09/15/22 revealed d depression. Review of Resident -It was dated 02/28/. -There was docume assistance with bath Interview with the im on 04/03/24 at 1:43g -Resident #3 did not -It was the the Healt responsibility to kee -The HCD position v -The ED would ultim care plans up to dat -Keeping paperwork long-term oversight. 10A NCAC 13F .090 Supervision	 a up-to-date had been a long m at the facility. nt #3's current FL2 dated iagnoses of dementia and #3's care plan revealed: 23. ntation she needed ing. terim Executive Director (ED) om revealed: thave an updated care plan. h Care Director (HCD) p files up to date. vas currently vacant. nately be responsible to keep e. up-to-date has been a 	D 259	The community engaged an RN consulting service on 4/16/24 to review all AL resident charts and care-plans according to each resident's needs.	5/3/24 On goir	
	Supervision (b) Staff shall provid	de supervision of residents in ch resident's assessed needs,		Community has initiated and implemented a system of reporting resident's personal care needs to the HCD and resident's physician for evaluation. Shift reports will be reviewed daily by the		
	This Rule is not me TYPE A1 VIOLATIO Based on observatio	-		HCD and all resident concerns will be addressed as reported. The HCD will supervise residents' care needs and communicate any change with resident's physician and resident's responsible person.		

ATEMENT OF DEFICIENC	S (X1) PROVIDER/SUPPI IDENTIFICATION N) MULTIPLE C BUILDING:	(X3) DATE SURVEY COMPLETED		
					R	
	HAL011361	B. \	B. WING			4/2024
ME OF PROVIDER OR SU	PPLIER	STREET ADDRESS	S, CITY, STATE	ZIP CODE		
ARMONY AT REYNOL	OS MOUNTAIN	41 COBBLERS ASHEVILLE, NO				
PREFIX (EACH	IMMARY STATEMENT OF DEFICIENC DEFICIENCY MUST BE PRECEDED E ATORY OR LSC IDENTIFYING INFOR	CIES BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLE DATE
reviews, the to 1 of 5 sa resident ha included sla residents a The finding Review of F 09/15/22 re -Diagnoses -The reside with no ass disoriented Interview w on 04/03/24 care plan a Review of F 12/28/23 re -Resident # fist, after th put her pills -The Prima responsible -Resident # mental eva -The incide MA. Review of F 12/28/23 re -Resident # another ind -Resident #	are: esident #3's current FL2 dat realed: included dementia and depre- nt was documented as ambu- stive devices and intermitten the interim Executive Dire- at 1:43pm revealed there wa ailable to review for Resider esident #3's incident report of realed: 3 hit a medication aide (MA), MA told resident #3 she con- in her cup of water. y Care Provider (PCP) and the party (RP) were notified. 3 was sent to the local hospit lation. t report was signed and date esident #3's hospital records realed: 3 presented in the ER for "pu- vidual in the face". 3 was not admitted and was back to the facility.	ervision to the at other ed ession. latory tly ctor (ED) as no at #3. dated with her uld not he tal for a ed by a s dated unching	270	On 5/3/24 the Clinical Special education for all resident care recognizing and communicatin care needs to the HCD. Moving forward, the HCD or d provide education to all newly care staff on recognizing and residents' personal care need reporting any change in condi	staff on ng resident esignee will hired resident understanding ds and	

STATEMENT	of Health Service Regu OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY			
		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 HE APPROPRIATE	(X5) COMPLETE DATE
D 270	Continued From pag	e 17	D 270			
	-Resident #3 was found in another resident's room with her fist raised.					
	-The other resident v	vas screaming and yelling for				
	help.					
		xtremely combative" and was				
	•	ut of the other resident's				
	room. Under the "Follow U	Ip" section there was				
	documentation staff					
	Resident #3's PCP.					
	Review of Resident #	#3's incident report dated				
	02/02/24 revealed:					
		pravated at another resident				
		t up and the other resident				
	the face.	#3 punched the resident in				
	-The PCP and RP w	vere notified.				
		mentation Resident #3 was				
	sent out for evaluation	on.				
	-The follow-up section	on was blank.				
	-The incident report v	was signed and dated by a				
		#3's hospital records dated				
	02/02/24 revealed:	ted in the ER for hitting				
	another resident.					
	-Resident #3 was no	t admitted and was				
	discharged back to the					
	Review of Resident #	#3's incident report dated				
	02/09/24 revealed:					
		e agitated and began hitting				
	another resident on t of his head.	the side of his face and back				
		ction documented Resident				
	-	r sitter, she was sent to				
		ER), and staff would follow up				
	with the PCP.	,,				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING:			R	
		HAL011361	B. WING		04/04/2024		
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
	AT REYNOLDS MOU	A1 COB	BLERS WAY				
		ASHEV	ILLE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 270	Continued From page	ge 18	D 270				
	Review of Resident #3's hospital records dated 02/09/24 revealed: -Resident #3 presented in the ER for a "violent outburst." -Resident #3 was not admitted and was discharged back to the facility.						
	02/12/24 revealed: -Resident #3 was for room at 5:55pm. -The other resident Resident #3, leaving Resident #3's wrist, Resident #3 from hi -Resident #3's RP v						
	03/15/24 revealed: -Resident #3 hit and -There was docume sending Resident #4 evaluation.	#3's incident report dated other resident in the face. entation the RP declined 3 to the hospital for an c was signed by a MA and the					
	(MHP) note dated 0 -Staff reported the r aggression and slap -There was also "su struck another resid -The provider docur another resident we	esident had worsening oped multiple staff members. ıspicion" Resident #3 had					

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STATEMENT	of Health Service Regi FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPLE	
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΤΔΙΝ	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 270	Continued From pag	e 19	D 270			
	adjustments to Resid medications.	dent #3's psychiatric				
	Review of a Resident #3's second MHP note for Resident #3 dated 02/08/24 revealed: -Facility staff had reported Resident #3 was					
	"hitting" and "biting" other residents. -Staff were notified that the resident was a danger to self and others on 02/08/24.					
	-The danger was documented as physical aggression with staff and other residents. -The resident might need a higher level of care if					
	she could not be stal	•				
		d a one-on-one sitter for her afety of other residents.				
	Observation in the fa revealed:	acility on 03/15/24 at 3:55pm				
		ng in a chair being assessed id (PCA) when Resident #3				
	-Resident #3 was sta	anding near the resident				
	PCA and then hit the	started arguing with another other resident. aff that Resident #3 hit a				
	resident while encou away from the other	raging Resident #3 to move resident, but Resident #3				
		ntered the room at that Resident #3 if she had hit				
		she had hit someone and				
	the RP.	itside in the courtyard with				
	4:00pm revealed:	on 03/15/24 at 3:20pm and				
	-Resident #3 had ap	dent #3 hit the other resident. proached the other resident				
	and "got into her face alth Service Regulation	e" unprovoked.				

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STATEMENT	of Health Service Regu r OF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			E SURVEY PLETED	
		HAL011361	B. WING		04	R 04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE			
	Y AT REYNOLDS MOUN	41 COB	BLERS WAY				
		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETE DATE	
D 270	Continued From page	e 20	D 270				
	and walk away, Resid right side of the head -Resident #3 had also stab the other resider and took the pencil. -Resident #3 was ofter residents. -A couple months ago Resident #3 shove a pinned the resident to -In that instance, staf two residents, and att situation. -The other resident wide techniques as part of -De-escalation consis separating the reside -Resident #3 was not RP declined sending -If a resident became trained to "just do the medical provider. -Staff were also instru- distance." -In this instance, the I aggression. -The MA was respons resident #3 did not I -The PCA did not know	o raised a pencil, as if to nt, but the PCA intervened en aggressive towards other o, the PCA observed resident to the floor, then o the floor in the hallway. f intervened, separated the tempted to de-escalate the vas not seriously injured and al treatment. o on de-escalation new hire training. sted of speaking calmly and nts. sent to the ER because her her out. aggressive, staff were best we can" and call the ucted to "keep their PCA informed the MA of the					
	Interview with a secon 3:37pm revealed:	nd PCA on 03/15/24 at resident #3 grab other y.					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
	AT REYNOLDS MOUN	ITAIN	BLERS WAY 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	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From pag	je 21	D 270			
	not recall specifically what the outcome w -If residents became another, staff were s separate the resider situation. -Resident #3 did not Interviews with a thin 4:33pm and 03/15/2 -Resident #3 had hit -Resident #3 aggres resident in early Fet -Resident #3 also hi few weeks. -Resident #3 had bit another resident. -She observed Resident on the arm. -She could not recal #3. -She did not think th needed emergency -Staff redirected Resident. -She notified the MA -She did not know of taken. -Resident #3 did not aggression because be sent to the ER.	a aggressive with one supposed to intervene, ints, and de-escalate the thave a one-on-one sitter. and PCA on 02/07/24 at 4 at 3:30pm revealed: 5, slapped, and choked staff. 5, slapped, and choked staff. 5, slapped, and choked staff. 5, sively grabbed another oruary 2024. t another resident in the last ten a staff member and dent #3 bite another resident I who was bitten by Resident e resident who was bitten medical attention. sident #3 when she bit the a of the incident. f any other action that was to get sent to the ER for her RP did not want her to thing with Resident #3's MHP				
		llness Director (HWD) was municating with the as well as initiating				
	Interview with a MA	on 02/07/24 at 4:45pm				

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STATEMEN	of Health Service Regu	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011361	B. WING		04	R 1/04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE	, ZIP CODE		
	Y AT REYNOLDS MOUN	41 COBI	BLERS WAY			
		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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
D 270	Continued From page	e 22	D 270			
	and slapped staff. -Resident #3 was also residents. -The resident had recover resident's room and where her bed. -Earlier that week, Recover aggressively grabbed -The facility had sent a couple of times, but sent her back to the for- Staff were keeping and a safety measure again aggression. -Residents could exit assistance but would their doors if they wat	cently been found in another was pinning that resident to esident #3 had also another resident's shirt. Resident #3 to the hospital t the ER did not treat her and acility. Il residents' rooms locked as ainst Resident #3's				
	and 4:00pm revealed -She was aware that another resident in th -In these situations, ti separate the resident the situation. -The MA should also resident to the ER so psychiatric evaluation -In this case, Residen Resident #3 to be ser -The MA would call h guidance on what to -Resident #3 was ofter residents.	Resident #3 had just hit e head. he MA was supposed to s and attempt to de-escalate send the aggressive that resident could have a h. ht #3's RP would not allow ht to the ER. er supervisor to get				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:				
		HAL011361	B. WING		04	R / 04/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
		41 COB	BLERS WAY				
1ARMON 1	AT REYNOLDS MOUN	ASHEVI	LLE, NC 28804				
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O		(X5)	
PREFIX TAG	,	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO		COMPLET DATE	
			_	DEFICIEN	NCY)		
D 270	Continued From pag	e 23	D 270				
	resident.						
	-In that situation, Res	sident #3 hit the other					
	resident in the face v	vithout provocation.					
	-The other resident h	nit Resident #3 back, and the					
	two residents began	slapping each other.					
	-Staff intervened and residents.	separated the two					
		all if either resident was					
	injured or required m						
	-Resident #3 did not						
		that Resident #3's PCP had					
	recommended a sitte						
		esponsible for deciding how					
		ng residents and when to					
	initiate discharges.						
	Interview with a four	th PCA on 04/02/24 at					
	2:51pm revealed:						
		the facility on leave for about					
		d to work on 04/01/24.					
		Resident #3 was aggressive					
	towards staff and oth						
	•	d shove other residents.					
	-When he returned to sitter.	o work, Resident #3 had a					
	-He has not seen an	y aggressive behavior in					
	Resident #3 since co	oming back to work.					
	Interview with the HV	ND on 02/07/24 at 4:51pm					
	revealed:						
		Resident #3 was frequently					
	aggressive towards						
		ere notifying the MHP and					
	PCP of Resident #3'						
	-	resident to the ER, but the					
	ER kept sending her treatment.	back to the facility without					
		e for deciding how to					
	manage resident bel						
1		naviors					

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			SURVEY LETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL011361	B. WING			R 04/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE	2	
	AT REYNOLDS MOUN	TAIN 41 COB	BLERS WAY			
		ASHEVI	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 TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 270	Continued From pag	e 24	D 270			
	about Resident #3's -They were currently locked because of R -There was no other other than continuing Interviews with the C at 5:15pm and 03/15 -He had not been ma aggressive behaviors -He had only recently facility and could not had been taken rega aggression in the pa -Resident #3's RP w sitter had been record	keeping resident rooms esident #3's aggression. safety measures in place g to work with the MHP. Clinical Director on 02/07/24 i/24 at 4:15pm revealed: ade aware of Resident #3's s prior to 02/07/24. y begun working at this comment on why no action irding Resident #3's				
	Resident #3.	d not to procure a sitter for y no other actions had been was declined.				
	12:15pm and 04/04/2 -He was working clos Resident #3's medic months. -Resident #3 had a s	dent #3's MHP on 03/29/24 at 24 at 9:55am revealed: sely with the facility to adjust ations over the past few significant increase in g around December 2023.				
	-The increase in agg dementia progressio the different medicat -He was part of a me Resident #3's RP an -The meeting was to Resident #3's aggres	ression was likely due to her n in addition to reactions to ions. eeting on 02/08/24 with d the HWD. discuss how to manage ssion since the resident was residents, and had at one				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		04	R I/ 04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	AT REYNOLDS MOUN	41 COB	BLERS WAY			
	TAI REINOLDS MOUN	ASHEV	ILLE, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLET DATE
D 270	Continued From pag	je 25	D 270			
	while her medication -When he left the me impression the resid sitter. -He found out at his with Resident #3 that sitter and the HWD I 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 Resident #3 would b 10 days while she at medication change. Telephone interview 04/03/24 at 3:30pm -She was originally t specialized in Alzhei -She was unhappy v received there.	een a lot of turnover at the ave contributed to Resident ter put in place. from the Interim Executive 02/28/24 revealed that be given a 24-hour sitter for djusted to a recent with Resident #3's RP on revealed: cold in 2022 that the facility imer's disease. with the care Resident #3 had irst brought up in 2/2024, she she thought her behaviors				
	were medication ind -After the incident or a sitter in place for F	n 03/15/24, she agreed to put				
	2:15pm revealed: -It had been his und had a sitter in Febru -He only recently for	ond Interim ED on 03/19/24 at erstanding that Resident #3 ary 2024. und out Resident #3 did not e the RP declined to procure				
	one. -It was an oversight	that no other protective en after the RP declined the				

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If continuation sheet 26 of 58

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NOMBER.	A. BUILDING:			
		HAL011361	B. WING		04	R / 04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY LLE, NC 28804			
	STIMWARA S			PROVIDER'S PLAN O		(20)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 270	Continued From pag	je 26	D 270			
	sitter.					
		e aggressive and needed to				
		id a resident's RP refused,				
		ict the ED or Clinical Director.				
		the facility nurse would				
		and send the resident to the				
	ER if needed.					
	-He was new to the f	facility and could not				
		action had been taken in the				
	past to address Resi					
		dministrator on 03/19/24 at				
		4:30pm and 03/27/24 at 4:53pm revealed:				
		have been required to have				
		ing aggressive toward staff				
	or residents while he adjusted.	er medications were being				
	•	ors was not an appropriate				
		nse to resident aggression.				
		istrator at a sister facility in				
		as not currently working at the				
		sted the operations to the ED.				
		with the facility but had not				
		t the issues with Resident #3.				
		me turnover in the ED and				
	HWD positions recei					
		IWD's responsibility to				
		rding resident care and to				
	initiate discharges if					
	A third telephone inte	erview with the Administrator				
	on 04/03/24 at 3:09p					
	-She had not been o 08/28/23.	nsite at the facility since				
		t Resident #3's aggression				
	from the AHS.					
		her Regional Director and				
		of Protection had been put				
	into place.					
	-She had not heard of	of any concerns from anyone				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:	COM!	E SURVEY PLETED	
					R	
		HAL011361	B. WING	04	/04/2024	
AME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATI	E, ZIP CODE		
	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY 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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
D 270	Continued From page	je 27	D 270			
	-The ED and RCC s sitter was put into pl recommended. -Resident #3 should hospital to find out w	hearing from the AHS. hould have made sure a ace when it was first have been sent out to the what was going on and should n adjustments, as well as had				
		ons, interviews, and record mined Resident #3 was not				
	Resident #3 who ha and dementia and w behaviors such as s other residents and being identified as a Resident #3's PCP r sitter was not impler resulting in Resident aggressive towards	other residents and staff. in serious abuse and neglect				
	protection in accord	provide an appropriate plan of ance with G.S. 131D-34. E FOR THIS TYPE A1				
	VIOLATION SHALL	NOT EXCEED MAY 4, 2024.				
D 338	10A NCAC 13F .090	9 Resident Rights	D 338	A1 .0909 Resident Rights	04/10/202	
	10A NCAC 13F .090			The community completed resident rights training for all employees by 4/10/24.	On going	
	all residents guarant Declaration of Resid	shall assure that the rights of eed under G.S. 131D-21, lents' Rights, are maintained ed without hindrance.		The community will ensure resident rights training is completed for all new hires in orientation and annually for all employees.		

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If continuation sheet 28 of 58

STATEMEN	of Health Service Regu FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		R	
		HAL011361	B. WING		04/04/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN				
			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 AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	e 28	D 338			
	This Rule is not met TYPE A1 VIOLATIO	-				
	reviews, the facility fa were free from menta neglect related to mu	ns, interviews, and record ailed to ensure residents al, physical abuse and Iltiple residents being by one resident (#3).				
	The findings are:					
	09/15/22 revealed: -Diagnoses included	#3's current FL2 dated dementia and depression. ocumented as ambulatory oriented.				
	Register dated 02/03 -The date of admissi					
	12/28/23 revealed: -Resident #3 hit a M/ told resident #3 she cup of water. -The PCP and the fa	#3's incident report dated A, with her fist, after the MA could not put her pills in her mily were notified. nt to the local hospital for a				
	12/28/23 revealed:	t admitted and was				

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If continuation sheet 29 of 58

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
NAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
	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 TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	je 29	D 338			
	01/24/24 revealed: -Resident #3 was for room with her fist rai -The other resident with help. -Resident #3 was "e redirected by staff or room. -Under the "Follow U documentation staff Resident #3's Prima Review of Resident # (MHP) note dated 0 -Facility staff reported aggression and slap -There was also "sus struck another resided -The provider docum another resident weat consider transferring facility."	was screaming and yelling for xtremely combative" and was ut of the other resident's Jp" section there was would follow up with ry Care Provider (PCP). #3's Mental Health Provider 1/24/24 revealed: the resident had worsening ped multiple staff members. spicion" Resident #3 had ent. nented if reports of striking re true, "we may need to g this resident to a different mentation of changes or				
	02/02/24 revealed: -Resident #3 got age	#3's incident report dated gravated at another resident				
	said no so Resident	it up and the other resident #3 punched the resident in				
	the face. -The PCP and RP w	ere notified.				
	-There was no docu	mentation Resident #3 was				
	-The follow-up section	on on the incident report. on was blank.				
		#3's Hospital Record dated				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE COMF	SURVEY
		HAL011361	B. WING			R / 04/2024
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE		
	Y AT REYNOLDS MOUN	41 COBE	BLERS WAY			
	TAT RETNOLDS MOON	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 ((EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	CTION SHOULD BE O THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 30	D 338			
	another resident. -Resident #3 was not discharged back to th Review of Resident # 02/08/24 revealed: -Facility staff had rep "hitting" and "biting" of	ne facility. 3's MHP note dated orted Resident #3 was				
	she could not be stab -Resident #3 required	umented as physical and other residents. leed a higher level of care if				
	02/09/24 revealed: -Resident #3 became another resident on th of his head. -The "Follow Up" sec #3 needed a 24-hour	3's incident report dated e agitated and began hitting he side of his face and back tion documented Resident sitter, she was sent to R), and staff would follow up				
	02/09/24 revealed:					
	02/12/24 revealed:	3's incident report dated				

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If continuation sheet 31 of 58

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
	S CONTRECTION	DENTITIONTION NOMBER.	A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΙΤΔΙΝ	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 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page 31 -The other resident became agitated and grabbed Resident #3, leaving fingerprint marks on Resident #3's wrist, while attempting to remove Resident #3 from his room. -Resident #3's RP was notified. Review of Resident #3's incident report dated		D 338			
	03/15/24 revealed: -Resident #3 hit ano -There was docume	#3's incident report dated ther resident in the face. ntation the RP declined to the hospital for an				
	evaluation.	dent #3 in the facility on				
	another resident.	revealed: ed that Resident #3 hit ng in a chair when Resident				
	#3 walked in front of					
	another resident ass	essing the resident's head. anding above the resident				
	-The PCA was encou away from the other	uraging Resident #3 to walk resident, but Resident #3				
	Resident #3 if she ha	ntered the room and asked ad hit someone.				
		she had hit someone and in the courtyard with her RP.				
	4:00pm revealed:	A on 03/15/24 at 3:20pm and				
	-Resident #3 had ap and "got into her fac	•				
	and walk away, Resi right side of the head	dent attempted to stand up ident #3 slapped her on the d. so raised a pencil as if to stab				

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STATEMENT	of Health Service Reg OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL011361	B. WING		R 04/04/2024
NAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE	
	Y AT REYNOLDS MOUN	41 COB	BLERS WAY		
	TAT KETNOEDS MOON	ASHEVI	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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE COMPLETE
D 338	Continued From pag	je 32	D 338		
		ut the PCA intervened and			
	took the pencil.				
		ten aggressive towards other			
	residents.				
		jo, the PCA observed			
		Resident #3 shove a resident to the floor, then pinned the resident to the floor in the hallway.			
		-			
		ff intervened, separated the			
		ttempted to de-escalate the			
	situation.				
	-Staff watched a vide				
	techniques as part o	-			
		isted of speaking calmly and			
	separating the reside				
		was not seriously injured and			
	did not require medi				
		ot sent to the ER because her			
	RP declined sending	e			
		e aggressive, staff were			
	-	e best we can" and call the			
	medical provider.				
	-Staff were also instr	ructed to "keep their			
	distance."				
	-In this instance, the aggression.	PCA informed the MA of the			
	-The MA was respor	sible for notifying the PCP.			
	-Resident #3 did not	have a one-on-one sitter.			
	-The PCA did not kn	ow why the resident was not			
		was recommended by the			
	PCP on 02/08/24.				
	Interview with a seco	ond PCA on 03/15/24 at			
	3:37pm revealed:				
	-	Resident #3 grab other			
	residents aggressive	-			
		"a few" times and she could			
		which other residents or			
	what the outcome w				
		aggressive with one			
		supposed to intervene,			
ion of Hea	alth Service Regulation	11,	I		

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
		HAL011361	B. WING		04	R / 04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREETA	DDRESS, CITY, STATE	, ZIP CODE		
	Y AT REYNOLDS MOUN	41 COBI	BLERS WAY			
	TAT RETNOLDS MOON	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 O (EACH CORRECTIVE AO CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From page	e 33	D 338			
	situation.	s, and de-escalate the				
	-Resident #3 did not i	have a one-on-one sitter.				
	Interviews with a third					
	4:33pm and 03/15/24 -Resident #3 had hit	at 3:30pm revealed: slapped, and choked staff.				
		sively grabbed another				
		uary 2024. another resident in the last				
	few weeks. -Resident #3 had bitte another resident.	en a staff member and				
		esident #3 bite another				
		which resident was bitten by				
	Resident #3. -She did not think the	resident who was bitten				
	needed emergency m					
	other Resident.	dent #3 when she bit the				
	-She notified the MA	of the incident. any other action that was				
	taken.					
		get sent to the ER for her RP did not want her to				
	be sent to the ER. -The facility was work	king with Resident #3's				
		o get medications adjusted.				
		ctor was responsible for				
	discharges or hospita	he MHP as well as initiating lizations.				
	Interview with a MA o revealed:	n 02/07/24 at 4:45pm				
	and slapped staff.	gressive and choked, hit,				
	-Resident #3 was also residents.					
	-She had recently bee alth Service Regulation	en found in another				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		IDENTIFICATION NORTHONIDER.	A. BUILDING:	A. BUILDING:		
		HAL011361	B. WING		04	R I/ 04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STATE,	ZIP CODE		
		41 COB	BLERS WAY			
	Y AT REYNOLDS MOUN	ASHEVI	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	e 34	D 338			
	resident's room and her bed.	was pinning that resident to				
	-Earlier that week, R	esident #3 had also				
	,	d 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 ag	ainst Resident #3's				
	aggression.					
	-Residents could exi					
		have to ask staff to unlock				
		anted to enter their rooms.				
		of any other safety measures				
	in place.					
	Interviews with anoth	ner MA on 03/15/24 at				
	3:15pm and 4:00pm					
		Resident #3 had just hit				
	another resident in th	-				
	-In these situations,	the MA was supposed to				
	separate the residen	ts and attempt to de-escalate				
	the situation.					
		send the aggressive				
		o that resident could have a				
	psychiatric evaluatio					
		ould not allow Resident #3 to				
	be sent to the ER.					
	-The MA would call h guidance on what to					
		en aggressive towards other				
	residents.					
		eeks, she observed Resident				
		I altercation with another				
	resident.					
		other resident in the face				
	without provocation.					
	-	nit Resident #3 back, and the				
		slapping each other.				
	-Staff intervened and	1	1			1

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STATEMENT	of Health Service Regination of Deficiencies	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL011361	B. WING	B. WING		R 04/04/2024	
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
			BLERS WAY	,			
ARMON	Y AT REYNOLDS MOUN	ITAIN	LLE, NC 28804				
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN O	F CORRECTION	(X5)	
PRÉFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLET DATE	
D 338	Continued From pag	le 35	D 338				
	residents.						
		either resident was injured or					
	required medical atte	-					
	-Resident #3 did not						
		that Resident #3's medical					
	provider had recomm	nended a sitter.					
		esponsible for deciding how					
		ng residents and when to					
	initiate discharges.						
	Interview with the He	ealth and Wellness Director					
	(HWD) on 02/07/24 a	at 4:51pm revealed:					
	-She was aware that	Resident #3 was frequently					
	aggressive towards	other residents.					
		otified the MHP and PCP of					
	Resident #3's aggres						
	-	resident to the ER, but the					
		back to the facility without					
	treatment.	· · · · · · ·					
		e for deciding how to					
	manage resident bel	naviors or initiating					
	discharges.	ered initiating a discharge yet					
	because she had no						
		the resident's family had a					
		about what to do about					
	Resident #3's aggres						
	••	keeping resident rooms					
		esident #3's aggression.					
	-There was no other	safety measures in place					
		g to work with the medical					
	provider.						
	Interviews with the C	Clinical Director on 02/07/24					
		5/24 at 4:15pm revealed:					
		vare of Resident #3's					
	aggressive behavior						
		, y began working at this					
		comment on why no action					
	had been taken rega	arding Resident #3's					

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
ND PLAN (JF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COM	
		HAL011361	B. WING		R 04/04/2024	
AME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		41 COBE	BLERS WAY			
ARMON	Y AT REYNOLDS MOUN	TAIN ASHEVII	LLE, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE A CROSS-REFERENCED TO DEFICIE	D THE APPROPRIATE	COMPLET DATE
D 338	Continued From page	e 36	D 338			
	aggression in the pas	st.				
		as informed that a 24-hour				
	sitter had been recon	nmended for the safety of				
	other residents.					
		I not to procure a sitter for				
	Resident #3.					
		no other actions had been				
	taken after the sitter	was declined.				
	Interviews with Resid	lent #3's MHP on 03/29/24 at				
		24 at 9:55am revealed:				
	•	sely with the facility to adjust				
	-	dications over the past few				
	months.					
	-Resident #3 had a s	-				
		g around December 2023.				
		ression was likely due to				
		in addition to reactions to the				
	different medications	eting on 02/08/24 with				
	Resident #3's RP and	0				
		discuss how to manage				
	•	sion since the resident was				
		residents, and had at one				
	point become aggres	sive with him.				
	-It was determined th					
		afely remain in the facility				
		s were being adjusted.				
		eting on 02/08/24, he was the resident would have a				
	one-on-one sitter.					
		next follow up with Resident				
		eclined the sitter and the				
	HWD had left her pos					
	meeting on 02/08/24.					
		en a lot of turnover at the				
		ave contributed to Resident				
	#3 not having the sitt					
	-He was aware a sitte within the last 2 week	er had been put into place				
	alth Service Regulation	١٥.				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		BERTH TO ATOM TO MODELA.	A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
	AT REYNOLDS MOUN	41 COBI	BLERS WAY			
		ASHEVI	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 OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	e 37	D 338			
	Review of an email from the Interim Executive Director (ED) dated 02/28/24 revealed that Resident #3 would be given a 24-hour sitter for 10 days while she adjusted to a recent medication change. Telephone interview with the RP on 04/03/24 at 3:30pm revealed: -She was originally told in 2022 that the facility specialized in Alzheimer's disease. -She was unhappy with the care Resident #3 had received there. -When a sitter was first brought up in February 2024, she refused it because she thought her behaviors were medication induced. -After the incident on 03/15/24, she agreed to put a sitter in place for Resident #3.					
	on 04/03/24 at 2:16p -He began working a -He found out about the Department of S the facility around 03 -A sitter was put into -His role was to mak they agreed to get a -He made sure the s	as RCC around 03/12/24. Resident #3's incidents when ocial Services (DSS) came to 8/20/24. place that same day. e phone calls to the RP, and				
	2:15pm and 04/03/2 -It was his understar sitter during the mon -He only recently fou	ond Interim ED on 03/19/24 at 4 at 1:45pm revealed: ading that Resident #3 had a th of February. and out Resident #3 did not e the RP declined to procure				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED
			A. BUILDING.		R	
		HAL011361	B. WING		04/04/2024	
IAME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	AT REYNOLDS MOUN	ITAIN				
a			LLE, NC 28804	PROVIDER'S PLAN OF	CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL & LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 338	Continued From pag	je 38	D 338			
	action had been take sitter.	en after the RP declined the				
		e aggressive and needed to				
		nd a resident's RP refused,				
		act the ED or Clinical Director.				
		the facility Nurse would				
	ER if needed.	and send the resident to the				
		facility as of 02/20/24 and				
		on why no action had been				
		address Resident #3's				
	behaviors.					
		Administrator on 03/19/24 at				
	4:30pm and 03/27/24 at 4:53pm revealed: -Resident #3 should have been required to have					
		have been required to have eing aggressive toward staff				
		er medications were being				
	adjusted.	initialitie word boing				
	-	oors was not an appropriate				
		nse to resident aggression.				
		ster facility and did not live in				
		he entrusted the operations				
	of the facility to the E	ב⊔. with the facility but had not				
	-	t the issues with Resident #3.				
		VD were new to their roles.				
	-It was the ED and H	HWD's responsibility to				
		manage issues regarding				
	resident care and to	initiate discharges if needed.				
	-	erview with the Administrator				
	on 04/03/24 at 3:09p					
	-She had not been c 08/28/23.	onsite at the facility since				
	-When she found ou	it about Resident #3's				
		Department of Social				
		4, she reached out to her				
	-	nd was informed a Plan of				
	Protection had been	put into piace.				

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			R
		HAL011361	B. WING		04	1/04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY ILLE, NC 28804			
(X4) ID	SUMMARY S			PROVIDER'S PLAN OF		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	COMPLET DATE
D 338	Continued From pag	je 39	D 338			
	at the facility. -The ED and RCC s sitter was put into pla- -Resident #3 should hospital to find out w have had medication a sitter in order to prother residents. Based on observation	of any concerns from anyone hould have made sure a ace. have been sent out to the what was going on and should a adjustments, as well as had otect Resident #3 and the ons, interviews, and record rmined Resident #3 was not				
	mental, physical har #3 verbally and phys residents when no ir place to stop it for m failure resulted in se constitutes a Type A	protect the residents from m and neglect when Resident sically assaulted other nterventions were put into ore than two months. This rious abuse and neglect and 1 Violation.				
	accordance with G.S 03/15/24 for this viol Plan of Protection or	5. 131D-34 on 02/08/24 and ation and an unacceptable n 04/04/24.				
		E FOR THIS TYPE A1 NOT EXCEED MAY 4, 2024.				
D 358	10A NCAC 13F .100 Administration	4(a) Medication	D 358			
	(a) An adult care ho preparation and adm prescription and non by staff are in accord	4 Medication Administration me shall assure that the ninistration of medications, -prescription, and treatments dance with: used prescribing practitioner				

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STATEMENT OF D AND PLAN OF CO		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE S COMPLE	
		HAL 011261			R	
ARMONY AT (X4) ID PREFIX TAG D 358 Cor whi (2)	(EACH DEFICIENC REGULATORY OR ntinued From pag	TAIN 41 COBE ASHEVIL TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	B. WING DDRESS, CITY, STA SLERS WAY LLE, NC 28804 ID PREFIX TAG D 358	TE, ZIP CODE PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY) Community engaged RN server review all assisted living resident charts, complete and update resident FL2s, LHPS, physician orders, and care-plans.	ON D BE PRIATE Vices to lent all	4/2024 (X5) COMPLE DATE
Bas revi wer (#1 thin The 1. F 02/2 oste a.R -A p (use -Th faxe -Th with on 0 Rev mee reve -Th -Th adn -Th adn -Th	eed on observation iews the facility fa e administered a & #3) related to 2 ners (#1) and an e findings are: Review of Residen 28/23 revealed di eoporosis and hy eview of Residen 28/23 revealed di eoporosis and hy eview of Residen obysician's order ed to treat vitamin ere was no document of the pharmac ere was a photocon documentation 02/05/24 at 7:17p view of Resident a dication administre ealed: ere was an entry ere was document ninistered 01/06/2 view of Resident a ealed: ere was an entry ere was document ninistered 02/01/2	t #1's record revealed: to discontinue Vitamin C in deficiency) 500mg daily. mentation the order was cy. opy of the 01/05/24 order it was faxed to the pharmacy it was faxed to the pharmacy it. #1's January 2024 electronic ration record (eMAR) for Vitamin C, 500mg daily. intation Vitamin C 500mg was 24 through 01/31/24. #1's February 2024 eMAR for Vitamin C, 500mg daily. intation Vitamin C 500mg was 24 through 02/06/24. intation Vitamin C 500mg was		On 4/30/24 the Clinical Speci provided education and trainin medication aides on order pro Moving forward, medication a fax all orders to the pharmacy also scan the orders to the He email. Moving forward the HCD will and approve all orders receiv	ng to all ocessing. iides will / and CD's review	/2024 on going

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
IAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY			
		ASHEVI	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	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. Interview with a medication aide (MA) on 04/03/24 at 9:54am revealed: -The order to discontinue Vitamin C 500 mg must have been missed getting faxed to the pharmacy					
	documentation that i	e order documented the fax				
	nurse on 04/03/24 at -Non-essential media were routinely discor receiving hospice se -Taking Vitamin C for detrimental but she o	cations such as Vitamins ntinued with residents				
	-A physician's order (used to treat vitamir -There was no docur faxed to the pharmad -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. ntation Vitamin D3, 50mcg				

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:		R	
		HAL011361	B. WING		04	/04/2024
AME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
	1	ASHEVI	LLE, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE	(X5) COMPLE ⁻ DATE
D 358	Continued From page 42		D 358			
	was administered 01	/06/24 through 01/31/24.				
	Review of Resident #1's February 2024 eMAR revealed: -There was an entry for Vitamin D3, 50mcg daily.					
	-There was documentation Vitamin D3, 50mcg was administered 02/01/24 through 02/06/24.					
	-There was documer was discontinued 02	ntation Vitamin D3, 50mcg /05/24.				
	facility's contracted p	with a pharmacist from the harmacy on 04/03/24 at first time the 01/05/24 order				
		n D3 50mcg was received at				
	Interview with a med 04/03/24 at 9:54am r	evealed:				
	must have been miss	inue Vitamin D3 50 mcg sed getting faxed to the he original order did not have				
	any documentation th					
	to the pharmacy on (
	nurse on 04/03/24 at	with Resident #1's hospice 10:13am revealed: cations such as Vitamins				
		ntinued with residents				
	-Taking Vitamin D for detrimental but she c	an extra month was not lid expect the MAs to				
	discontinue administ ordered to do so.	ering medications when				
	-A physician's order t	nt #1's record revealed: to discontinue Xarelto (used				
	as a blood thinner) 2 -There was no docur faxed to the pharmad	nentation the order was				

STATE FORM

STATEMENT	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BUILDING:	BUILDING:		R	
		HAL011361	B. WING		04	1/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 358	Continued From pag	e 43	D 358				
	•	opy of the 01/05/24 order it was faxed to the pharmacy m.					
	Review of Resident #1's January 2024 electronic medication administration record (eMAR) revealed:						
		for Xarelto 20mg daily ntation Xarelto 20 mg was 24 through 01/31/24.					
	revealed: -There was an entry -There was documer administered 02/01/2	ntation Xarelto 20mg was					
	facility's contracted p 9:20am revealed the	with a pharmacist from the pharmacy on 04/03/24 at first time the 01/05/24 order o 20mg was received at the 2/05/24.					
	have been missed g because the original documentation that i	revealed: tinue Xarelto 20mg must etting faxed to the pharmacy order did not have any					
	to the pharmacy on (02/05/24.					
	nurse on 04/03/24 at -Xarelto 20mg was n to prescribe for resid	ot a medication hospice liked ents receiving services.					
		n extra month was not did expect the MAs to					

Division of Health Service Regulation STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		(X3) DATE S COMPL	
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
IARMON	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 ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 44	D 358			
	discontinue administory ordered to do so.	ering medications when				
	-A physician's order to blood thinner) 81mg -There was no docur faxed to the pharmace -There was a photoce with documentation on 02/05/24 at 7:17p Review of Resident # medication administr	nentation the order was cy. opy of the 01/05/24 order it was faxed to the pharmacy m. #1's January 2024 electronic				
	revealed: -There was an entry starting 02/05/24.	#1's February 2024 eMAR for aspirin 81mg daily, nentation aspirin 81mg was 24 through 02/05/24.				
	facility's contracted p					
	have been missed ge because the original documentation that it	revealed: tinue aspirin 81mg must etting faxed to the pharmacy order did not have any t was faxed. e order documented the fax				
	Telephone interview nurse on 04/03/24 at alth Service Regulation	with Resident #1's hospice 10:13am revealed:				

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If continuation sheet 45 of 58

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:		(X3) DATE SURVEY COMPLETED R	
		HAL011361	B. WING		04	/04/2024
AME OF PI	ROVIDER OR SUPPLIER	STREET #	ADDRESS, CITY, STATE	ZIP CODE		
ARMON	Y AT REYNOLDS MOU	NTAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page 45 -Aspirin was the only blood thinner they liked to prescribe for residents receiving hospice services. -Taking Xarelto rather than the prescribed aspirin for an extra month was not detrimental but she did expect the MAs to administer medications as ordered.		D 358			
	Refer to interview w 04/03/24 at 9:25am	ith a medication aide (MA) on				
	Refer to interview w at 9:33am.	ith a second MA on 04/03/24				
	Refer to interview w 9:54am.	ith a third MA on 04/03/24 at				
		ith the Resident Care on 04/03/24 at 9:43am and				
	Refer to interview w Director (ED) on 04,	ith the Interim Executive /03/24 at 1:43pm.				
		ons, interviews and record mined Resident #1 was not				
	09/15/22 revealed: -Resident #3 had di	ent #3's current FL2 dated agnoses of dementia and				
	devices.	mbulatory with no assistive				
	-She was intermitted	d disoriented.				
	-A physician's order (anti-psychotic) 25 r	#3's record revealed: to discontinue Seroquel ng daily on 02/08/24. Imentation an order was faxed				

STATE FORM

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		04	R / 04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	DDRESS, CITY, STATE, 2	ZIP CODE		
	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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From pag	e 46	D 358			
	to the pharmacy.					
	administration record -There was an entry	for Seroquel, 25mg daily. ntation Seroquel 25 mg was				
	facility's contracted p 11:18am revealed: -Resident #3 had an Seroquel, 25 mg, on -Resident #3 had a c 25mg, on 02/23/24 th facility.	liscontinue date for Seroquel, nat was faxed from the e an order to discontinue				
	discontinued on 02/0 -She was unaware th to be given even tho an order for it to be o -If the physician was	revealed: Resident #3's Seroquel was 18/24. The medication had continued ugh the physician had written liscontinued. not onsite and did not hand , it was easy for it be get				
		ond MA on 04/03/24 at was unaware Resident #3's tinued on 02/08/24.				
	Refer to interview wi 04/03/24 at 9:25am.	th a medication aide (MA) on				
	Refer to interview wi at 9:33am.	th a second MA on 04/03/24				

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY
			A. BUILDING:			
		HAL011361	B. WING		R 04/04/2024	
AME OF PF	OVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	, ZIP CODE		
	AT REYNOLDS MOU	NTAIN	BLERS WAY			
		ASHEVI	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D 358	Continued From page 47 Refer to interview with a third MA on 04/03/24 at 9:54am.		D 358			
		vith the Resident Care on 04/03/24 at 9:43am and				
	Refer to interview w Director (ED) on 04	vith the Interim Executive /03/24 at 1:43pm.				
	04/03/24 at 9:25am -When a medication the order to the faci	dication aide (MA) on revealed: n was discontinued, she faxed lity's contracted pharmacy. dications from the cart were				
		pmeone from the pharmacy to				
	written, it was hand	s on site when the order was ed to the MA to process. s off-site, the orders were or to the pharmacy.				
	Interview with a sec 9:33am revealed:	cond MA on 04/03/24 at				
	physician either wro MA or faxed the oro	n was discontinued, the ote the order and gave it to the ler to the pharmacy. nsible for faxing the orders to				
	the facility's contract -The pharmacy rem					
		n was no longer on the eMAR, removed from the cart.				
		d a return to pharmacy sheet and medication were placed in				
	•	if the MA does not scan the				

STATE FORM

STATEMENT	of Health Service Regi OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
HAL01		HAL011361	B. WING		04	R / 04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
ARMON	YAT REYNOLDS MOUN	ITAIN	BLERS WAY LLE, NC 28804			
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		PROVIDER'S PLAN C		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIE!	D THE APPROPRIATE	COMPLET DATE
D 358	Continued From pag	je 48	D 358			
	medication has beer	n discontinued.				
		I MA on 04/03/24 at 9:54am				
	revealed: -When an order was	written by a provider to				
		tinue a medication, the MA				
	working at that time was responsible for faxing					
	the order to the phar					
		faxed, the MA made a note the order was faxed and				
	-	opy of the order in the				
	resident's record.					
	-Cart audits were conducted weekly on third shift					
	and any medication order discrepancies should be identified during that audit.					
		esident Care Coordinator				
	revealed:	at 9:43am and 10:13am				
	-He started as RCC	on 03/12/24.				
		at the facility's process was				
	when medications w	ere discontinued. s should be responsible for				
	faxing orders to the					
	0	edications could continue to				
		sician had discontinued the				
	medication was the orders could have been					
	order or fax .	o one did anything with the				
	-He was unaware of	any orders being				
	discontinued by physicians and not being followed					
	through.					
		terim Executive Director (ED)				
	on 04/03/24 at 1:43p					
		terim ED on 02/20/24. rere discontinued, the				
		As) were responsible for				
	faxing the orders to	pharmacy.				
	-He was unaware the	e current system the facility				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		,	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
	HAL011361		B. WING		R 04/04/2024	
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STA	TE, ZIP CODE		
	AT REYNOLDS MOUN	TAIN 41 COB	BLERS WAY			
	AI KEINOLDS MOON	ASHEVI	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLET DATE	
D 358	Continued From pag	e 49	D 358			
	management should	working. should manage orders and follow up on everything. checking orders daily.				
D 366	10A NCAC 13F .100 Administration	4 (i) Medication	D 366			
	Administration 10A NCAC 13F .1004 Medication Administration (i) The recording of the administration on the medication administration record shall be by the staff person who administers the medication immediately following administration of the medication to the resident and observation of the resident actually taking the medication and prior to the administration of another resident's medication. Pre-charting is prohibited. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medication aides observed 2 of 5 sampled residents (#4 and			The HCD will conduct an in-servic for all Medication Aides on the sev rights of Medication Administration by 5/24/24. The HCD will conduct routine medication pass observations to ensure compliance.	ven	
	medications left on a	ations related to morning resident's coffee table (#4) tive left on a resident's				
	11/27/23 revealed: -Diagnoses included	nt #4's current FL2 dated dementia and hypertension. ermittently disoriented.				
	Review of the Reside revealed an admission	ent Register for Resident #4 on date of 11/01/22.				
	Review of physician'	s orders for Resident #4				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
			A. BUILDING:			
	HAL011361		B. WING		04	R / /04/2024
IAME OF PF	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	ZIP CODE		
		41 COBE	BLERS WAY			
ARMON	Y AT REYNOLDS MOUN	ASHEVI	LE, 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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLET DATE
D 366	Continued From pag	ge 50	D 366			
	revealed:					
	-There was an order	for donepezil (medication				
	11/27/23.	tia) 10mg daily dated				
		r for sertraline (medication				
	used to treat depression) 25mg daily dated 01/11/24.					
	-There was an order					
		et daily dated 01/29/24. r for vitamin D (supplement)				
	2000 units daily date					
	-There was an order to remove all medications					
	from resident's room and staff to administer all					
	medications dated 0	1/26/23.				
	Observation during	the initial tour on 04/02/24 at				
		ere was a medication cup on				
		esident #4's living room with				
	4 medication tablets	in the cup.				
	Interview with Resid revealed:	ent #4 on 04/02/24 at 9:45am				
	-He did not know ho	w long the medications were				
	there. -He did not know if h	ne had taken his morning				
	medications or not.	5				
		staff observed him take his				
	medications.					
	Review of Resident	#4's electronic Medication				
		ord (eMAR) for 04/02/24				
	revealed:	f 1 1140 1 11 11				
	-There was an entry an administration tin	for donepezil 10mg daily with				
		lonepezil was administered at				
	9:00am.					
		for sertraline 25mg daily with				
	an administration tin					
		lonepezil was administered at				
	9:00am.					

STATE FORM

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CC			E SURVEY PLETED	
			A. BUILDING:	A. BUILDING:		R	
HAL011361		HAL011361	B. WING		04	k/04/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY				
			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 C (EACH CORRECTIVE AC CROSS-REFERENCED TC DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE	
D 366	Continued From pag	le 51	D 366				
	Continued From page 51 -There was an entry for multivitamin 1 tablet daily with an administration time of 9:00am and documentation the multivitamin was administered at 9:00am. -There was an entry for vitamin D 2000 units with an administration time of 9:00am and documentation the vitamin D was administered at 9:00am. Interview with the medication aide (MA) on 04/02/24 at 10:08am revealed: -She administered the 9:00am medications to Resident #4 and observed him take the medications. -The 4 tablets in the medication cup were donepezil, sertraline, vitamin D, and a multivitamin. -She did not know who left the medications on the						
	-She did not see the entered his room to	ve been from another day. medications when she administer his medications. ive medications in residents'					
	Refer to the interview 04/03/24 at 10:00am	w with a second MA on n.					
		w with the Resident Care on 04/02/24 at 3:45pm.					
	Refer to the interview with the Interim Executive Director (ED) on 04/03/24 at 1:48pm.						
	2. Review of Reside 07/07/23 revealed: -Diagnoses included hypertension, and rig						
	-She was ambulator disoriented.						

STATEMENT	of Health Service Regi TOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE S COMPL	
			A. BUILDING:	A. BUILDING:		र
HAL0113		HAL011361	B. WING			04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΙΤΔΙΝ	BLERS WAY			
		ASHEVI	LLE, NC 28804			1
(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 DEFICIEN	TION SHOULD BE	(X5) COMPLETI DATE
D 366	Continued From pag	e 52	D 366			
	Review of the Reside revealed an admission	ent Register for Resident #5 on date of 07/14/23.				
		s orders for Resident #5 aled polyethylene glycol one pation.				
	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.					
	revealed: -Staff informed her s polyethylene glycol in -She took the medica -She did not always medication.	n her room. ation as needed. tell staff when she took the y of the polyethylene glycol				
	dated 04/02/24 revea polyethylene glycol 1 administration time o	rd (eMAR) for Resident #5 aled there was an entry for				
	04/02/24 at 10:08am -She administered th Resident #5 and obs medications. -She thought Reside brought the polyethy -She knew medication	e 9:00am medications to served her take the ent #5's family member lene glycol to the resident. ons should not be left in				
		I only to document the				

Division of Health Service Regulation STATE FORM

6899

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:	A. BUILDING:		R
HAL011361		HAL011361	B. WING		04	/04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN O (EACH CORRECTIVE AC	TION SHOULD BE	(X5) COMPLET DATE
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO DEFICIEN		DATE
D 366	Continued From pag	je 53	D 366			
	observation of admir	nistration.				
	Refer to the interview 04/03/24 at 10:00am	w with a second MA on n.				
	Refer to the interview with the Resident Care Coordinator (RCC) on 04/02/24 at 3:45pm.					
	Refer to the interviev Director (ED) on 04/	w with the Interim Executive 03/24 at 1:48pm.				
	10:00am revealed: -She knew medication residents' rooms. -She would stand new observe the resident then document the a -She found medication	ons left in rooms in the past. orporate nurse about one ne continued to find				
	(RCC) on 04/02/24 a -MAs were trained to medications. -Medications should	esident Care Coordinator at 3:45pm revealed: o observe residents take their not be left in resident rooms why there were medications				
	on 04/03/24 at 1:48p -He did not know tha the past in residents -The MAs were train	at medications were found in ' rooms. ed to document the dications after they observed				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE S COMPLI	
					R	
HAL011361		HAL011361	B. WING		04/0	4/2024
AME OF PF	ROVIDER OR SUPPLIER	STREETA	ADDRESS, CITY, STA	TE, ZIP CODE		
	AT REYNOLDS MOUN	TAIN	BLERS WAY			
			LLE, NC 28804		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 CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLET DATE
D980	Continued From pag	e 54	D980			
D980	G.S. § 131D-25 Imp	lementation	D980	A1 GS 131D-25 Implementation		
	this Article shall rest facility. Each facility training to staff to im	nentation blementing the provisions of with the administrator of the shall provide appropriate blement the declaration of ided in G.S. 131D-21.		On 5/2/24 The Regional Operations S completed training for all managers of ensure residents were protected by supervision, maintaining their reside and how to appropriately discharge resident who was mentally and phys abusive. The community completed resident right	n how to providing nt rights, a sically	5/3/24 Ongoir
	This Rule is not met A1 VIOLATION	as evidenced by: ns, interviews and record		for all employees by 4/10/24. The community will ensure resident right is completed for all new hires in orientati annually for all employees.		
	reviews the Administ overall operations of compliance with the care homes as relate residents were prote- supervision, maintair	rator neglected to ensure the the facility to maintain rules and regulations of adult ed to failing to ensure the cted by providing ning their resident rights, and rge a resident (#3) who was				
	The findings are:					
	Review of the facility had a capacity of 99	's license revealed the facility residents.				
	Review of the facility 04/02/24 was 75 resi					
	04/03/24 at 2:55pm r -There was an admir on the wall. -The Administrator do was the same name	nistrator's certification posted ocumented on the certificate as the Administrator /24 at 4:30pm, 03/27/24 at				

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:			E SURVEY PLETED
			A. BUILDING:			
НА		HAL011361	B. WING		04	R / 04/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	, ZIP CODE		
	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY			
			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 ACT CROSS-REFERENCED TO DEFICIENC	FION SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D980	Continued From pag	je 55	D980			
	-The certificate was scheduled to expire	issued on 01/01/23 and was on 12/31/24.				
	on 03/19/24 at 2:15p revealed: -He was new to the t -He was in constant Administrator. -He had informed the	erim Executive Director (ED) om and 04/03/24 at 1:45pm facility as of 02/20/24. contact with the e Administrator that the state site and would be contacting				
	4:30pm and 03/27/2 -She did not reside i work at the facility, s operations of the fac -She kept in contact been informed abou -There had been sor Health and Wellness -It was the ED and t	ility to the interim ED. with the facility but had not t resident isssues. me turnover in the ED and s Director resident. he Health and Wellness lity to manage issues				
	-She had not been of 08/28/23. -She had only 2 con since he started on 0 -She heard from an survey team entered the interim ED did no -She had not been k the facility from anyo	03/24 at 3:09pm revealed: insite at the facility since versations with the interim ED				

	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE COME	SURVEY
			A. BUILDING:			
HAL		HAL011361	B. WING			R / 04/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN				
			LLE, NC 28804		0000000000	
(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 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLET DATE
D980	Continued From pag	e 56	D980			
	Non-compliance was the following rule are	s identified at violation level in eas:				
	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. [Refer to Tag 0224, 10A NCAC 13F .0702(b) Discharge of Residents (Type A1 Violation)].					
	reviews, the facility fa to 1 of 5 sampled Re resident having aggr included slapping, hi					
	reviews, the facility fa were free from menta neglect related to mu physically assaulted	ns, interviews, and record ailed to ensure residents al, physical abuse and ultiple residents being by one resident (#3). [Refer CAC 13F .0909 Resident ation)].				
	for the operations of non-compliance with related to resident rig resident (#3) was no became physically a residents on five occ through 03/15/24. The discharged after the	Primary Care Provider				
		narm to self and others.The e to ensure responsibility for , administration,				

STATEMENT OF DEFICIENCIES (AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		R	
HAL011361		HAL011361	B. WING			/04/2024
AME OF PF	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
	AT REYNOLDS MOUN	ΙΤΔΙΝ	BLERS WAY LLE, NC 28804			
(X4) ID	SUMMARY S		ID	PROVIDER'S PLAN C		(X5)
PREFIX TAG	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE) THE APPROPRIATE	COMPLET DATE
D980	Continued From pag	ge 57	D980			
	resulted in serious n	upervision of the facility eglect of the residents and es a Type A1 Violation.				
	The facility failed to provide an acceptable plan of protection in accordance with G.S. 131D-34 by 04/04/24.					
		E FOR THIS TYPE A1 NOT EXCEED MAY 4, 2024.				