Division of Health Service Regulation

	FOF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· '		(X3) DATE SURVEY COMPLETED
			7 501251110.		
		HAL011361	B. WING		R 08/20/2024
NAME OF D		OTDEET AS	DDECC CITY CTA	TE 7/D 000E	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN	LERS WAY LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
	County Department of a follow-up survey and on 08/14/24 through ( The complaint investing Buncombe County De	gation was initiated by the			
D 188	, ,	e(e)(1) Personal Care And	D 188		
	(e) Homes with capa shall comply with the home is staffing to ce below 21 residents, the ahome with a census (1) The home shall hithe needs of the residuty hours on each 8-be at least:  (A) First shift (morning for facilities with a cer residents; and 16 hou additional hours of aid 10 or fewer residents or capacity of 40 or more capacity of additional hours additional 10 or fewer census or capacity of staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing chart, see Ru (C) Third shift (evening the staffing the staffing chart, see Ru (C) Third shift (evening the staffing	ave staff on duty to meet lents. The daily total of aide chour shift shall at all times  ag) - 16 hours of aide duty hours or capacity of 21 to 40 are of aide duty plus four de duty for every additional for facilities with a census hore residents. (For staffing of this Subchapter.)  ernoon) - 16 hours of aide a census or capacity of 21 6 hours of aide duty plus			

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE TITLE

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		HAL011361	B. WING		08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	AIN 41 COBBLI ASHEVILLI	ERS WAY E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 188	.0606 of this Subchap (D) The facility shall I meet the needs of the residents equal to the by Medicaid. As used "heavy care resident" residing in an adult ca "heavy care" by Medic is receiving enhanced (E) The Department if it determines the ne	or staffing chart, see Rule ster.) have additional aide duty to e facility's heavy care amount of time reimbursed it in this Rule, the term, means an individual are home who is defined as caid and for which the facility	D 188			
	reviews the facility fail were present to meet of 42 shifts sampled for the findings are:  Review of the facility of Division of Health Ser 01/01/24 revealed the assisted living with a composition of the facility of the fa	current license by the vice Regulation effective a facility was licensed as an capacity of 99 beds.  the initial tour on 08/14/24 am revealed the facility was licensed in sement floor, a first floor, a ird floor accessible by an				

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Division of Health Service Regulation

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:  HAL011361  NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY  ASHEVILLE, NC 28804   (X4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOWN TAGE)  PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION)  TAG  REGULATORY OR LSC IDENTIFYING INFORMATION)  A. BUILDING:  B. WING  B. WING  DEFICIENCY  B. WING  COBBLERS WAY  ASHEVILLE, NC 28804	R 08/20/2024
NAME OF PROVIDER OR SUPPLIER  HARMONY AT REYNOLDS MOUNTAIN  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY  ASHEVILLE, NC 28804   (X4) ID  SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APP	
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	OULD BE COMPLETE
D 188 Continued From page 2 D 188	
Review of the facility's current census on 08/14/24 revealed:  -There were 22 residents who resided on the locked unit on the basement floor.  -There were 10 residents who resided on the first floor.  -There were 30 residents who resided on the second floor.  -There were 20 residents who resided on the short floor.  -There were 20 residents who resided on the third floor.  -There were a total of 82 residents who resided in the facility.  Review of the staff time records from 07/10/124-07/117/24 revealed:  -On 07/06/24, the census was 63 requiring 24 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 8 staff hours.  -On 07/07/24, the census was 63 requiring 24 staff hours on third shift and a total of 20 hours were provided leaving a shortage of 4 staff hours.  -On 07/11/124, the census was 63 requiring 24 staff hours on third shift and a total of 20 hours were provided leaving a shortage of 8 staff hours.  -On 07/11/24, the census was 63 requiring 24 staff hours on third shift and a total of 16 hours were provided leaving a shortage of 8 staff hours.  Interview with a resident 08/16/24 at 2:45pm revealed:  -She required staff assistance with bathing, dressing, toileting, and transfers.  -She had recently had to wait for an hour for staff to assist her off the toilet.  -The staff routinely told her when they responded to her call light that they only had one staff	
member assigned to provide care for all the residents who lived on the first, second, and third floors.  -The staffing was short at least one shift every dayTasks that were "not necessary" like making the bed were left undone by the staff.	

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	T OF DEFICIENCIES  OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
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		HAL011361	B. WING		08/2	0/2024	
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HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY				
	I	ASHEVI	LLE, NC 28804				
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iAO		,	IAG	DEFICIENCY)			
D 400	0 " 15	0	D 400				
D 188	Continued From page	e 3	D 188				
	Interview with a perso	onal care aide (PCA) on					
	08/19/24 at 2:30pm r	evealed:					
	-There were times wh	hen they worked short					
	staffed on the first, se	econd, and third floors.					
	-Agency staff had bee	en brought in to provide					
	additional staff.						
	-When they were sho	ort staffed, residents had to					
	wait longer to receive	e care.					
	-Residents would at t	times get tired of waiting for					
	staff to come help the	em and they would try to get					
	up without assistance						
	-When residents tried	d to do things on their own					
	without waiting for sta	•					
	increased risk for falls	S.					
	- '	ere was one medication aide					
		ninister medications to the					
	residents on first and						
		MA who was assigned to					
		ns to the residents on					
	second floor.						
	_	o PCAs assigned to assist					
	residents on first, sec	cond, and third floors.					
	Interview with a MAA	on 08/19/24 at 2:50pm					
	revealed:	οπ σο <i>ι 19/24</i> αι 2.ουρπ					
	-The facility was shor	rt staffed					
		d gave you limited time with					
	each resident.	a gave you infliced time with					
		d to care for the residents.					
	-	ying to hire more staff.					
	a.iagomone was tr	,g .5 5					
	Interview with a seco	nd MA on 08/20/24 at					
	3:00pm revealed:						
		ere were five residents who					
		nce or extensive assistance					
	from staff with their a						
	(ADLs).	<del>,</del>					
		ere was one resident that					
	· ·	assistance for transfers, was					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		HAL011361	B. WING	B. WING		024
NAME OF PR	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	AT REYNOLDS MOUN	FAIN 41 COBB	LERS WAY			
TIARMON	AI KETHOLDO MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 188	Continued From page	e 4	D 188			
	extensive assistance mornings and at bedt -The normal staffing a and one PCA for the AL residentsIf the third floor MA v medications and the I giving a shower, a resassistance on the firs 30-45 minutes for hel -Management hired nafter working a short -The regular staff concover the shiftsAgency staff had beet the staffing shortages Interview with the Het (HWD) on 08/19/24 a recruiting new staff at and at job fairs.  Interview with the Adr 5:45pm revealed:	ime. assignment was three MAs first, second, and third floor was administering PCA was on the third floor sident who called out for t floor might have to wait for p. lew staff and they would quit while. stantly worked overtime to				
	what staffing hours re- -Agency staffing was	vable hours were above				
D 259	10A NCAC 13F .0802	2(a) Resident Care Plan	D 259			
	developed for each re	Resident Care Plan ne shall assure a care plan is resident in conjunction with				

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	ATEMENT OF DEFICIENCIES D PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		
		HAL011361	B. WING		R 08/20/20	)24
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	ΓΕ, ZIP CODE		
LIA DMON	Y AT REYNOLDS MOUNT	AIN 41 COBB	LERS WAY			
HARMON	TAT RETNOLDS MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE CO	(X5) DMPLETE DATE
D 259	Continued From page	: 5	D 259			
	.0801 of this Section.	nission according to Rule The care plan is an program of personal care				
	facility failed to ensure the physician within 1	ews and interviews the e a care plan was signed by 5 days of completion (#3) condition (#13) on 2 of 8				
	The findings are:					
	Review of Resident # revealed: -She required supervi	3's care plan dated 02/21/24				
	-She required limited and transfers. -She required total ca dressing, and groomi	assistance with ambulation re with toileting, bathing,				
	was totally dependant	to 9:45am revealed she				
	on 08/20/24 at 11:31a	for ensuring care plans				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION ( A. BUILDING:		(X3) DATE SURVEY COMPLETED		
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		HAL011361	B. WING		08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE		
HARMON'	Y AT REYNOLDS MOUN	TAIN	SLERS WAY			
			LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPL	LETE
D 259	Continued From page	e 6	D 259			
	helped to get care plasurveyShe had not reviewe yet to see that it was Interview with the Co 08/16/24 at 2:37pm responsible for gettin physician with 15 day updated with a chang days. Interview with the Additional survey.	a contracted nursing agency ans updated after the last and Resident #3's care plan not signed by the physician.  The properties of the RCD was a care plan signed by the sys of the assessment and the period of condition within 10 ministrator on 08/16/24 at				
	care plan signed by t	s responsible for getting a he physician with 15 days of updated with a change of ays.				
	05/29/24 revealed dia dementia, major depr	at #13's current FL2 dated agnoses included vascular ressive disorder, history of erlipidemia, and carotid				
	05/13/24 revealed: -He required supervis and transferringHe required extensiv bathing and dressing	et13's current care plan dated sion while eating, ambulating we assistance with toileting, assistance with personal				
	report on 06/06/24 re -Resident had a majo -Resident was engag	or change in his behavior. ing in aggressive behavior. ve behavior required him to				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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		HAL011361	B. WING		08/20	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL ASHEVILI	.ERS WAY .E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 259	Continued From page	÷ 7	D 259			
	report on 06/24/24 re -Resident had a sitter -Resident required he Review of Resident # care plan after sudde Interview with Reside physician on 08/19/20 -Resident #13 had sh significant increase ir him to have a sitterThe facility and resid to the need for a sitte -She was unaware w by the facilityShe tried to encoura	r due to behavior. elp during a choking episode. 13's record revealed no new n behavioral changes.  Int #13's primary care of at 5:00pm revealed: Int a sudden and n aggression which required Itent's family member agreed of r. International changes Itent's family member agreed of				
	at 2:30pm revealed: -The resident was ve -The resident had bel -The resident had a s time.	itter for a short period of				
	08/20/24 at 11:31am -Residents who expe behavior needed a ne	rienced major changes in				
	08/16/24 at 2:37pm responsible for getting	rporate Clinical Specialist on evealed the RCD was g a care plan signed by the rs of the assessment and				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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		HAL011361	B. WING		08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AI	ODRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 259	Continued From page	÷ 8	D 259		
		e of condition within 10			
	2:31pm the RCD was care plan signed by the	ninistrator on 08/16/24 at responsible for getting a ne physician with 15 days of updated with a change of tys.			
D 271	10A NCAC 13F .0901 Supervision	(c) Personal Care and	D 271		
	an accident or incider	d immediately in the case of nt involving a resident to rvention according to the			
	This Rule is not met a TYPE A1 VIOLATION				
	facility failed to provid according to the facility	ty's policy and procedures sidents who choked, lost			
	The finding are:				
	Review of the facility's	s Medical Emergency Policy			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	-	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL ASHEVILL	ERS WAY E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
D 271	care when needed to -The staff would notify services (EMS, call 9 exhibits signs and syr emergency condition consciousnessThe Health and Well Director HWD/RCD or required to obtain per family/responsible pe EMS.  Review of Resident # revealed diagnoses in dementia and hypoth Review of Resident #1 Copper of Treatment (revealed: -Resident #1 did not vertically (DNR, no CPR) shou breathing and/or have -There was a directive manual treatment of a needed for comfortDo not transfer to the needs cannot be met  Review of Resident # 07/09/24 at 5:28pm re (MA) documented Re episode, turned blue	led: eccive emergency medical prevent further illness. y emergency medical 11) when the resident mptoms of distress and/or for choking or loss of  ness Director/Resident Care r caregivers were not mission from the rson before summoning  1's FL-2 dated 07/03/23 ncluded diabetes, vascular yroidism.  1's Resident Register was admitted on 07/03/23.  1's Medical Orders for MOST) form dated 08/18/23  want to be resuscitated Id Resident #1 stop e no pulse. e to use oxygen, suction and	D 271			

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION (X: A. BUILDING:			X3) DATE SURVEY COMPLETED	
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		HAL011361	B. WING		08	3/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE			
HARMON	Y AT REYNOLDS MOUNT	'AIN	LERS WAY				
	ı	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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
D 271	Continued From page	10	D 271				
	Review of Resident # 07/17/24 at 8:45pm re -The Resident Care Da late entry for 07/09/ -On 07/09/24, the star #1 choked while eating -The RCD was inform performed the Heimling #1's airway was clear -Afterwards she obsethe dining room with redistress.  Attempted review of Fincident/Accident Regunsuccessful and not Interview with a medicular medicular at 19pm re -On 07/09/24, she war 7:00pmOn 07/09/24, she war 7:00pmOn 07/09/24, she war MA covered the residulating lunchThe MA reported to rechoking during lunch, performed the Heimling not calledAfter a choking episor staff to notify EMS for -The policy directed sepermission from the fat (RP)/Power of Attorner	1's progress note dated evealed: Director (RCD) documented 24.  If notified her that Resident g beets. Led that a third party CNA ch Maneuver and Resident ed.  Inved Resident #1 sitting in no signs or symptoms of  Resident #1's cort dated 07/09/24 was provided prior to exit.  Leation aide (MA) on evealed: Les the MA from 7:00am to  It is son break while another ents when Resident #1 was the resident #1					
	to not send anyone of family/RP/POA permi Telephone interview v 08/15/24 at 12:03pm	ssion. vith a second MA on					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
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	HAL011361	B. WING		08/20/2024	
NAME OF PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMONY AT REYNOLDS MOUNTAI	M 41 COBBL	ERS WAY			
HARMONT AT RETNOEDS MOUNTAIN	ASHEVILL	E, NC 28804			
PREFIX (EACH DEFICIENCY M	EMENT OF DEFICIENCIES JUST BE PRECEDED BY FULL CIDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 271 Continued From page 1	1	D 271			
Special Care Unit (SCU) choked.  -A personal care aide (P Director (AD) were respet the residents at the time. During lunch she was a down the hall when the was choking.  -When she arrived in the #1 had a bluish tent to h CNA was performing the her, the second third parperforming finger sweep Resident #1's mouth.  -After the choking episod and the MA assigned to -The RCD and the MA to day room.  -The facility did not call I she was not sent to the after the choking episod -Resident #1 had a coug due to a history of esoph was always capable of general respective response.	when Resident #1  PCA) and the Activity consible for supervising of Resident #1 choked. Assisting another resident AD yelled Resident #1  e dining room, Resident her skin and a third party e Heimlich Maneuver on rty CNA was assisting and o to get the food out of  de, she called the RCD the SCU. cook Resident #1 to the  EMS for Resident #1 and hospital for evaluation le. Igh and strangled some hageal cancer but she getting her throat cleared wention, but this time was Resident #1 turned blue  10 08/15/24 at 3:10pm  working at the facility for a the dining room during from Resident #1 and a ent #1 when Resident #1 bed her chest. ent #1 if she was ok and	D 271			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
		41 COBB	LERS WAY		
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 271	271 Continued From page 12		D 271		
D 271	coughingShe ran to get the M -As she yelled for the party CNAs were pas roomThe MA came running Resident #1 was blueShe saw one of the telephone interview was 139pm revealed: -On 07/09/24, he was #1 when she started for the party of the party	perform the Heimlich desident #1 was not time and then she stopped  A.  MA's assistance, two third using her outside the dining and down the hall and and not responding. Third party CNAs move the when the PCA said he did not at the CNA cleared the food touth as the first CNA did the the Heimlich Maneuver but a could do at this facility AD.  With the PCA on 08/16/24 at a standing beside Resident	D 271		
		ed while she was eating.  It #1 and waited to see if ear the food herself.			
	-After a few seconds, Resident #1 was not obstruction.				
	he had not performed -There were two third	lue and became  The Heimlich Maneuver, but  If it on a real person before.  If party CNAs that showed up			
	and he let them take because he felt they				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION			
			A. BUILDING:			PLETED
		HAL011361	B. WING		05	R 3/ <b>20/2024</b>
		HALUTIOU			1 00	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
		ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 271	D 271 Continued From page 13		D 271			
	Heimlich maneuver a obstruction from Res -In CPR training, whi Maneuver, the first the -The facility staff did	ident #1's throat. ch included the Heimlich ning to do was to call 911. not call 911 and Resident #1				
	was not sent out to the hospital.  Telephone interview with a third party CNA on 08/16/24 at 1:46pm revealed:  -On 07/09/24, she and her co-worker were at the facility providing care for a resident.  -She and her co-worker were taking a resident to the dining room when they heard staff yelling "she's choking".  -There was a staff member beside the resident who was choking.  -The PCA stated he did not know what to do and Resident #1 was blue, her chin was to her chest and drooling, she was unresponsive.  -Her co-worker moved the PCA out of the way and began performing the Heimlich Maneuver					
	looked liked chunks of came upAs her co-worked per thrusts, she cleared to Resident #1's mouth -On the third abdominable to clear the airwight became responsiveShe was able to clear chunks of food from -The RCD came to congave Resident #1 was "finiquite "a bit"She asked the RSD be sent out and the Food from the RCD came to congave Resident #1 was "finiquite "a bit".	nal thrust, her co-worker was ray of Resident #1, and she ar a large mouth full of Resident #1's mouth. heck on Resident #1 and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
THE FERNIOR GOVERNMENT	IBENTII 16, WIGH NOMBER	A. BUILDING: _		001111111111111111111111111111111111111		
	HAL011361	B. WING		R 08/20/20	)24	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
HARMONY AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804				
PREFIX (EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE CO	(X5) OMPLETE DATE	
did not go the hospital choking, turning blue having the Heimlich II Interview with the RC revealed: -She started working was the RCD for the -She was in a meeting at lunch on 07/09/24 -About 15 to 20 minus at lunch, she checked -Resident #1 was in a gave Resident #1 so still an issue with sware -She and the MA mo room and Resident #1 still was -She suspected aspin requested and order xrayWith her experience fine and did not need after chokingOn 07/09/24, she was choked at lunch, requested and continued in the second in th	not call 911 and Resident #1 al for evaluation after e, losing consciousness and Maneuver performed.  CD on 08/16/24 at 9:46am  about 8-9 weeks ago and Special Care Unit (SCU). ng when Resident #1 choked d on Resident #1. the dining room and she me water to see if there was allowing. ved Resident #1 to the day f1 was "fine". s coughing and hoarse. ration pneumonia so she for a chest xray form mobile e, she knew Resident #1 uired the Heimlich Maneuver d became unresponsive, but nt #1 out to be evaluated at Resident #1 was "fine". v was to send Resident #1 out nderstanding the MA notified and they did not want the hospital. it could take some time for	D 271				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBB	LERS WAY		
HARMON	TAT KETHOLDO MOON	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 271	71 Continued From page 15		D 271		
	aspiration.				
	aopiration.				
	care provider (PCP) or revealed: -When Resident #1 or non-responsive, and Maneuver she also rephysicianOn 07/09/24, she was Resident #1's choking-she would character choking episode as a where her airway was resulting in her not be consciousnessWhen someone choairflow to their lungs a breath or talk, their facould not breathe or flow and then their fallower when Resident #1's serious risk of decrease.	face turned blue she was at ased blood flow to the brain			
	which could lead to d	leath. utes before brain damage or			
	death to happen after	r someone chokes.			
	-At the point Resident #1 turned blue and lost consciousness, the Heimlich Maneuver was to be performed and 911 should have been calledAfter Resident #1's severe choking episode				
	Resident #1 needed				
	aspiration and other i	harmful effects of choking hageal cancer			
		ffects of choking include the			
	lungs filling up with fl	uid leading to inflammation			
	and hypoxia from the				
		of those complications			
	could lead to death.	Medical Orders for Scope of			
		orm which indicated Resident			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
	HAL011361		B. WING		R <b>08/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
HARMON	HARMONY AT REYNOLDS MOUNTAIN 41 COBBL		ERS WAY		
TIAKWON	TATRETHOEDS MICON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 271	Continued From page 16		D 271		
	#1 should have been sent to the hospital for because comfort measures such as suctioning the airway and oxygen could have been provided at the hospital and could not have been provided at the facility.  Interview with the Corporate Clinical Specialist on 08/16/24 at 2:37pm revealed: -The policy stated a resident was to be sent out to the hospital after a choking episode and or a loss of consciousness in order to be evaluated by a physicianOn 07/09/24, since Resident #1 choked, turned blue and lost consciousness, 911 was to be called while a staff member performed the Heimlich Maneuver, and she was not informed				
	that 911 was not calle	ed and Resident #1 did not il 07/12/24 after Resident #1			
	Telephone interview v Administrator on 08/1 -He was the Administ 07/12/24.				
	-He did know about Resident #1's 07/09/24 choking episode and not sent out, through email, either that day or the next day911 should have been called on 07/09/24 and				
	sent to the hospital for on choking and Residunresponsive.	r evaluation per the policy dent #1 becoming			
	Interview with the Administrator on 08/16/24 at 2:31pmShe began working as the Administrator on 08/12/24.				
	•	he staff to call 911 and for e a medical evaluation after			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 271	Power of Attorney (Po and 08/16/24 at 5:05p Review of Resident # revealed Resident #1 immediately due to ra sequentially over day pneumonia.  [Refer to tag 0273, 10 Health Care (Type A1)  The facility failed to in according to their poli included notifying EM consciousness when turned blue and beca 07/09/24. The resider after the Heimlich Ma but was not sent to the medical evaluation or comfort. This failure rewhich constitutes a Tyme The facility provided a accordance with G.S. this violation.  THE CORRECTION I	interview with Resident #1's DA) on 08/16/24 at 4:00pm om was unsuccessful.  1's death certificate died on 07/12/24 at 7:55pm pid onset of hypoxia and so due to aspiration  DA NCAC 13F .0902(b)  Violation)]  Inmediately respond cy and procedure which S for choking or loss of Resident #1 began choking, me unconscious on at regained consciousness neuver was administered, the emergency room for measures to provide esulted in serious neglect type A1 Violation.	D 271		
D 273	` '		D 273		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE	SURVEY PLETED	
		1101 044004	B. WING			R
		HAL011361			08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	ΓE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 18	D 273			
	of residents.					
	This Rule is not met TYPE A1 VIOLATION					
	interviews, the facility and referral for 8 of 1 #3, #4, #5, #6, #10 & who had two choking of a primary care prochanges of three poublood pressure, and trates out of paramete (#2), notification to th (PCP) about medication anxiety, and diabetes injury (#4), weekly we medication with parar trauma for a resident	ns, record reviews, and failed to provide follow-up 3 sampled residents (#1, #2, #13) related to a resident gepisodes (#1), notification vider (PCP) about weight nds, medications to treat blood pressures and heart or to administer metoprolol e primary care provider ons to treat blood pressure, (#3), about fall with a head eights (#5), a diabetic meters (#6), a fall with head on antiplatelet medications ghts with parameters (#13).				
	The findings are:					
	policy dated 03/18/24	ty's medical emergency revealed the resident's otified after 911 was called came unconscious or				
		1's FL-2 dated 07/03/23 ncluded diabetes, vascular yroidism.				
		1's Resident Register was admitted on 02/05/24.				
	07/09/24 at 5:28pm re	t #1's progress note dated evealed a medication aide sident #1 had a choking				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED
		HAL011361	B. WING	····	08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	•	
		41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Certified Nursing Ass cardio-pulmonary res cardio-pulmonary res Review of Resident # 07/17/24 at 8:45pm re-The Resident Care It a late entry for 07/09/-On 07/09/24, the star #1 choked while eatire. The RCD was inform performed the Heimli #1's airway was cleared -Afterwards she obsetthe dining room with a distress.  Review of the facility' 07/09/24 revealed: -The MA documented episode during the startner was no document of the primary Care Provided Attempted review of It Incident/Accident Requires at the provided station physician book. Primary Care in "physician book"On the outside of the with contact informatics.	in the face and a hospice istant (CNA) performed uscitation (CPR).  1's progress note dated evealed: Director (RCD) documented 24. If notified her that Resident ag beets. It is determined that a hospice nurse is determined. It is more reported that a hospice nurse is more reported at the resident and resident and resident are signs or symptoms of the second signs of symptoms of the second signs of symptoms of the restrictions. It is referenced that is the restriction of the restriction of the provided prior to exit.  If care Unit (SCU) nurses is revealed: In give binder, there were cards on for two of the PCPs. In the resident prior to exit. If care unit the restriction of the property is performed to the property in the provided prior to exit. If care unit (SCU) nurses is revealed: In give binder, there were cards on for two of the PCPs. In the restriction of the property is performed to the property	D 273	DEFICIENC		
	January 2024-Decem	ne communication form				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		, ,	SURVEY PLETED	
			B. WING			R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY			
			LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	20	D 273			
	-There was a block of	•				
	Interview with a medication aide (MA) on 08/14/24 at 4:19pm revealed: -On 07/09/24, she was the MA from 7:00am to 7:00pmOn 07/09/24, she was off the floor while another MA covered the residents when Resident #1 was eating lunchThe MA reported to her, during lunch Resident #1 began choking, a 3rd party Certified Nursing Assistant (CNA) did the Heimlich ManeuverThe RCD was responsible to notify Resident #1's PCP of the choking episode on 07/09/24.					
	when Resident #1 chi- The staff in the dining supervising the reside #1 choking was a per the Activity Director (A- During lunch she wa down the hall when th was chokingWhen she arrived in was blue and a 3rd pa Heimlich Maneuver of second 3rd party CNA finger sweep to get th mouthAfter the choking epi	revealed: us the MA covering the SCU oked. g room responsible for ents at the time of Resident sonal care aide (PCA) and AD). s assisting another resident he AD yelled Resident #1 the dining room Resident #1 arty CNA was performing the n Resident #1 and the A was assisting by doing a he food out of Resident #1's sode, she called the RCD				
	and the MA assigned	to the SCU. dent #1's PCP because she				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _			
			D MANAGO		R	
		HAL011361	B. WING		08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUN	41 COBBLI	ERS WAY			
HARMON	TAI RETNOLDS MOUN	ASHEVILLI	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
D 273	273 Continued From page 21		D 273			
2 2.0	thought the RCD calledIt was the MA responsibility to notify the PCP, but the RCD said she would take care of notification to the PCP.		2 2.0			
	revealed: -She started working was the RCD for the 3-On 07/09/24, when FlunchAbout 15 to 20 minut at lunch, she went to -Resident #1 was in t gave Resident #1 sor still an issue with swa-She and the MA mov room and Resident #1-Resident #1 still was -She suspected aspir requested and order trayAfter looking through	Resident #1 choked while  tes after Resident #1 choked check on Resident #1. he dining room and she me water to see if there was allowing.  yed Resident #1 to the day 1 was fine. coughing and hoarse. ation pneumonia so she for a chest xray form mobile  the orders on 08/16/24, she				
	07/09/24She was probably co and she did not notify did not have access t system on 07/09/24She was trained by t Specialist (CCS) to us triage system but was -Since she did not ha based triage system s Resident #1's PCP, b because Resident #1 after the choking epis the chest xray.	se the computer based is not given a login.  ve a login for the computer is she could have called but did not call the PCP is was not in distress anymore is sode and she had requested				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO		, , ,	E SURVEY PLETED	
			A. BUILDING.			
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
<b>П</b> АВМОМ	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
HARWON	TAT RETNOLDS MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST 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) COMPLETE DATE
D 273	Continued From page	e 22	D 273			
	after turning blue and did not send Resider the hospital or call the was "fine".  -The MAs were responsible incident/Accident repontification to the physchoking episodes on she was responsible incident/Accident reponcerns to the Admistand up meeting.  -She did not know the was not filled out.  -She was responsible issues or concerns on she did not follow-up PCP was notified on	dired the Heimlich Maneuver I became unresponsive, but It #1 out to be evaluated at It #1 out to be eva				
	care provider (PCP) or revealed: -Resident #1 had a count turned blue, became the Heimlich Maneuv a physician and a che-she was not made a choking incident on the Supervisory Physistaff made the Super #1's choking episode -Resident #1's 07/09 characterized as a "swhere her airway wa	nware of Resident #1's 1/09/24 until 07/11/24 when sician was at the facility and visory Physician of Resident				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
AND PLAN	OF CORRECTION	A. BU			COMPLETED	
		HAL011361	B. WING		R 08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIECT OF THE APPRO	D BE COMPLE	ETE
D 273	airflow to her lungs a breath or talk, her face not breath or talk decided then her face turned. When Resident #1's serious risk of decrease which could lead to delt only took 4-6 minuted death to occur after such the point Resident consciousness, the performed and 911 such the performed and 911 such the consciousness, the performed and 911 such the saturation and other such the saturation and other such the saturation, while both could lead to death. Resident #1 had a furth that the such that the suc	choked, the food blocked and making it hard for her to be turned red until she could creasing the oxygen flow and blue.  If ace turned blue she was at ased blood flow to the brain eath.  It is before brain damage or comeone choked.  It #1 turned blue and lost deimlich Maneuver was to be severe choking episode to be evaluated for marmful effects of choking.  If ects of choking include the uid leading to inflammation of decreased oxygen of those complications.  If edical Orders for Scope of form which indicated Resident sent to the hospital to 's airway, and possibly sures related to the build up suctioning and oxygen to to treat the hypoxia.  If #1's progress note dated revealed:  If a MA went into Resident ter bedtime medications and lying on her right side in her resident #1 and did not get a digreen vomit on Resident	D 273			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C  A. BUILDING:			E SURVEY PLETED
		HAL011361	B. WING		08	R 8/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
		41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 24	D 273			
	Resident #1 took two ceased911 was called and f by the EMS at 7:55pr -The RCD arrived at 1 Resident #1 without at Review of the facility' 07/12/24 revealed: -On the 7:00am to 7:0 documented Resident throwing upOn the 7:00pm to 7:0 documented Resident Residen	the facility and found a pulse and no respirations.  s 24 hour report dated  Opm section, it was t #1 was coughing and				
		died on 07/12/24 at 7:55pm apid onset of hypoxia and				
	SCU, 7:00am to 7:00 -On 07/12/24, Resided diet, from the serving pureed for breakfast a out of it and and start coughing episodes at -She removed the reg Resident #1 and Resident #1 was ser and she removed it o -She spoke to a Physical diet.	revealed: as the MA on duty in the pm. ant #1 was served a regular containers, that was not and had maybe a bite or two ed having some heavy and choked. gular diet plate from ident #1 did not eat any				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	,
		41 COBBLI	ERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	E, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	V (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	25	D 273		
D 2/3	served a pureed diet Room (DM) and the co-About and hour after that Resident #1 was and vomiting.  -She went to the day coughing very bad and The RCD came into clean Resident #1 up on Resident #1 up on Resident #1 and the office.  -She went to the RCD did she need to send for evaluation and was thought Resident #1 and as long as the ph Resident #1 was "ok" pneumonia it was nor out.  -The RCD told her to check to see if the resident #1's PCP of was ordered on 07/09 episode was completed. Resident #1's PCP of was not told to cont tell the PCP's office again and was vomiting. She informed the RCD not having the chest winquired if she could shospital.  -The RCD denied her #1 was "fine" now.	and notified the Dining liet was changed for supper. Iunch, a PCA informed her in the day room coughing  room and found Resident #1 id vomiting a lot. the dayroom and helped and told to "keep an eye" he RCD went back to her  and asked at what point Resident #1 to the hospital s told by the RCD that she had aspiration pneumonia allegm was coming out then because with aspiration mal for the phlegm to come  call the PCP's office and sults of a chest xray that allegh and read. Iffice told her that the chest received. It is anything else and she did the that Resident #1 choked	D 273		
	9:23am revealed: -On 7/12/24, she was	working with another , when the MA on duty in the			
		ssistance to make sure			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE. ZIP CODE	
		41 COBBL		,	
HARMON'	Y AT REYNOLDS MOUNT	TAIN	E, NC 28804		
0/10/15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	·	PROVIDER'S PLAN OF CORRECTION	1 0/5
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE COMPLETE
D 273	Continued From page	26	D 273		
	supposed to be on a garegular diet at breakepisodeOn 07/12/24, there was performed on Resideral She called the Speed Resident #1's PCP to -On 07/12/24, the ST pureed diet on 07/11/with Resident #1On 07/12/24, before before lunch she clarithe kitchen staff but diet on Resident #1.	ned that Resident #1 was pureed diet and was served what and had a choking was no Heimlich Maneuver at #1 that she was aware of the Therapist (ST) and verify the correct diet order. clarified he recommended a 24 due to a choking episode when the diet for pureed with id not see what was served			
	from Resident #1's Pochoking on 07/09/24 and Resident #1's diet to a common of the com	erived a call from a physician CP office about Resident #1 and a request to change a pureed diet.  Int #1's diet was changed to pureed by the PCP the er to take the new order to the diet to the therapeutic diet list			
	-The PT wanted clarif -He told the PT that R served a pureed diet. -The PT said she wou the correct order.	uld make sure dietary had ot served a pureed diet,			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
			A. BOILDING.			
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			BLERS WAY	,		
HARMON'	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C	ORRECTION	(X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	COMPLETE DATE
D 273	Continued From page	e 27	D 273			
D 273	Interview with the RC revealed: -On 07/12/24 about 1 was sitting in her office and Resident #1 was -Resident #1 began with the day room and clesshe asked the MA to check to see if the chreceived and to let the was vomitingThe MA came back told her that the chesshe thought the MA is was vomitingOn 07/11/24, a provious office was rounding of informed the provider choking episode on 0-On 07/11/24, she resprovider ordered a chrossible aspiration propossible aspiration proposition propo	2D on 08/16/24 at 9:46am  1-2 hours after lunch, she be across from the day room be sitting in the day room.  I comiting and she went into be and Resident #1 up.  I call Resident #1's PCP and best xray report results were be PCP know Resident #1  I in less than 30 minutes and but xray was not received and but array from Resident #1  I der from Resident #1's PCP  I on other residents when she but about Resident #1's  I compared the mest xray and the but array for evaluation of	D 273			
	-On 07/12/24, she lef	to the hospital for evaluation. It work about 5:40pm to				
	b:00pm and around 7	7:50pm she was notified that				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:	ONSTRUCTION		E SURVEY PLETED
			A. BOILDING.			Б
		HAL011361	B. WING	<u>-</u>	08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	. ZIP CODE		
			BLERS WAY	,		
HARMON	Y AT REYNOLDS MOUN	ΓAIN	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	· ·	l. e determined the chest xray	D 273			
	when she put the ord after Resident #1 cho found out it was not of provider order another -On 07/12/24, the MA	est xray was completed er request in on 07/09/24 eked and the on 07/11/24 completed, she had a er one. A informed her that the chest				
	xray was not completed but she still did not notify the PCPThe MAs were responsible for completing the Incident/Accident report which included notification to the physician and documenting the choking episodes on the 24 hour report.					
	sheets the following r the concerns to the A stand up meeting. -She was responsible	ort, and the 24 hour report morning and to report all of dministrator at the morning e for following-up with any				
	care physician (PCP) revealed: -On 07/09/24, Reside was characterized as	with Resident #1's primary on 08/19/24 at 8:25am ent #1's had choking episode a "severe choking" episode s completely obstructed				
	resulting in her not be consciencesShe was notified abore episode after her Sup Resident #1 and orde 07/11/24On 07/12/24, she was	e able to cough, and loose out the 07/09/24 choking pervisory Physician saw				
		until after Resident #1 died. hoked while eating,				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		HAL011361	B. WING		08	R 8 <b>/20/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DDRESS, CITY, STATE	. ZIP CODE			
			LERS WAY	,			
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From pag	e 29 esident #1 was at higher risk	D 273				
	of death related to as esophageal cancer.	spiration and a history of					
	episode and turned be which put her at a ve	ent #1 had a severe choking blue and lost consciousness, ry high risk for complications					
	•	g. fter Resident #1 were ungs and hypoxia related to					
	aspirationA complete blockage	e of Resident #1's airway,					
	due to inflammation could occur with in 36 hours of a severe choking incident and death could happen within 36 hours of the severe choking						
	incident.	isode, Resident #1 should					
	have been evaluated have been called and	l at the hospital or she should d she could have completed ery least to evaluate for					
	complications after c						
	08/16/24 at 2:37pm r						
	-	onsible for notifying the PCP noking and receive new some.					
		onsible for following-up with noking and make sure there					
	Telephone interview Administrator on 08/ -He was the Adminis						
	07/12/24.	onsible for notifying the PCP					
	about incidents such -The RCD was respo						

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURV COMPLETED	
		HAL011361	B. WING		R 08/20/2	024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	•	-
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBLI	ERS WAY E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
D 273	implementedHe was told by the R choking episode on 0 PCP was notified, but the caseThere was no Incider for him to review for F episode on 07/09/24There was an Incider for him to review for F 07/12/24 but not a cholor linterview with the Adr 2:31pmShe began working a 08/12/24The MA's were responsible to the PCP and for revier reports.  Attempted telephone Power of Attorney (PC and 08/16/24 at 5:05pc Attempted telephone Supervisory Physiciar was unsuccessful.  2. Review of Resident 09/25/23 revealed diamellitus 2, hypertensid dementia and a cognical. Review of Resident order dated 05/20/24	CD, Resident #1 had a 7/09/24, 07/12/24 and the later found out that was not int/Accident report available Resident #1's choking int/Accident report available Resident #1's death dated oking episode on 07/12/24. Ininistrator on 08/16/24 at as the Administrator on onsible for notifying the PCP oking. Insible for following-up with wing the Incident/Accident interview with Resident #1's DA) on 08/16/24 at 4:00pm om was unsuccessful. Interview with the in on 08/19/24 at 1:00pm of the following diabetes on, hypothyroidism, tive disorder.	D 273			
	Resident #3's blood s	ugar three times a day.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		1 ' '	E SURVEY PLETED	
		HAL011361	B. WING		08	R 3/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 00	
		41 COBE	BLERS WAY	,,		
HARMON	Y AT REYNOLDS MOUN	ΓAIN	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 31	D 273			
	dated 07/15/24 revea	3's signed physician's order led an order to check sugar two times a day.				
	Review of Resident # Medication Record (e -There was an entry to sugar (FSBS) three to 2:00pm and 8:00pmThe FSBS was docu 06/11/24 and 06/12/2  Review of Resident # revealed: -There was an entry to a day, with an original scheduled at 8:00am -On 07/04/24 at 8:00am documented as "refusion 07/05/24 at 8:00am documented as "refusion 07/11/24 at 8:00am -On 07/11/24	3's June 2024 electronic MAR) revealed: to check a finger stick blood mes a day at 8:00am,  mented as refused on 4 at 8:00am.  3's July 2024 eMAR to check a FSBS three times I date of 05/20/24, 2:00pm and 8:00pm. tom, the FSBS was sed". tom, the FSBS was tole to take medication". tom, the FSBS was tole to take medication". tom, the FSBS was tole to take medication. tom, the FSBS was tole to take medication. tom, the FSBS was tole to take medication. tom, the FSBS was tole tole tole tole tole tole tole tole				
	documented as "waiti -On 07/13/24 at 8:00a documented as "no g -On 07/13/24 at 2:00p documented as "no te -On 07/14/24 at 8:00a documented as "no la -On 07/15/24 at 8:00a	ing on glucose strips".  am, the FSBS was lucose strips on the cart".  om, the FSBS was est strips".  am, the FSBS was ancets in cart".  am, the FSBS was ing on the pharmacy".  om, the FSBS was ole to check".				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILDING.			5
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
	V AT DEVALOU DO MOUN	41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUN	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	day with an original of at 8:00am, 2:00pm at 8:00am, 2:00pm at -On 07/19/24 at 8:00 as "refused"On 07/20/24 at 2:00 as "test strips not in -On 07/20/24 at 8:00 as "already ate"On 07/21/24 at 8:00 as "med not on cart" -On 07/24/24 at 8:00 as "refused".  After review of Resident interview with the Phanch of the BS was refused 07/01/24 to 07/016/2. The BS was not obtout the st strips for 4 out on the BS was not obtout another to obtain for 100 and	d glucose strips". to check FSBS two times a date of 07/16/24, documented and 8:00pm. fam, the BS was documented form, the BS was documented form, the BS was documented fram, the BS was documented f	D 273	DEFICIENC		
	-On 08/12/24 at 8:00 as "unable to take m	am, the BS was documented				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HADMON	AT DEVINOL DO MOUNT	41 COBBI	ERS WAY		
HARMON	AT REYNOLDS MOUNT	ASHEVILI	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	÷ 33	D 273		
	lancets and 25 test st				
	iancets and 25 test st	nps.			
	contracted pharmacy revealed: -There was an order of Resident #3's FSBS to -There was an order of Resident #3's FSBS to -On 05/28/24, a 16 da were dispensed to the -On 05/29/24, a 33 da were dispensed to the -On 06/06/24, a 33 da were dispensed to the -On 07/24/24, a 50 da were dispensed to the -On 07/15/24, a 50 da were dispensed to the -The lancets and test and it was the facility' refills.	dated 07/16/24 to check wo times a day. ays supply of 50 test strips, e facility. ays supply of 100 test strips, e facility. ays supply of 100 lancets, e facility. ays supply of 100 lancets, e facility. ays supply of 100 lancets, e facility. ays supply of 100 test strips, e facility. ays supply of 100 test strips, e facility. strips were not on cycle fill s responsibility to request ave been out of lancets			
	Review of the memor physician book revea	=			
	-On the outside of the	binder, there were cards			
		on for two of the Primary			
	Care Provider (PCPs	). ormation included phone			
	number, email addres	•			
		onthly dividers including			
	January 2024-Decem				
		ne communication form			
	under each monthly of				
		d "request to be seen".			
		f space for staff to enter the of request, concern, and			
	which staff if was requ				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
		HAL011361	B. WING		08	R 8 <b>/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
	T	ASHEVI	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 34	D 273			
	-There were no entrice month of June - July	es for Resident #3 for the 2024.				
	write missing supplie the 24 hour hour rep -The PCP would look visit which could be t -She notified the RCI missing FSBS suppli would take care of it.	revealed: Director (RCD) trained her to so in the physician book and ort log at the nurses station. At at that entry on the next wo weeks away. D when Resident #3 was es and the RCD stated she with Resident #3's PCP on				
	-Resident #3 was be medications along winightIt was important for checked every day s diabetic medications Resident #3's BSShe was not informed of diabetic test supplications and the staff to closely medications.	ing treated with oral diabetic ith a long acting insulin at  Resident #3 to have her BSs or she could regulate the administered and control and when Resident #3 ran out				
	diabetic supplies.  Refer to a second int 08/20/24 at 8:00am.					
	Refer to interview wit at 8:30am.	th a second MA on 08/20/24				
	Refer to interview wit 9:46am.	th the RCD on 08/16/24 at				
	Refer to interview wit	th the Corporate Clinical				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		0.5	R 3/20/2024
					1 00	720/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	ZIP CODE		
HARMON'	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 OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	je 35	D 273			
	Specialist on 08/16/2	24 at 2:37pm.				
	Refer to interview wi 08/16/24 at 2:31pm.	th the Administrator on				
	order dated 05/14/24 furosemide (a medic	nt #3's signed physician's 4 revealed an order for eation to treat high blood solution, take 2ml = 20mg				
	dated 07/21/24 revea	#3's signed physician's order aled an order for furosemide ke 4ml = 40mg every				
	dated 07/21/24 revea	#3's signed physician's order aled an order for furosemide ke 6ml = 60mg every				
	-There was an entry solution, take 2ml = 3 original date of 05/14 administered at 8:00 -On 06/02/24 at 8:00 documented as "refu-On 06/08/24 at 8:00	Dam, the furosemide was used". Dam, the furosemide was				
	documented as "refu-On 06/12/24 at 8:00 documented as "refu-On 06/15/24 at 8:00 documented as "refu-On 06/30/24 at 8:00 documented as "wai-The furosemide was	Dam, the furosemide was used". Dam, the furosemide was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
	A. BUILD		A. BUILDING:			
		HAL011361	B. WING		0.5	R 3/ <b>20/2024</b>
		TIALST 1301			00	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	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 ACTI CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From pag	e 36	D 273			
	-There was an entry solution, take 2ml = 2 original date of 05/14 of 07/22/24 schedule 8:00amOn 07/01/24 at 8:00 documented as "wai-On 07/02/24 at 8:00 documented as "refu-On 07/03/24 at 8:00 documented as "not pharmacy"On 07/05/24 at 8:00 documented as "refu-On 07/08/24 at 8:00 documented as "refu-On 07/11/24 at 8:00 documented as "una-On 07/11/24 at 8:00 documented as "refu-There was an entry solution, take 6ml = 0 original date of 07/22 of 07/30/24 schedule 8:00amOn 07/30/24 at 8:00 documented as not a -There was an entry solution, take 6ml = 0 original date of 07/30 administered at 8:00 followed up with pha -The furosemide was administered for 8 or	dam, the furosemide was used".  Itam, the furosemide was on cart, ordered from the furosemide was used".  Itam, the furosemide was used".  Itam, the furosemide was used from pharmacy".  Itam, the furosemide was used to take medication".  Itam, the furosemide was used".  Itam, the furosemide was used to take medication and the furosemide at the furosemide was used to be administered at the furosemide was used the furosemide was used the furosemide at the furo				
		for furosemide 10mg/ml				

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A. BUILDING:		
	R	
HAL011361 B. WING 08/20/20	2024	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE		
HARMONY AT REYNOLDS MOUNTAIN  41 COBBLERS WAY		
ASHEVILLE, NC 28804		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 273 Continued From page 37 D 273		
solution, take 6ml = 60mg every morning with an original date of 07/30/24 scheduled at 8:00am.  -On 08/03/24 at 8:00am, the furosemide was documented as "intot on cart, refill requested by RCD".  -On 08/04/24 at 8:00am, the furosemide was documented as "med not available, RCD followed up with pharmacy".  -On 08/06/24 at 8:00am, the furosemide was documented as "RCD followed up with pharmacy".  -On 08/106/24 at 8:00am, the furosemide was documented as "RCD followed up with pharmacy".  -On 08/12/24 at 8:00am, the furosemide was documented as "unable to take".  -The furosemide was not administered for 4 out of 14 opportunities.  Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:  -On 05/14/24, there was an order for furosemide 10mg/ml solution, take 2ml = 20mg every morning.  -The pharmacy dispensed furosemide 10mg/ml solution, 6ml a 30 day supply on 05/14/24 and 07/01/24.  -On 07/21/24, there was an order for furosemide 10mg/ml solution, 120ml, a 30 day supply on 07/22/24.  -On 07/30/24, there was an order for furosemide 10mg/ml solution, 120ml, a 30 day supply on 07/22/24.  -On 07/30/24, there was an order for furosemide 10mg/ml solution, 120ml, a 30 day supply on 07/20/24.  -Based on dispense history, Resident #3 would have been out of the furosemide 2ml 06/13/24 until 07/01/24.		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
HAI 044264		B. WING	R WING		R	
		HAL011361	5		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY			
	I	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 (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 38	D 273			
	there was a bottle of the with a label dated 07/administer 6ml = 60ml hypertension with 8ml.  Review of the memoral physician book reveal.	ls left to administer.				
	Primary Care Provide 8:25am revealed: -The furosemide was #3's hypertensionOn 07/21/24, Reside visit for weeping in he swelling and she incre 2ml = 20mg to 4ml = -On 07/29/24, she sat and there was no doo blood pressure (BP) if she went off of June 2 high, and the visit from Resident #3's legs sw increased the furosen morning and sent the -She did not know Re	w Resident #3 at the facility sumentation of Resident #3's for the month of July 2024, 2024's BP which was a little m 07/21/24 related to relling and weeping, so she nide to 6ml = 60mg every order to pharmacy.				
	ordered on 07/21/24 vas 6ml instead of 4ml -Resident #3 could have pressure causing fluid and weeping in Resident with a MA or revealed she notified	the furosemide 4ml = 40mg was possibly administered for 8-9 days in July 2024. ave increased blood d retention causing swelling lent #1's legs.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
		January Hombert	A. BUILDING: _		OOWII ELTED	
		HAL011361	B. WING		R 08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	FAIN 41 COBBL				
			E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 39	D 273			
	stated that she would	take care of it.				
	Refer to a second into 08/20/24 at 8:00am.	erview with a MA on				
	Refer to interview with at 8:30am.	h a second MA on 08/20/24				
	Refer to interview with 9:46am.	h the RCD on 08/16/24 at				
	Refer to interview with Specialist on 08/16/24	h the Corporate Clinical 4 at 2:37pm.				
	Refer to interview with 08/16/24 at 2:31pm.	h the Administrator on				
	c. Review of Residen order dated 06/10/24 medication used to tro 0.5mg/0.5ml to forear	eat anxiety/agitation)				
	orders dated 07/25/24	3's signed physician's 4 for lorazepam gel 1mg/1ml hairless area every night at				
		led there were no entries for north of July 2024 to request				
	original date of 06/11/ administered on 06/13	or lorazepam gel m two times a day with an				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	<del></del>	
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIR CODE	
TVAINE OF T	NOVIDEN ON OUR FEIEN		LERS WAY	WE, ZII GOBE	
HARMON	Y AT REYNOLDS MOUNT	TAIN	LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	TION (X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 273	Continued From page	e 40	D 273		
	-On 06/11/24 at 8:00a	am, the lorazepam was			
	documented as "not i	· · · · · · · · · · · · · · · · · · ·			
	-On 06/11/24 at 8:00p	om, the lorazepam was			
	documented as "med	not on cart".			
	-On 06/12/24 at 8:00a	am, the lorazepam was			
	documented as "refus	sed".			
		am, the lorazepam was			
	documented as "med				
	-	not administered for 4 out of			
	60 opportunities.				
	Review Resident #3's July 2024 eMAR revealed:				
	-There was an entry f				
	0.5mg/0.5ml to forear	m two times a day with an			
	original date of 06/11	/24 documented as			
		1/24 to 07/13/24 at 8:00am			
	-	4 at 8:00pm, 07/17/24 to			
		nd 8:00pm, 07/19/24 at			
	· ·	4 to 07/25/24 at 8:00am and			
	8:00pm. -On 07/14/24 at 8:00a	am there was no			
		why the lorazepam was not			
	administered.	wity the lorazepain was not			
		am, the lorazepam was			
	documented as "waiti				
		om, the lorazepam was			
	documented as "med				
	-On 07/16/24 at 8:00a	am, the lorazepam was			
	documented as "not i	n cart".			
		am, the lorazepam was			
	documented as "refus				
		am, the lorazepam was			
	documented as "disco				
	to forearm at night wi	for lorazepam gel 1mg/1ml			
	07/25/24 scheduled to	_			
	8:00pm.	o be administered at			
	•	om, the lorazepam was			
	documented as "disco				
		3/24 at 8:00pm, there was			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION			
7.11.2.1.2.11.1			A. BUILDING:			LETED
HAL011361		B. WING		I	R <b>/20/2024</b>	
NAME OF D	ROVIDER OR SUPPLIER	STDEET A	DDRESS, CITY, STATE	= 7IP CODE		
NAME OF T	NOVIDEN ON 3011 EIEN		BLERS WAY	-, ZII GODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRI	ECTION	(X5)
PREFIX TAG	`	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SECROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETE DATE
D 273	Continued From page	e 41	D 273			
	no documentation as not administered.	to why the lorazepam was				
	-The lorazepam was of 60 opportunities.	not administered for 11 out				
	facility's contracted p	with a Pharmacist from the harmacy on 08/20/24 at				
		vas an order for lorazepam				
	gel 0.5mg/0.5ml to forearm two times a dayThe pharmacy dispensed lorazepam gel 0.5ml =					
	0.5mg, 30mls, 30 day supply on 06/11/24 and 07/16/24.					
	Gel 1mg/1ml to forear	vas an order for lorazepam				
	-The pharmacy was u	_				
		pecause the pharmacy could edication before it was				
	discontinued on 07/3					
	-According to their re 1mg/ml was not avail 07/25/24 to 07/31/24.	able for administration				
	-Lorazepam was use	d for anxiety/agitation and if				
	not received as order display increased bel	red dose the resident could naviors.				
		with the facility's contracted er (PCP) on 08/19/24 at				
	-The lorazepam was	•				
	Resident #3's agitation	on and anxiety. ot get the lorazepam as				
		ıld increase the risk of				
	behaviors.					
	-She was not notified medications and bein	of the refusals of g out of the medications.				
	Telephone interview v	with a representative from				
		ed mental health (MH)				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		I	R <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	FAIN 41 COBE	BLERS WAY			
		ASHEVII	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	IOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 42	D 273			
	-The lorazepam was anxietyHe was not aware of lorazepam which cau changesIf the lorazepam was ordered the Resident in behaviors which was change the lorazepam 07/31/24.  Refer to a second into 08/20/24 at 8:00am.  Refer to interview with at 8:30am.  Refer to interview with 9:46am.	Resident #3 refusing the sed him to make medication is not administered as #3 would have an increase as the reason he had to in to clonazepam on herview with a MA on her a second MA on 08/20/24 the the RCD on 08/16/24 at her the Corporate Clinical				
	Refer to interview with 08/16/24 at 2:31pm.	th the Administrator on				
	order dated 05/14/24	t #3's signed physician's for metformin (a medication s) 500mg/5ml, administer				
	dated 05/14/24 for me	e daily with breakfast and				
		led there were no entries for north of July 2024 in regard				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE	CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
					R	
		HAL011361	B. WING		1	/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		41 COBBI	LERS WAY			
HARMON	Y AT REYNOLDS MOUN	ΓAIN	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	ON	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	COMPLETE DATE
D 273	Continued From page	e 43	D 273			
	-There was an entry f solution, administer 1 day, with an original of as administered at 8:1 -On 06/02/24 at 8:00 adocumented as "refus -On 06/02/24 at 8:00 adocumented as "not i -On 06/08/24 at 8:00 adocumented as "refus -On 06/08/24 at 8:00 adocumented as "not i -On 06/09/24 at 8:00 adocumented as "refus -On 06/11/24 at 8:00 adocumented as "refus -On 06/12/24 at 8:	am, the metformin was sed".  om, the metformin was n cart".  am, the metformin was sed".  om, the metformin was n cart".  om, the metformin was n cart".  am, the metformin was n cart".  am, the metformin was sed".  am, the metformin was sed".  am, the metformin was sed".				
	-There was an entry f solution, administer 1 day with an original d discontinue date of 0 administered at 8:00a -On 07/02/24 at 8:00a documented as "refus -On 07/03/24 at 8:00a documented as "disco -There was an entry f solution, administer 5 day with meals, break original date of 07/03 administered at 8:00a	7/03/24 scheduled to be am and 8:00pm. am, the metformin was sed". om, the metformin was ontinued". for metformin 500mg/5ml aml = 500mg two times a created and supper with an 1/24 scheduled to be am and 5:00pm. am, the metformin was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED	
HAL011361		B. WING		R <b>08/20/2024</b>		
NAME OF D			DECC CITY CTA	TE ZID CODE	1 00/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	41 COBBL	DRESS, CITY, STA	ie, zip code		
HARMON	Y AT REYNOLDS MOUN	ΓΑΙΝ	E, NC 28804			
	CUMMA DV CT		·	PROVIDERIC DI ANI CE CORRECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 273	Continued From page	e 44	D 273			
	-On 07/11/24 at 8:00a documented as "unal -On 07/16/24 at 5:00p documented as "not or -On 07/17/24 at 5:00p documented as "not or -On 07/18/24 at 5:00p documented as "not or -On 07/19/24 at 8:00a documented as "refus -On 07/20/24 at 5:00p documented as "not or -On 07/21/24 at 8:00a documented as "not or -On 07/22/24 at 8:00a doc	am, the metformin was pole to take medication".  om, the metformin was pon cart".  om, the metformin was pon cart".  om, the metformin was pon cart".  am, the metformin was seed".  om, the metformin was no cart".  am, the metformin was no cart".  am, the metformin was no cart".  om, the metformin was no cart".  om, the metformin was no cart".  om, the metformin was no cart".				
	revealed: -There was an entry f solution, administer 5 with meals, breakfast date of 07/03/24 sche 8:00am and 5:00pmOn 08/02/24 at 8:00a documented as "refus-On 08/11/24 at 5:00p documented as "refus-On 08/12/24 at 8:00a documented as "unat-On 08/13/24 at 5:00p documented as "resic Review of Resident # administration on 08/3 there was a bottle of	for metformin 500mg/5ml sml = 500mg two times a day and supper with an original eduled to be administered at am, the metformin was seed". om, the metformin was seed". am, the metformin was ole to take". om, the metformin was ole to take". om, the metformin was dent asleep".  3's medications available for 20/24 at 11:18am revealed metformin 500mg/5ml liquid, 122/24 containing 200ml, to				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
HAL011361			B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	'AIN	_ERS WAY _E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	÷ 45	D 273		
	hypertension with 8m	l left to administer.			
	Primary Care Provide 8:25am revealed: -The metformin was of #3's high blood sugar -On 07/03/24, she characteristic metformin from 8:00a day with breakfast and digestive issues related on an empty stomach -On 07/29/24, she say and there was documbeing out of the medical administered incorrect medications prior to the -Resident #3's last He test that measures the blood sugar in a personal revealed.	anged Resident #3's m and 8:00pm to twice a d lunch to help prevent ed to taking the medication . w Resident #3 at the facility entation of refusals and cation. of the refusals, tly or being out of the			
	Refer to a second into 08/20/24 at 8:00am.	erview with a MA on			
	Refer to interview with a second MA on 08/20/24 at 8:30am.				
	Refer to interview with 9:46am.	n the RCD on 08/16/24 at			
	Refer to interview with Specialist on 08/16/24	n the Corporate Clinical 4 at 2:37pm.			
	Refer to interview with 08/16/24 at 2:31pm.	n the Administrator on			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		
AND I EAR OF CONNECTION IDENTIFICATION NOWIDER.		A. BUILDING: _		COMPLETED	
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF F	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		41 COBBL	ERS WAY	•	
HARMONY AT REYNOLDS MOUNTAIN			.E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 46	D 273		
U 2/3	A second interview w 8:00am revealed: -She was trained by t Director (HWD) to ord using the eMAR syste RCD when she saw t were down to two dos -She was not aware s about refills for medic when the PCP told he pharmacy and check supplies that were no Resident #3She spoke to the RC pharmacy or PCP, an report sheet and the p -Since late July 2024 pharmacy or physicia physician's book at th hour report sheetIf a medication or su administer, she docur cart" on the eMARIf a resident's medica prior to the time for ba pharmacy, the MAs w deliver the medication -Third shift staff were supplies and medicat placed in the medicat  Interview with a secon 8:30am revealed: -The pharmacy delive middle of the night an responsible for makin placed on the correct -She had started her	the Health and Wellness der supplies and mediations em and to notify him and the hat supplies/medications ses, she informed the RCD. She could call the pharmacy cations until late July 2024 er, during a visit, to call the on a medications and at available to administer to add document it in the 24 hour physician's book at the desk. When she notified the in, she documented it in the edesk and put it on the 24 pplies were not available to mented medication "not in ation or supplies ran out atch refill from the vaited on the pharmacy to not in the edesk and put it on the state of the edit o	D 213		

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING:			E SURVEY PLETED
						R
		HAL011361	B. WING		90	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON'	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
TIPARAMOR	TAT KETHOLDO MOON	ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 47	D 273			
	the pharmacy and the them away.	e third shift MA did not put				
	revealed she was stil					
	could not complete a	outting out all the "fires", she Il the follow-ups related to P, medications and supplies.				
	08/16/24 at 2:37pm r- -The MAs were responsible about Resident #3 law refused medications.	onsible for notifying the PCP ck of supplies, missing or				
	the PCP about the m medications/supplies	nsible for following-up with edication refusals and or missing. e MAs were notifying the				
	RCD and the RCD di	d not follow-up with the he residents missed or				
	2:31pm.	ministrator on 08/16/24 at				
	08/12/24. -The MAs were respo	as the Administrator on onsible for notifying the PCP				
	missing medications/	nedication refusals and supplies. nsible for ensuring contact				
	was made with the Parallable.	CP and supplies were e RCD did not follow-up with				
		to the residents missed or				
	06/05/24 revealed:	nt #2's current FL2 dated				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		ETED
		HAL011361	HAL011361 B. WING		08/2	? :0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 273	high blood pressure) hoursResident #2 was add facility on 06/05/24.  a. Review of Resident (PCP) order dated 06-5tart twice weekly working the PCP via the weight change of three weight change of three Review of Resident #06/24/24 revealed: -Start twice weekly working the PCP via the weight change of three weight change of three weight change of three Review of Resident #07/01/24 revealed: -Please make sure to application for weight three poundsResident #2 had sign 07/01/24-07/02/24He has had highly voice and PCP was never to revealed: -There was an entry to 04/15/24) once daily PCP of weight gain good scheduled at 8:00 am -The documented weight 240.1lbs269lbsOn 06/10/24, the documented weight 240.1lbs269lbs.	for metoprolol (used to treat 25mg one tablet every 12 mitted from a skilled nursing at #2's primary care provider 6/10/24 revealed: eight. elehealth application for see pounds or more. E2's PCP order dated eights. elehealth application for see pounds or more. E2's PCP order dated eights. elehealth application for see pounds or more. E2's PCP order dated enotify PCP via telehealth again or loss of greater than enificant weight gain from enificant weight in June 2024 enotified. E2's June 2024 electronic ation record (eMAR) for weight check (starting for monitoring and notify the reater than three pounds eight range was cumented weight was	D 273			
	was 243.4lbs. a decre	1/24 the documented weight ease of 20.2lbs.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF D			DECC CITY CTA	TE 710 000E	1 00/20/2024
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	
HARMONY AT REYNOLDS MOUNTAIN			ERS WAY E, NC 28804		
0(0)15	SLIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTIO	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 49	D 273		
	-On 06/13/24, the doc 243.2lbs and on 06/14 was 240.1lbs. a decree -On 06/14/24, the doc lbs and on 06/15/24 the 265.4lbs. an increase -On 06/15/24, the doc 265.4lbs and on 06/18 was 241lbs. a decrea -On 06/18/24, the doc and on 06/19/24 the ce 260.2lbs. an increase -On 06/19/24, the doc 260.2lbs and on 06/2 was 264.6lbs. and increase -On 06/23/24, the doc and on 06/24/24 the ce 261lbs. a decrease of -On 06/26/24, the doc 265.4lbs and on 06/2 was 269lbs. an increase -On 06/29/24, the doc 265.4lbs and on 06/29/24, the doc 260.00 ce 265.4lbs. an increase -On 06/29/24, the doc 260.00 ce 260.20 ce 260.2	cumented weight was 4/24 the documented weight ease of 3.1lbs. cumented weight was 240.1 the documented weight was 6 of 25.3lbs. cumented weight was 8/24 the documented weight se of 24.4lbs. cumented weight was 241lbs documented weight was 1/24 the documented weight crease of 4.4lbs. cumented weight was 1/24 the documented weight crease of 4.4lbs. cumented weight was 6 of 19.2lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs. cumented weight was 1/24 the documented weight crease of 3.6lbs.			
	Review of Resident #2's July 2024 eMAR revealed:  -There was an entry for weight check (starting 04/15/24) once daily for monitoring and notify the PCP of weight gain greater than three pounds scheduled at 8:00am.  -The documented weight range was 236.4lbs-272lbs.  -On 07/01/24, the documented weight was 264.6lbs. and on 07/02/24 the documented weight was 271lbs an increase of 6.8lbs.  -On 07/04/24, the documented weight was 272.1lbs and on 07/05/24 the documented weight was 236.4lbs a decrease of 35.7lbs.  -On 07/05/24, the documented weight was				

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Division of	Division of Health Service Regulation						
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	URVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED	
					F		
		HAL011361	B. WING		08/2	0/2024	
NAME OF D	ROVIDER OR SUPPLIER	STREET AT	DRESS, CITY, STA	TE ZID CODE			
NAME OF FI	NOVIDER OR SUFFLIER		, ,	TE, ZIF CODE			
HARMON	Y AT REYNOLDS MOUNT	TAIN	LERS WAY				
		ASHEVIL	LE, NC 28804				
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PRÉFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE	
				DEI IGIENCI)			
D 273	Continued From page 50		D 273				
	2.0 Continued From page 50						
	236.4lbs and on 07/06/24 the documented weight						
	was 244.1lbs an incre	ease of 7.7lbs.					
	-On 07/07/24, the doc	cumented weight was					
	238.1lbs and on 07/0	8/24 the documented weight					
	was 263.2lbs an incre	ease of 25.1lbs.					
	-On 07/11/24, the doc						
		3/24 the documented weight					
	was 269.6lbs an incre	•					
		cumented weight was					
		1/24 the documented weight					
	was 254.8lbs a decre	•					
	-On 07/21/24, the doc						
		2/24 the documented weight					
	was 270.4lbs an incre	ease of 15.6lbs.					
	1						
		<sup>‡</sup> 2's August 2024 eMAR from					
	08/01/24-08/13/24 rev	vealed:					
	-There was an entry f	for weight check (starting					
	04/15/24) once daily f	for monitoring and notify the					
	PCP of weight gain gr	reater than three pounds					
	scheduled at 8:00am.						
	-The documented we						
	252.4lbs-273.8lbs.						
	-On 08/02/24, the doc	cumented weight was					
	·	3/24 the documented weight					
	was 253.1lbs a decre						
	-On 08/06/24, the doc	_					
		8/24 the documented weight					
	was 259.0lbs an incre						
	·	cumented weight was					
		9/24 the documented weight					
	was 255.2lbs a decre						
	-On 08/09/24, the doc	•					
	255.2lbs and on 08/1	0/24 the documented weight					
	was 263.8lbs an incre	ease of 8.6lbs.					
	-On 08/10/24, the doc	cumented weight was					
		3/24 the documented weight					
	was 258.2lbs a decre	_					
	was 258.2lbs a decrease of 5.6lbs.						

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Interview with the Resident Care Director (RCD)

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HADMON	HARMONY AT REYNOLDS MOUNTAIN 41 COBB				
TIAKWON	TAT RETHOLDS MOON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	= 51	D 273		
	on 08/15/24 at 2:38pm revealed she and the HWD received access to communicate directly with primary care providers (PCP) through the telehealth application "today" (08/15/24).  Interview with the Health and Wellness Director				
	(HWD) on 08/16/24 at 8:32am revealed:  -There was a chair scale for the medication aides (MA) to perform weights for residents with orders.  -The MAs were supposed to report weight variances according to the parameters given by making an entry in the physician book.  -If there were no entries in the physician book or in the facility's electronic documentation application, he did not know if the weight changes				
		PCP. vas in the facility weekly on lents about health concerns.			
	Interview with a medication aide (MA) on 08/16/24 at 10:14am revealed: -She was aware of the order to weigh Resident #2 and report weight changes of 3lbsShe had not had an occurrence when she had taken Resident #2's weight which required PCP notificationIf she needed to report a weight change, she had been trained to make an entry in the physician				
	book that was kept at -The PCP looked at the weekly visits to the fa	he physician book on their			
	Review of the memory care nurses station physician book revealed there were no entries for Resident #2 from June 2024-August 2024 regarding weight changes.				
		2's electronic progress note -08/14/24 revealed there ding weight changes.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED	
	HAL011361	B. WING		R 08/20/2024	
NAME OF PROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
HADMONY AT DEVNOLDS MOUNTAIN	41 COBB	LERS WAY			
HARMONY AT REYNOLDS MOUNTAIN	ASHEVIL	LE, NC 28804			
PREFIX (EACH DEFICIENCY MU	IENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE	
D 273 Continued From page 52	73 Continued From page 52				
Telephone interview with 08/15/24 at 4:36pm revealed the staff to check weights changes of three pounds -She was not notified of Figure pound weight changes in 2024.  -Resident #2 was at an incongestive heart failure, spulmonary edema, and pwhen she was not proper resident's weight gains an Telephone interview with registered nurse (RN) on revealed the facility staff Resident #2's weight flucture with the Corport 08/20/24 at 4:16pm revealed the facility staff.  -The order written for Resident #2's weight gains and loss of three pounds should by staff.  -The MAs needed a base evaluate the exact increase linterview with the Administration of Resident #2's weight gounds or more.  -The MAs were responsite of Resident #2's weight gounds or more.  -The MAs were responsite and the RCD the weight foccurred with Resident #2. The HWD and RCD were	aled: sed with heart failure. on three occasions for and notifiy her of or more. Resident #2's three June 2024-August acreased risk of shortness of breath, otential hospitalization rely notified of the nd losses.  Resident #2's hospice 08/16/24 at 12:16pm had not reported tuations to her.  ate Clinical Specialist on aled: sident #2's weight report weight gain or ald have been clarified at weight to go by to se and decrease.  strator on 08/20/24 at ble for notifying the PCP ains or losses of three  ble for notifying the HWD fluctuations which 2.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	CONSTRUCTION	· /	(X3) DATE SURVEY COMPLETED	
ANDIEAN	or contribution	BENTI TOATION NOWBER.	A. BUILDING: _		COM	LETED
		HAL011361	B. WING		I	R <b>/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
		41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUNT	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 273	Continued From page	÷ 53	D 273			
	fluctuations were repo	orted to the PCP.				
		ns, interviews and record ned that Resident #2 was				
	b. Review of Resident #2's current FL2 dated 06/05/24 revealed there was an order for metoprolol (used to treat high blood pressure) 25mg one tablet every 12 hours.  Review of Resident #2's June 2024 electronic medication administration record (eMAR) revealed: -There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic blood pressure was greater than 130 and or if heart rate (HR) was less than 65 hold medication and notify MD if systolic blood pressure (BP) greater than 160On 06/15/24 at 8:00am, the documented BP was 174/111 and the HR was 82On 06/18/24 at 8:00am, the documented BP was 183/82 and the HR was 75On 06/22/24 at 8:00am, the documented BP was 176/100 and the HR was 73.					
	169/99 and the HR w -On 06/25/24 at 8:00p 175/108 and the HR v -On 06/27/24 at 8:00a	am, the documented BP was as 70. om, the documented BP was was 94. am, the documented BP was				
	163/88 and the HR w -On 06/28/24 at 8:00p 184/104 and the HR v	om, the documented BP was				
	Review of Resident #	2's July 2024 eMAR				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		41 COBBI	LERS WAY		
HARMONY AT REYNOLDS MOUNTAIN  ASHEVIL			_E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 273	73 Continued From page 54		D 273		
	revealed:				
	-There was an entry	with a start date of 11/22/23			
	_	take one half tablet (25mg)			
	two times a day sche				
	•	pressure before morning			
	1	pressure was greater than			
		te (HR) was less than 65			
		notify MD if systolic blood			
	pressure (BP) greate				
	164/106 and the HR	am, the documented BP was			
	,	was 73. am, the documented BP was			
	164/108 and the HR				
		am, the documented BP was			
	166/95 and the HR w				
		om, the documented BP was			
	162/104 and the HR				
	-On 07/13/24 at 8:00	om, the documented BP was			
	187/108 and the HR				
		am, the documented BP was			
	170/76 and the HR w	as 73.			
	-On 07/19/24 at 8:00	am, the documented BP was			
	167/100 and the HR	was 73.			
		am, the documented BP was			
	171/98 and the HR w	as 93.			
		2's August 2024 eMAR			
	revealed:				
	_	with a start date of 11/22/23			
		take one half tablet (25mg)			
	two times a day sche				
	I	pressure before morning			
	1	pressure was greater than			
		te (HR) was less than 65 notify MD if systolic blood			
	pressure (BP) greate				
		am, the documented BP was			
	190/119 and the HR was 99.				

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170/99 and the HR was 70.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
ANDIEAN	or contraction	IDENTIFICATION NOMBER.	A. BUILDING: _	A. BUILDING:		
		HAL011361	B. WING		I	R <b>/20/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	HARMONY AT REYNOLDS MOUNTAIN  41 COBB					
_		ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 273	Continued From page 55		D 273			
	According to the National Institute of Health, a normal blood pressure for most adults is less than 120/80 mmHg.					
	Resident #2She was aware Resident #2 some of his medication -Resident #2's BP ware -She did not think she BPs for Resident #2's -She was trained to wooncerns in the physical stationThe physician book trained to communicate Review of the physician reveals	evealed: stered medications to  ident #2 was ordered to have rior to administration of on.  is "always high." had ever reported any high to the PCP. write entries about resident cian book at the nurses was the way they were ate concerns to the PCP. an book at the memory care ed there were no entries for				
	Resident #2 from June 2024-August 2024 regarding elevated BPs.  Review of Resident #2's electronic progress note entries from 05/09/24-08/14/24 revealed there were no entries regarding elevated BPs.  Interview with the Health and Wellness Director (HWD) on 08/16/24 at 8:32am revealed: -The MAs were supposed to follow the guidelines in the order for reporting BPs to the PCPIf the PCP wrote an order to contact them when a BP was outside of a certain parameter, then that was what should be done.  Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed if there was an					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL011361 B. WING			R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	τΔIN 41 COBBL	ERS WAY		
TIARRIGIA	TATRETHOEDO MICON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 56	D 273		
	order to report parameters to the PCP, the MAs were expected to reach out to the PCP by phone to report values outside the parameters.				
	08/19/24 at 8:55am re-She was not notified pressures during Jun-Resident #2 had an attack, stroke, and we when his blood press greater than 160She would have expnotify Hospice of the the PCP triage so that been made to Reside	of Resident #2's high blood e-August 2024. increased risk of heart brsening kidney disease ures were systolically ected the facility staff to high blood pressures and at adjustments could have ent #2's medications.			
	Telephone interview with Resident #2's hospice registered nurse (RN) on 08/16/24 at 12:16pm revealed:  -The facility staff had not reported Resident #2's high blood pressures to her.  -She was more concerned with staff reporting low BP as it might increase Resident #2's risk of falls.				
	Interview with the Corporate Clinical Specialist on 08/20/24 at 4:16pm revealed:  -The MAs should notify the PCP when they took an abnormal BP or HR.  -The RCD should email or call the PCP to let the PCP know what's going on with a residentIt was also acceptable for the MAs or RCD to fax vital sign results to the PCP and follow-up with a call to make sure they knew about abnormal values.				
	values.  Interview with the Administrator on 08/20/24 at 5:45pm revealed: -The MAs were responsible to follow the order the PCP wrote for Resident #2 concerning notification				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
						R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBB	LERS WAY			
		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 CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 57	D 273			
	of BP's and HR outsid	de the parameters. osed to notify the HWD and and HR's, so the HWD and				
	Based on observations, interviews and record review it was determined that Resident #2 was not interviewable.					
	(PCP) order dated 07 notify PCP via telehea #2 refused metoprolo	t #2's primary care provider //01/24 revealed please alth application if Resident I or if his blood pressure R) are out of parameters to rolol.				
	Review of Resident #2's July 2024 electronic medication administration record (eMAR) revealed:  -There was an entry with a start date of 11/22/23 for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure before morning dose if systolic BP was greater than 130 and or if HR was less than 65 hold medication and notify MD if systolic BP greater than 160.  -On 07/02/24 at 8:00am, there was no documented BP or HR, metoprolol was documented as not administered due to "patient refused medication."  -On 07/06/24 at 8:00am, the documented BP was 117/77 and the HR was 60, metoprolol was documented as not administered due to "BP out of range."  -On 07/07/24 at 8:00am, the documented BP was 122/78 and the HR was 69, metoprolol was documented as not administered due to "BP out					
		am, the documented BP was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL011361	B. WING		0:	R 8/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
нармон	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
HARMON	TAI RETNOLDS 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 ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 58	D 273			
	in range." -On 07/18/24 at 8:00p 111/80 and the HR wadocumented as not a order." -On 07/21/24 at 8:00p 126/80 and the HR wadocumented as not a order." -On 07/25/24 at 8:00p 122/83 and the HR wadocumented as not a in range." -On 07/28/24 at 8:00p 128/80 and the HR wadocumented as not a range." -On 07/31/24 at 8:00p 93/73 and the HR wa	dministered due to "BP not om, the documented BP was as 105, metoprolol was dministered due to "held per om, the documented BP was as 66, metoprolol was dministered due to "held per om, the documented BP was as 102, metoprolol was dministered due to "BP not om, the documented BP was as 99, metoprolol was dministered due to "out of om, the documented BP was as 99, metoprolol was dministered due to "out of om, the documented BP was so 99, metoprolol was dministered due to withheld				
	revealed: -There was an entry of for metoprolol 50mg to two times a day sche 8:00pm; check blood dose if systolic BP was less than 65 MD if systolic BP greating-on 08/02/24 at 8:00a 148/76 and the HR with documented as not a refused medication." -On 08/02/24 at 8:00a 103/65 and the HR with with the	pressure before morning as greater than 130 and or if hold medication and notify				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION			
			A. BUILDING:		COMPLETED	
		HAL011361	B. WING			R 3/ <b>20/2024</b>
NAME OF PR	OVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
		41 COBB	LERS WAY			
HARMONY	AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TION SHOULD BE ITHE APPROPRIATE	(X5) COMPLETE DATE
D 273	273 Continued From page 59		D 273			
	-On 08/04/24 at 8:00; 99/57 and the HR wa documented as not a in range." -On 08/05/24 at 8:00; 124/80 and the HR wa documented as not a order." -On 08/05/24 at 8:00; 125/84 and the HR wa documented as not a givenOn 08/07/24 at 8:00; documented BP or Hadocumented as not a refused medication." -On 08/08/24 at 8:00; 120/83 and the HR wadocumented as not a refused medication." -On 08/12/24 at 8:00; 120/83 and the HR wadocumented as not a per orderOn 08/12/24 at 8:00; 108/75 and the HR wadocumented as not a order." -On 08/13/24 at 8:00; 97/78 and the HR wadocumented as not a order." -On 08/14/24 at 8:00; 129/82 and the HR wadocumented as not a order." -On 08/14/24 at 8:00; 129/82 and the HR wadocumented as not a order." -On 08/14/24 at 10:14am -She had not contact care provider (PCP) to outside of ordered paragust 2024.	pm, the documented BP was as 61, metoprolol was dministered due to "BP not am, the documented BP was as 66, metoprolol was dministered due to "held per pm, the documented BP was as 84, metoprolol was dministered with no reason am, there was no R, metoprolol was dministered due to "patient pm, the documented BP was as 81, metoprolol was dministered due to withheld pm, the documented BP was as 87, metoprolol was dministered due to "held per pm, the documented BP was as 87, metoprolol was dministered due to "held per pm, the documented BP was as 75, metoprolol was dministered due to "held per pm, the documented BP was as 71, metoprolol was dministered due to "held per pm, the documented BP was as 71, metoprolol was dministered due to "med".				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		, , ,	(X3) DATE SURVEY COMPLETED	
			7.1. 56.25.1.16. <u>—</u>			R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	E, ZIP CODE		
		41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 60	D 273			
	a resident by docume book.	enting a note in the physician				
	nurses station in mer 10:38am revealed the book for Resident #2 regarding instances of administered due to of the medication.  Interview with the Re on 08/15/24 at 2:38p-If there was an orde PCP, the MAs were PCP by phone to repparametersThe MAs did not have application Resident written 07/01/24.	r to report parameters to the expected to reach out to the ort values outside the  ve access to the telehealth #2's PCP wrote in the order  and Wellness Director given access to the				
	Telephone interview on 08/15/24 at 4:36pm results of 15/24 at 4:36pm result	the facility notify her of BP but of parameter to brolol. the facility notify her if the metoprolol. ver" notified her of blood rates outside the parameters for Resident #2 or of the				
	revealed:	VD on 08/16/24 at 8:32am				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:					(3) DATE SURVEY COMPLETED		
			A. BUILDING:	A. BUILDING:		_	
		HAL011361	B. WING		08	R 8/ <b>20/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE			
LADMON	Y AT REYNOLDS MOUN	41 COBB	SLERS WAY				
HARMON	TAI RETNOLDS WOUN	ASHEVIL	LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From pag	e 61	D 273				
	to day operations in -Resident #2's PCP MondaysThere might be entr concerning issues th Resident #2The MAs should foll order and notify the Interview with the Co 08/20/24 at 4:16pm -The MAs could notif abnormal BP or HR medicationThe HWD could em PCP know what's go -It was also acceptal fax vital sign results	CP as she was over the day the memory care area. visited the facility weekly on ies in the provider book at required follow-up for ow the guidelines in the PCP PCP as per the order. orporate Clinical Specialist on revealed: fy the PCP when they took an or when a resident refused a ail or call the PCP to let the ing on with a resident. ole for the MAs or HWD to to the PCP and follow-up with they knew about abnormal					
	5:45pm revealed: -The MAs were resp PCP wrote for Resid of BP's and HR outs any refused medicat -The MAs were supp RCD about the BP's medications so the H up with the PCP.  Based on observation review it was determinatin	osed to notify the HWD and					
		coronary artery disease and					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION			
7.1.2.2.1.1		.52.11.11.07.11.01.11.01.12.11.	A. BUILDING: _		""	PLETED
						R
		HAL011361	B. WING	<del></del>	08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
IIA DMON	V AT DEVALOR DO MOUNT	41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUNT	IAIN ASHEVIL	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF COR	RECTION	(X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	COMPLETE DATE
D 273	Continued From page	e 62	D 273			
	hyportonsion					
	hypertension.  There was an order t	for clopidogrel (prevents				
		together and forming a				
	blood clot) 75mg one					
	, ,	for aspirin (used to lower				
		troke, or blood clot) 81mg				
	one tablet daily at bed					
	,					
	Review of the facility's	s fall response procedure				
	policy dated 03/18/19	revealed:				
	-Should a resident ex	perience a fall, staff will				
	provide immediate ca	re and follow through with				
	care planning.					
		I, caregivers are instructed				
		e assistance from the Health				
	Care Coordinator or N	<del>-</del>				
		ove the resident , except to				
	protect against furthe					
	-The Health Care Cod	, ,				
	, ,	performs a brief overview				
	and inspection for ble deformities.	eding and obvious				
		cks for range of motion				
	ability.	cks for range of motion				
	,	allow the resident to be				
		if the head did not receive				
		nor was struck during the				
	fall.					
		tacted immediately for				
	further instructions.	•				
	-If the resident had tra	auma resulting in deformity,				
		n level of consciousness or				
		d or significant trauma, the				
		Il summon emergency				
	medical services.					
		anticoagulants and there is a				
	II '='	ma, the HCC or caregiver				
	will summon emerger					
	, ,	after any fall, the HCC or				
	MA on each shift will	monitor the resident and				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
		HAL011361	B. WING		08	R / <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBB	LERS WAY			
HARWON	TAT KETHOEDS MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	Continued From page	e 63	D 273			
	made a brief narrative	e charting entry.				
	07/29/24 revealed: -Resident #10 fell in the pavementThe incident report in the incident.  Review of the 911 cald 1:37pm revealed "assimate in the incident report revealed: -On 07/29/24, she vision to the incident report revealed report report revealed report report revealed report r	tation 911 was contacted on out the resident was not for evaluation. tation the family was notified  Il entry dated 07/29/24 at sist subject up."  with Resident #10's primary on 08/19/24 at 8:55am  sited Resident #10 for a  ent #10 with bruises on his d gone to the emergency  ort Resident #10's fall and her visit. she received about the				
	(HWD) on 08/20/24 a -He recalled Resident parking lot as he was -Resident #10 said th car, but actually his fa from the car so he co	t #10 had a fall in the trying to start his car. e battery was dead in the amily removed the battery				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _	A. BUILDING:		150
		HAL011361	B. WING		08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL	ERS WAY			
TIARMON	TAT KETHOEDO MIOON	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 273	Continued From page	e 64	D 273			
	evaluation when they -The resident's PCP s about the fallHe did not know if th the fallThe incident report a documentation as to notified about the fall.  Telephone interview w attorney (POA) on 08 -Facility staff notified 07/29/24They told him Reside and "appeared to be of Resident #10 was no evaluation after the fallHe did not know if Re the hospital or he did hospital.	is to send residents out for hit their head with a fall. should have been notified about about the fall should have whether or not the PCP was with Resident #10's power of 1/20/24 at 10:14am revealed: him of Resident #10's fall on the fall in the parking lot ok."  obtail. esident #10 refused to go to not need to go to the allow Resident #10 to be				
	08/20/24 at 11:17am -Resident #10 should hospital for evaluation his head on pavemer -Resident #10 hit his	have been sent out to the n on 07/29/24 because he hit				
	08/20/24 at 4:16pm re- It was the facility's postruck their head duri the hospital to be "che- The POA could refus	olicy when a resident fell and ng the fall they should go to				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(Y2) MI II TIDI E	CONSTRUCTION	(X3) DATE S	I IDV/EV
	OF CORRECTION	IDENTIFICATION NUMBER:			COMPLE	
			A. BUILDING: _			
						<b>?</b>
		HAL011361	B. WING		08/2	0/2024
NAME OF D	DOVIDED OD SUDDIJED	STDEET A	DDBESS CITY STA	TE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	I E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
		ASHEVII	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOUL		COMPLETE DATE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	RIATE	DATE
D 273	Continued From page	e 65	D 273			
	this to the EMS response	` ,				
		(MA) was responsible for				
	calling 911, filling out	•				
		and notifying the PCP.				
	_	e MA through the process of				
	the facility's response					
		notified about every fall .				
		o the hospital for evaluation,				
		e summary should be placed				
		for the PCP to see on their				
	next visit to the facility	<del>-</del>				
		t go out to be evaluated the				
		ealth care concerns form				
	with the date and time					
		ınding the fall and place it in				
		r the PCP to see on their				
	next visit to the facility	у.				
		ministrator on 08/20/24 at				
	5:45pm revealed:					
		hould have followed the				
		r response to Resident #10's				
	fall on 07/29/24.					
		notified the PCP about				
	Resident #10's fall.	maticinal than LINAID at 1				
		notified the HWD about				
	Resident #10's fall.					
		onsible to follow-up with the				
	PCP about all issues	reported to them.				
	Dood an abarrati	oo intomious and no				
		ns, interviews and record				
		ned that Resident #10 was				
	not interviewable.	t #Elo ourront El O deted				
	-	t #5's current FL2 dated				
		agnoses included severe				
		nea, adenocarcinoma,				
	cerebrovascular accid	dent, and systematic lupus.				
	,	1 1 1 1 0 0 / 4 0 / 0 4				
		orders dated 06/10/24				
	revealed an order to (	check weekly weights.	1			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
					1 00/20/2021
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY		
		ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 273	Continued From page	e 66	D 273		
	medication administrative revealed: -There was an entry for the rewas a docume 06/12/24There was no docume 06/19/24There was a docume 06/26/24.  Review of Resident # revealed: -There was an entry for the rewas no docume 07/03/24There was no docume 07/10/24.	for weekly weights. ented weight of 92 lbs. on mented weight recorded on ented weight of 94.8 lbs. on 5's July 2024 eMAR for weekly weights. mented weight recorded on mented weight recorded on			
	-There was no documented weight recorded on 07/17/24There was a documented weight of 93.6 lbs. on 07/24/24There was no documented weight recorded on				
	07/31/24.  Review of Resident # revealed: -There was an entry f -There was a docume 08/07/24.	5's August 2024 eMAR			
	Interview with Reside 10:28am revealed: -She thought she was was not sure. -She had never refus	s getting weekly weights but			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	(X3) DATE SURVEY COMPLETED		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	-
HARMON	Y AT REYNOLDS MOUNT	'AIN	LERS WAY		
	I		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 CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
D 273	Continued From page	e 67	D 273		
	-She did not inform the refused to be weighed instructions on the eN she had never been to	evealed: efused to be weighed. e PCP when Resident #5 d because there were no MAR to inform the PCP and old to notify the PCP.			
	Care Provider (PCP) on 08/19/24 at 4:39pr -She had not been no for Resident #5.	lity's contracted Primary on 08/15/24 at 4:35pm and n revealed: tified of any weight refusals dvanced stage of lung			
	cancerWeekly weight recordings could help her become Hospice eligible and could help determine if she was declining in her healthShe expected staff to report weight refusals.				
	***************************************	n, insomnia, acute			
	revealed: -An order to obtain da -An order to notify Pri	order dated 05/13/24  nilly weights for monitoring.  mary Care Provider (PCP)  s. in 24 hours or 5 lbs. in one			
	medication administra revealed: -There was an entry f -There was an entry t				

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	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IND PLAN OF CORRECTION IDENTIFICATION NUMBER:		I ' '	(X2) MULTIPLE CONSTRUCTION			
			A. BUILDING:	A. BUILDING:			
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
		41 COBE	BLERS WAY				
HARMON	Y AT REYNOLDS MOUN	ITAIN ASHEVIL	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 OF (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 273	Continued From pag	ge 68	D 273				
	06/01/24, 06/02/24, 06/09/24, 06/09/24, 06/10/24, 06/10/24, 06/27/24, or 06/30/2 -There was a weight 06/03/24There was a weight 06/05/24There was a weight 06/08/24There was a weight 06/11/24There was a weight 06/12/24There was a weight 06/13/24 -There was a weight 06/13/24 -There was a weight 06/13/24	mented weight recorded on 06/04/24, 06/06/24, 06/07/24, 06/14/24-06/24/24, 06/26/24, 4. It recorded of 178.2 lbs. on recorded of 180.0 lbs. on recorded of 177.0 lbs. on recorded of 179.2 lbs. on recorded of 178.8 lbs. on recorded of 178.8 lbs. on recorded of 179.2 lbs. on					
		recorded of 179.6 lbs. on					
	revealed: -There was an entry -There was an entry gain of 3 lbs. in 24 h one weekThere was an entry weight checks at 11There was a weight 07/01/24There was no docu 07/02/24-07/06/24, 0 07/16/24-07/19/24, 0 07/28/24, 07/30/24, -There was a weight 07/07/24.	to notify physician of weight ours or 5 lbs. weight gain in dated 07/15/24 for morning 30am. recorded of 178.4 lbs. on mented weight recorded on 07/08/24, 07/10/24-07/14/24, 07/22/24, 07/23/24, 07/25/24,					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL	ERS WAY		
TIARRIOR	TAT KETHOLDO MOON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 273	Continued From page	e 69	D 273		
	07/15/24There was a weight of the control of the	recorded of 181.0 lbs. on recorded of 134 lbs. on recorded of 178.8 lbs. on recorded of 181.3 lbs. on recorded of 181.2 lbs. on recorded of 181.0 lbs. on recorded of 182.2 lbs. on			
	revealed: -There was an entry f -There was an entry f 11:30amThere was an entry t gain of 3 lbs. in 24 ho one weekThere was no docum 08/01/24-08/15/24There was a weight i 08/16/24There was a weight i 08/17/24There was a weight i 08/18/24.	or daily weights. o check weight daily at o notify physician of weight urs or 5 lbs. weight gain in ented weight recorded on recorded of 209.2 lbs. on recorded of 182.6 lbs. on recorded of 181.4 lbs. on			
	Primary Care Provide 4:35pm revealed: -Resident #13 had co	vith the facility's contracted or (PCP) on 08/15/24 at or gestive heart failure. or daily weight checks and			

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STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE S	
ANDILAN	O CONNECTION	IBENTI TOATION NOMBER.	A. BUILDING: _		OOWII E	LILD
			B WING		F	
		HAL011361	B. WING		08/2	0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	ERS WAY			
			.E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 273	Continued From page	e 70	D 273			
D 2/3	asked to be notified of monitor for early symfailure exacerbationSigns and symptoms Resident #13 include shortness of breath, and fatigueResident #13 had do of breath, peripheral of the exact without knowing Resident #13 had do of breath, peripheral of the exact without knowing Resident #13 had do of breath, peripheral of the exact without knowing Resident #13 had do of breath, peripheral of the exact without knowing Resident #13 had do of breath, peripheral of the exact without knowing Resident #13 had do of breath, peripheral of the exact without hospitalizationShe was not notified gainsShe expected to be interested weights or weight with the Resident #10 had and the exact with the Resident #10 had and that staff members herWeights should be of the exact with	of weight gains so she could ptoms of a congestive heart as she was watching for with d weight gain, edema, cough, increased heart rate eveloped a slight shortness edema, and cough. Sident #13's weight, she he was having early onset of the reand could possibly need of weight refusals or weight motified when residents eight gains was obtained.  Sident Care Director (RCD) am revealed: esident #13 on 06/20/24. The resident #13 on 06/20/24. The resident who weighed btained as ordered. To notify the RCD or the Director (HWD) for weight sals. The primary Care sponsibility to notify the PCP weight gain for Resident who keep attempting to try	DZIS			
	refuse 3 times in a ro -She expected staff to weights if weights we	w. b keep attempting to try				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		1141 044004	B. WING		R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ITE, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUNT	ASHEVILL	.ERS WAY .E, NC 28804		
0/0.15	SLIMMADV ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	N OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	Continued From page	: 71	D 273		
	on 08/20/24 at 4:39pr	n revealed:			
		another resident's weight on			
	Resident #13's eMAR	•			
	-She reported the inci				
	-She reported any we	ight refusals to the HWD.			
	Interview with the med	dication aide (MA) on			
	08/20/24 at 3:10pm re	, ,			
	-She was aware she	should notify the Primary			
Care Provider (PCP) about weight refusals or		about weight refusals or			
	missed weights.				
	-She had not been no				
	,	VD) or PCP because she			
	did not have time.	er medications to residents			
	on two separate floors				
	'				
		lity's contracted Primary			
		on 08/15/24 at 4:35pm and			
	on 08/19/24 at 4:39pr				
	-She expected orders	of any weight refusals.			
	instructed.	to be followed as			
		report weight refusals.			
		/D on 08/20/24 at 11:10am			
	revealed: -He was never told to	ensure staff obtained			
	weights as ordered.	crisure stail obtained			
	_	hat over" about a month			
	ago when he realized				
	-He expected MA's to				
	ordered.				
	-He expected MA's to				
		rs were not completed, he			
		ervisor and the supervisor			
	_	and talk to them about it. ity to be sure weights were			
	done and the PCP wa				
	GOIL GIRG HIE FOR WA	as notined.			

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MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY ASHEVILLE, NC 28804    (KA) ID PREFIX TAG   (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG   PROVIDER'S PLAN OF CORRECTION     (EACH OFFICIENCY ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DATE   DATE   DATE   DATE   DATE   DATE   DATE   DATE   CROSS-REFERENCED TO THE APPROPRIATE DATE   PROVIDER'S PLAN OF CORRECTION     (EACH ORDERITY & CORRECTION CROSS-REFERENCED TO THE APPROPRIATE DATE   DA		F OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE S	
NAME OF PROVIDER OR SUPPLIER  STREETADRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY.  A1 COBBLERS WAY.  A54 HUNLE, NC 28804     CACH DEFICIENCY MUST BE PRECEDED BY FULL RESULT FOR DEFICIENCIES RECOVERY MARKET STATEMENT OF DEFICIENCIES PUBLIC RECOVERY MARKET STATEMENT OF DEFICIENCIES PUBLIC RECOVERY MARKET STATEMENT OF DEFICIENCIES PUBLIC RECOVERY MARKET STATEMENT OF DEFICIENCIES RECOVERY MARKET STATEMENT OF DEFICIENCIES PUBLIC RECOVERY MARKET STATEMENT OF DEFICIENCIES PUBLIC RECOVERY MARKET STATEMENT OF DEFICIENCY MARKET STATEMENT OF DEFICIENCES TO MARKET STATEMENT OF DEFICIENCES STATEMENT OF DEFICIENCES TO MARKET STATEMENT OF DEFICIENCES TO MARKET STATEMENT OF DEFICIENCES TO MARKET STATEMENT OF DEFICIENC				A. BOILDING		_	
ARRIMONY AT REYNOLDS MOUNTAIN			HAL011361	B. WING		1	
(x4) ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCE) TO THE APPROPRIATE D 273  Continued From page 72  Interview with the supervisor on 08/20/24 at 11:39am revealed: -She did not notify the PCP's each time weights were not obtained as orderedShe notified the PCP weekly when they came to the facility to see residentsShe had never been told to notify the PCP after each refusal or missed weightIt was the responsibility of the HWD to make sure the PCPs were notified when weights were not obtained.  Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Missed or refused weights, and weight gains, needed to be documented and the PCP needed to be notified every timeIt was the HWD's responsibility to be sure the PCPs were notified of missed or refused weights.  Interview with the Administrator on 08/20/24 at 5:41pm revealed: -The PCP should be notified right away of missed or refused weightsLack of training and accountability could be reasons why PCP's had not been notified of	NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
SUMMARY STATEMENT OF DEFICIENCIES   PREFIX   TAG   PROVIDERS PLAN OF CORRECTION   CACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX TAG   PREFIX TAG   CROSS-REFERENCED TO THE APPROPRIATE   DATE   DATE	HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ				
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION)  D 273  Continued From page 72 Interview with the supervisor on 08/20/24 at 11:39am revealed: -She did not notify the PCP's each time weights were not obtained as orderedShe notified the PCP weekly when they came to the facility to see residentsShe had never been told to notify the PCP after each refusal or missed weightIt was the responsibility of the HWD to make sure the PCPs were notified when weights were not obtained.  Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Missed or refused weights, and weight gains, needed to be documented and the PCP needed to be notified every timeIt was the HWD's responsibility to be sure the PCPs were notified of missed or refused weights.  Interview with the Administrator on 08/20/24 at 5:41pm revealed: -The PCP should be notified right away of missed or refused weightsLack of training and accountability could be reasons why PCP's had not been notified of		I	ASHEVILL	E, NC 28804			
Interview with the supervisor on 08/20/24 at 11:39am revealed: -She did not notify the PCP's each time weights were not obtained as orderedShe notified the PCP weekly when they came to the facility to see residentsShe had never been told to notify the PCP after each refusal or missed weightIt was the responsibility of the HWD to make sure the PCPs were notified when weights were not obtained.  Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Missed or refused weights, and weight gains, needed to be documented and the PCP needed to be notified every timeIt was the HWD's responsibility to be sure the PCPs were notified of missed or refused weights.  Interview with the Administrator on 08/20/24 at 5:41pm revealed: -The PCP should be notified right away of missed or refused weightsLack of training and accountability could be reasons why PCP's had not been notified of	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI	BE	COMPLETE
11:39am revealed: -She did not notify the PCP's each time weights were not obtained as orderedShe notified the PCP weekly when they came to the facility to see residentsShe had never been told to notify the PCP after each refusal or missed weightIt was the responsibility of the HWD to make sure the PCPs were notified when weights were not obtained.  Interview with the Corporate Clinical Specialist (CCS) on 08/20/24 at 3:35pm revealed: -Missed or refused weights, and weight gains, needed to be documented and the PCP needed to be notified every timeIt was the HWD's responsibility to be sure the PCPs were notified of missed or refused weights.  Interview with the Administrator on 08/20/24 at 5:41pm revealed: -The PCP should be notified right away of missed or refused weightsLack of training and accountability could be reasons why PCP's had not been notified of	D 273	Continued From page	e 72	D 273			
-The MAs were responsible to notify PCP's right away on each missed or refused weights and weight gainsThe HWD and the Resident Care Director (RCD) were responsible for making sure PCPs were notified.  7. Review of Resident #4's current FL2 dated 05/13/24 diagnoses included hyperlipidemia and memory impairment.  Review of Resident #4's Resident Register		Interview with the sup 11:39am revealed: -She did not notify the were not obtained as -She notified the PCF the facility to see resignation and the facility to see the facility to see resignation and the facility to see the facility t	pervisor on 08/20/24 at e PCP's each time weights ordered. P weekly when they came to dents. told to notify the PCP after ad weight. lity of the HWD to make notified when weights were  rporate Clinical Specialist a:3:35pm revealed: eights, and weight gains, ented and the PCP needed me. sponsibility to be sure the f missed or refused weights. ministrator on 08/20/24 at notified right away of missed accountability could be ad not been notified of possible to notify PCP's right or refused weights and resident Care Director (RCD) making sure PCPs were  t #4's current FL2 dated included hyperlipidemia and				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE	SURVEY LETED
			A. BUILDING: _			_
		HAL011361	B. WING		I	R <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ODRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
	OUR MAA DV OT			DDOL/IDEDIO DI ANI OF	00000000000	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273	Continued From page	e 73	D 273			
	dated 07/04/24 reveal -She was brought to following a fall where -Resident was assess found.	the emergency room				
	Review of emergency room discharge summary dated 07/16/24 revealed: -She was brought to the emergency room following a fall where she hit her headCT showed a "closed head injury with no fracture"An order was given for follow-up with PCP within 48 hoursResident #4 was discharged back to the facility on 07/16/24.					
	dated 07/04/24 reveal -Resident #4 was four bathroom after an uning-She stated to staff stated to staff stated to staff stated.	ind sitting on the floor in her				
	dated 07/16/24 reveal-Resident #4 had actipendantResponding facility sher roomThe resident was obher head and it was bar-Resident #4 was ser	ivated her emergency staff found her on the floor of served to have a "bump on bleeding". ht to the ER.				
	Interview with the Pri	mary Care Provider (PCP)				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08	R 8/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN		BLERS WAY			
HARWON	TAT RETNOLDS MOUN	ASHEVII	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 ACTIV CROSS-REFERENCED TO TI DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 273	D 273 Continued From page 74 on 08/19/24 at 05:00pm revealed:		D 273			
	-She was not informed the ER on either occurs of the ER on either occurs. She was not informed injury".  -An untreated closed headaches, confusion status changes.  -A follow-up examinal	hed of either fall. Hed of resident being sent to assion. Hed of the "closed head" Head injury could result in n, possible bleeding, mental tion within 48 hours was appropriate treatment and				
	(HWD) on 08/20/24 a -He was responsible notified of any reside including hospitalizat -He would review the orders if resident retu he was workingHe didn't realize Res follow-up with the PC "missed" itStaff working at the could place the resid the week.	for ensuring the PCP was nt related health concerns ions. hospital discharge notes for urned to the facility on a day sident #4 required a 48 hour CP after the head injury, he time of the resident's return ent on the physicians list for for ensuring provider				
	05/29/24 revealed did mellitus type 2, Parki hypertension, and bat Review of Primary Codated 06/24/24 reveal -There was an order blood sugar) 10mg ta	llance instability. are Provider (PCP) order				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
						R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
HARMON	V AT DEVIOU DE MOUNT	41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUNT	ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 273	D 273 Continued From page 75		D 273			
	blood sugar was less	than 200.				
	medication administrative revealed:  -There was an entry fill blood sugar) 10mg tate daily at 8:00am for disphysician in blood sugar.  - On 06/26/24 at 11:0 was 181, there was dwas administered, and documentation PCP was 123, there was dwas administered, and documentation PCP was 136, there was dwas administered, and documentation PCP was 136, there was dwas administered, and documentation PCP was 123, there was dwas 123, there was dwas administered, and documentation PCP was 123, there was dwas administered, and documentation PCP was 124 at 8:00	for Jardiance (used to lower blet, take one tablet once abetes, hold and notify gar was less than 200.  8am, the documented FSBS ocumentation Jardiance d there was no was notified.  1am, the documented FSBS ocumentation Jardiance d there was no was notified.  4 am, the documented FSBS ocumentation Jardiance d there was no was notified.  5 am, the documented FSBS ocumentation Jardiance d there was no was notified.  5 am, the documented FSBS ocumentation Jardiance d there was no was notified.  am, the documented FSBS ocumentation Jardiance d there was no was notified.				
	medication administrative revealed:					
	-There was an entry f take one tablet once hold and notify physic than 200.	for Jardiance 10mg tablet, daily at 8:00am for diabetes, cian in blood sugar is less				
	was 110, there was d	ocumentation Jardiance was ere was no documentation				

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STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
. WILL I LAW			A. BUILDING: _		
		1141 044004	B WING		R
		HAL011361	D. WING		08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBB	LERS WAY		
	. 711 112 1110 230 1110 0111	ASHEVIL	_E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 273	73 Continued From page 76		D 273		
	PCP was notified.				
	-	4am, the documented FSBS			
		ocumentation Jardiance was			
		ere was no documentation			
	PCP was notified.	ore was no assumentation			
	_	2am, the documented FSBS			
		locumentation Jardiance			
	was administered, an				
	documentation PCP v	was notified.			
	-On 07/05/24 at 9:19a	am, the documented FSBS			
	was 133, there was d	locumentation Jardiance			
	was administered, an				
	documentation PCP v				
		am, the documented FSBS			
		locumentation the Jardiance			
	was notified.	vas no documentation PCP			
		am, the documented FSBS			
		locumentation Jardiance			
	was administered, an				
	documentation PCP v				
		7am, the documented FSBS			
	was held, and there v	ocumentation the Jardiance vas no documentation PCP			
	was notified.	Sam the decumented ESPS			
		6am, the documented FSBS locumentation the Jardiance			
		vas no documentation PCP			
	was netified.	vas no documentation i Ci			
		am, the documented FSBS			
		locumentation the Jardiance			
		vas no documentation PCP			
	was notified.				
	-On 07/11/24 at 8:25a	am, the documented FSBS			
		ocumentation the Jardiance			
	was held, and there was notified.	vas no documentation PCP			
	-On 07/12/24 at 8:32a	am, the documented FSBS			
		locumentation Jardiance			

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was administered, and there was no

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SUR	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETE	בט
			D WING		R	
		HAL011361	B. WING		08/20/2	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBBL	ERS WAY			
HARWON	TAI RETNOLDS MOUNT	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
	was 153, the medicat no documentation PC -On 07/14/24 at 8:24a was 102, there was d	n, the documented FSBS ion was held, and there was				
	was notified.  -On 07/15/24 at 8:00am, the documented FSBS was "not recorded", there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/16/24 at 8:09am, the documented FSBS was 127, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/17/24 at 8:36am, the documented FSBS was 132, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/18/24 at 08:28am, the documented FSBS					
	was held, and there was notifiedOn 07/19/24 at 07:57 was 107, there was dwas held, and there was notified.	ocumentation the Jardiance vas no documentation PCP  ram, the documented FSBS ocumentation the Jardiance vas no documentation PCP				
	was 119, there was d administered, and the PCP was notified. -On 07/21/24 at 07:42	am, the documented FSBS ocumentation Jardiance was ere was no documentation  2am, the documented FSBS ocumentation the Jardiance				
	was held, and there was notifiedOn 07/22/24 at 09:06 was 115, there was d	ovas no documentation PCP Sam, the documented FSBS ocumentation the Jardiance vas no documentation PCP				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SI	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	: IED
					R	
		HAL011361	B. WING		08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	ITE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBBL	ERS WAY			
HARWON	TAT RETNOLDS MOUNT	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
	was 126, there was d was held, and there was notifiedOn 07/24/24 at 7:53a was "not recorded", the Jardiance was held, a documentation PCP was 110, there was d was held, and there was notifiedOn 07/26/24 at 7:54a	was notified.  am, the documented FSBS ocumentation the Jardiance was no documentation PCP  am, the documented FSBS				
	was 116, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/27/24 at 8:20am, the documented FSBS was 123, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/28/24 at 8:25am, the documented FSBS was 136, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/29/24 at 8:27am, the documented FSBS was 148, there was documentation the Jardiance was held, and there was no documentation PCP was notified.  -On 07/30/24 at 8:03am, the documented FSBS was 118, there was documentation the Jardiance					
	was notified. -On 07/31/24 at 8:00a was 120, there was d	_				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ATE, ZIP CODE	
		41 COBB	LERS WAY		
HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVIL	LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	FION (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
D 273	273 Continued From page 79		D 273		
	-There was an entry f	or Jardiance 10mg tablet,			
		daily at 8:00am for diabetes,			
		cian in blood sugar is less			
	than 200.				
	-On 08/01/24 at 8:00a	am, the documented FSBS			
	was 110, there was d	ocumentation the Jardiance			
	was held, and there v	vas no documentation PCP			
	was notified.				
		am, the documented FSBS			
	· ·	ocumentation the Jardiance			
	· ·	vas no documentation PCP			
	was notified.				
		am, the documented FSBS			
	· ·	ocumentation Jardiance			
	was administered, an documentation PCP v				
	_	am, the documented FSBS			
		ocumentation the Jardiance			
	· ·	vas no documentation PCP			
	was notified.	rae ne accamentation i ei			
	-On 08/05/24 at 9:06a	am, the documented FSBS			
	was 106, there was d	ocumentation the Jardiance			
	was held, and there v	vas no documentation PCP			
	was notified.				
	-On 08/06/24 at 8:18a	am, the documented FSBS			
	· ·	cumentation the Jardiance			
	· ·	vas no documentation PCP			
	was notified.	the deciment of 5000			
		am, the documented FSBS			
	Jardiance was held, a	nere was documentation the			
	documentation PCP v				
	_	am, the documented FSBS			
		ocumentation the Jardiance			
	· ·	vas no documentation PCP			
	was notified.				
		am, the documented FSBS			
		ocumentation the Jardiance			
	· ·	vas no documentation PCP			
	was notified.				

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AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` '	ONSTRUCTION		E SURVEY PLETED
		A. BUILDING:			
	HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF PROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	, ZIP CODE		
	41 COBB	BLERS WAY			
HARMONY AT REYNOLDS MOUNTA	AIN .	LE, NC 28804			
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO ' DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 273 Continued From page 8	D 273 Continued From page 80				
-On 08/10/24 at 7:08an was 114, there was do administered, and there PCP was notifiedOn 08/11/24 at 8:08an was 136, there was do was held, and there was notifiedOn 08/12/24 at 8:08an was 132, there was do was held, and there was notifiedOn 08/13/24 at 7:44an was 140, there was do was held, and there was notifiedOn 08/14/24 at 8:05an was 135, there was do was held, and there was notifiedOn 08/15/24 at 8:53an was 140, there was do was held, and there was notifiedOn 08/15/24 at 8:53an was 140, there was do was held, and there was notifiedOn 08/16/24 at 8:35an was 143, there was do was held, and there was notifiedOn 08/16/24 at 8:35an was 143, there was do was held, and there was notifiedOn 08/16/24 at 8:35an was 143, there was do was held, and there was notifiedInterview with PCP on revealed: -She was not informed June, July or August 20,-She was not informed administered despite the	in, the documented FSBS cumentation Jardiance was a was no documentation in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in, the documented FSBS cumentation the Jardiance as no documentation PCP in the documented FSBS cumentation the Jardiance as no documentation PCP in the	D 273			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HADMON	V AT DEVNOI DO MOUN	41 COBB	LERS WAY		
HARMON	Y AT REYNOLDS MOUN	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRI DEFICIENCY)	JLD BE COMPLETE
D 273	Continued From page 81		D 273		
	O8/16/24 at 10:48am -She did not realize suchen it was to be he paying attention to the She was responsible if medications were limitedShe was responsible administration regardShe was responsible administration regard. Interview with the He (HWD) on 08/20/24 and -He instructed the Monon a daily basisUltimately he was responsible holes and refusals a attention to any paraigust that they were and He was responsible notified of any reside including missed or limited from the suddentified of any reside including missed or limited from the facility failed to might a such the suddentified to might a such the suddentified to might a such that they were and the such that they were an attention to any paraigust that they were attention to any paraigust that they were an atten	she had given the medication and because she was not be parameters.  e for contacting the physician held, administered late, or the for communication with ding resident issues.  Bealth and Wellness Director at 4:45pm revealed:  As to complete eMAR audits the eMAR audits the eMAR, he looked for and he did not pay close the meters to hold medications, dministered.  For ensuring PCP was the related health concerns the medications.  OA NCAC 13F .1004(a) the medication of the medi			
	notified and on 07/12 episode and the PCF a delay of care and t hypoxia leading to R	rmed, the PCP was not 2/24 a second choking P was not notified resulted in reatment for aspiration and esident #1's death on This failure resulted in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
74101 2741	or contraction	IDENTIFICATION NO.	A. BUILDING: _		
	HAL011361 B. WING			R 08/20/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL ASHEVILL	ERS WAY E, NC 28804		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	I (X5)
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 273	Continued From page 82		D 273		
	constitutes a Type A1 Violation.  The facility provided a plan of protection in accordance with G.S. 131D-34 08/15/24.  THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 19, 2024.				
D 276	10A NCAC 13F .0902	2(c)(3-4) Health Care	D 276		
	10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.				
	This Rule is not met a TYPE A2 VIOLATION				
	reviews, the facility fa 5 of 13 sampled resid #11) related to urinaly #11) and application a	ns, interviews, and record iled to implement orders for ents (#2, #3, #6, #9, and reis lab collections (#2 and and removal of compression and #11) and obtaining ars (#3).			
	The findings are:				
		nt #2's current FL2 dated agnoses included multiple s, and dementia.			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
			A. BOILDING.			<b>D</b>
		HAL011361	B. WING		08	R / <b>20/2024</b>
NAME OF B	ROVIDER OR SUPPLIER	CTDEET A	DDRESS, CITY, STATE	ZIR CODE	, ,	
NAME OF P	ROVIDER OR SUPPLIER		BLERS WAY	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	HE APPROPRIATE	COMPLETE DATE
D 276 Continued From page 83		D 276				
	(PCP) progress note	at #2's primary care provider dated 06/10/24 revealed odor to Resident #2's urine inence.				
	Review of Resident #2's PCP order dated 06/10/24 revealed: -Please obtain urine sample for urinalysis and					
	reflex to cultureCall lab when ready.					
	Review of Resident #2's PCP progress note dated 06/24/24 revealed Resident #2 continued to have issues with frequency with urination.					
	Review of Resident #2's PCP order dated 06/24/24 revealed: -Please obtain urine sample for urinalysis and					
	reflex to cultureCall lab when ready.					
	Review of Resident #2's record revealed there were no urinalysis results or urine culture results for June 2024 or July 2024.					
	Interview with the Resident Care Director (RCD) on 08/15/24 at 2:38pm revealed: -She did not see the urinalysis and culture for Resident #2 written down on the staff's 24 hour report sheets around the dates of 06/10/24 and					
	06/24/24She did not know if t samples on Resident -She did not know if t trained on putting orce	he staff collected urine #2 for 06/10/24 or 06/24/24. he staff were properly lers on the 24 hour report e staff were aware the urine				
	-Resident #2's orders was prior to her starti	or collected.  If or urinalysis and cultures  If or work at the facility.  If or inection (HWD) would				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL011361	B. WING		30	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN		BLERS WAY			
HARWON	TAT RETNOLDS WOON	ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	IATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From pag	e 84	D 276			
	have been responsible labs were completed	ole at that time to ensure the as ordered.				
		#2's record revealed the d to Hospice on 07/05/24.				
	08/19/24 at 8:55am r -The urinalysis and r Resident #2 in June -Staff reported Resid urinary tract infection increased frequency -A benign urinary trackidney infectionKidney infection councesident #2 at an incomplete at an incomplete at a second threatening condition body's immune systems to infection, causing Telephone interview	eflex cultures she ordered for 2024 were never collected. Jent #2 had symptoms of a including odor and ct infection could turn into a lid cause delirium and put creased risk for falls. Dould turn into sepsis (a life in that happened when the em had an extreme response				
	urinary frequency an -She obtained an ord treat urinary tract infe	desident #2 was experiencing durgency.  der for Bactrim DS (used to ection) on 08/06/24 for him.  a urinalysis was obtained				
	08/20/24 at 4:16pm r -Resident #2's orders cultures ordered on 0 not completed. -The staff were to att sample for three day	s for urinalysis and reflex 06/10/24 and 06/24/24 were empt to collect a urine				

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	FOF DEFICIENCIES DF CORRECTION	` '		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL 044264	B. WING		R	
		HAL011361	2		08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN	.ERS WAY .E, NC 28804			
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	DN (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLÉTE	
D 276	Continued From page	e 85	D 276			
		supposed to notify the PCP to collect the urine sample.				
	Interview with the Adr 5:45pm revealed:	ninistrator on 08/20/24 at				
	-The medication aides	s (MAs) were responsible				
	_	mples for ordered labs. ble to collect a urine sample,				
		e to tell the Health and				
	Wellness Director (H\					
	<ul><li>The HWD was respo they were unable to c</li></ul>	nsible for notifying the PCP				
	andy word unable to a	oncot a anno campio.				
		ns, interviews, and record ned Resident #2 was not				
	(PCP) order dated 10	t #2's primary care provider /11/23 revealed an order to on and compression hose.				
	Review of Resident #	2's DCD order dated				
	05/09/24 revealed ap (TED hose-thrombo-e stockings that help pr	ply compression stockings embolic deterrent hose are				
	Review of Resident #	2's PCP order dated				
	0.70.72	sident #2 for TED hose.				
	medication administra 06/17/24-06/30/24 rev -There was an entry f leg every morning for bedtime scheduled at	or TED hose apply to each edema and remove at				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STATE	E. ZIP CODE	·	
			SLERS WAY	-,:		
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	to "not in cart."  -On 06/24/24, the TE to "waiting on measur."  -On 06/30/24, the TE to "not in cart."  Review of Resident # revealed:  -There was an entry f (starting 06/17/24) ap morning for edema ar scheduled at 8:00am  -The TED hose were occurrences out of 31 -On 07/02/24, TED ho "patient refused."  -On 07/03/24, TED ho "waiting on pharmacy -On 07/04/24, TED ho "not in cart."  -On 07/06/24, TED ho "not in cart."  -On 07/07/24, TED ho "not in cart."  -On 07/08/24, TED ho "not in cart."  -On 07/12/24, TED ho "not in cart."  -On 07/15/24, TED ho "not in cart."  -On 07/15/24, TED ho "need measurements"  -On 07/18/24, TED ho "not in cart."	D hose were not applied due rements." D hose were not applied due rements." D hose were not applied due 2's July 2024 eMAR  for TED hose knee hi (1 pair) ply to each leg every not remove at bedtime and 8:00pm. documented as applied 19 opportunities. ose were not applied due to refill requested." ose were not applied due to	D 276	DEFICIENC	1)	
	"resident does not ha	ose were not applied due to ve TED hose." 2's August 2024 eMAR				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		I \ '	E SURVEY PLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBB	LERS WAY			
		ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	FATEMENT OF DEFICIENCIES FY 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) COMPLETE DATE
D 276	revealed: -There was an entry (starting 06/17/24) at morning for edema at scheduled at 8:00 am - The TED hose were occurrence out of 1 cross - Telephone interview facility's contracted point 1:50 pm revealed: -They received the most of 1:50 pm revealed: -The swelling in his legsShe ordered TED hose swelling under control more diuretic medical Resident #2's fall risk.  Interview with the Cool 08/20/24 at 4:16 pm responsible for meas TED hose for resider - The Health and Wel responsible for supple hose to the facility's contract responsible for supple hose to the facility for - It should not take an an order was written hose in the facility.  Based on observation	for TED hose knee hi (1 pair) oply to each leg every and remove at bedtime and 8:00pm. documented as applied 1 opportunity. discontinued on 08/02/24.  with a pharmacist from the charmacy on 08/15/24 at heasurements for Resident 6/10/24. hose were sent to the facility  with Resident #2's PCP on evealed: art failure which caused  ose to try and keep the ol without having to order attion which could increase c.  orporate Clinical Specialist on revealed: lness Director (HWD) was suring residents to obtain ants. cited pharmacy was lying the correctly sized TED	D 276			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED	
						R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE,	ZIP CODE		
HARMON	V 47 DEVALOU DO MOUIN	41 COBI	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	ITAIN 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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	TON SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From pag	ne 88	D 276			
	interviewable.					
	10/10/23 revealed di	nt #11's current FL2 dated agnoses included chronic Alzheimer's disease, and on.				
		nt #11's primary care provider 5/09/24 revealed please n reflex to culture.				
	05/15/24 revealed: -Please collect urine culture.	#11's PCP order dated for urinalysis with reflex to				
	-Please call lab when	n ready.				
	05/20/24 revealed: -Please collect urine -Call lab when ready	used to treat infection)				
	08/19/24 at 8:55am of a collection of a collec	with Resident #11's PCP on revealed: urine sample for a urinalysis dent #11 was "dragged out for ct infection could turn into a ould turn into sepsis (a life in that happened when the				
	body's immune syste to infection, causing Interview with the Re on 08/19/24 at 4:24p -Resident #11's orde	em had an extreme response organ dysfunction). esident Care Director (RCD)				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	'AIN	.ERS WAY .E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES  / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 276	facility and she did not not collected at the tire. Interview with the Cor 08/20/24 at 4:16pm re-The staff were to atte sample for three dayself the staff were unable three days, they were they had been unable. Interview with the Adr 5:45pm revealed:  The medication aider for collecting urine sale of the MAs were unable were responsible. Wellness Director (HV-The HWD was responsible were unable to compare they were they were they were unable to compare they were they were unable to compare they were t	lected until 05/29/24. In her employment at the toknow why the urine was the of the first order.  Imporate Clinical Specialist on evealed: Imporate to collect a urine Index to collect the urine within supposed to notify the PCP to collect the urine sample.  Ininistrator on 08/20/24 at the set (MAs) were responsible emples for ordered labs. Index to tell the Health and the within supposed to notifying the PCP to collect a urine sample, at the tell the Health and the within supposed to notifying the PCP to collect a urine sample.  In the set of the urine sample is the tell the Health and the within supposed to the urine sample.  In the set of the urine sample is the tell the Health and the within sample is the tell the Health and the within sample.  It set the urine sample is the tell the Health and the within sample is the tell the Health and the within sample is the tell the Health and the within sample is the tell t	D 276		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08	R 8/ <b>20/2024</b>
					1 90	,,,,,
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	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 ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From pag	je 90	D 276			
		#11's PCP order dated iscontinue order for TED				
		#11's PCP order dated iscontinue order for TED				
	medication administration revealed:	#11's June 2024 electronic ration record (eMAR) for TED hose knee hi apply				
		orning for edema and remove asurements scheduled at .				
	-TED hose were doc occurrences out of 3	cumented as applied 14 0 opportunities.				
	not applied due to "r					
	· ·	nose were documented as need measurements waiting				
		nose were documented as not in cart."				
	not applied due to "r					
	not applied due to "r					
	not applied due to "r					
	not applied due to "o					
	not applied due to "r					
	not applied due to "r	nose were documented as not were documented as not				
	applied due to "not in					
	not applied due to "r	nose were documented as not in cart."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
						R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΓAIN	BLERS WAY			
		ASHEVII	LLE, 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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 276	Continued From page	91	D 276			
	-On 06/14/24, TED he not applied due to "not applied due to "wo-On 06/24/24, TED he not applied due to "wo-On 06/30/24, TED he not applied due to "wo-On 06/30/24, TED he not applied due to "wo-On 06/30/24) for TED ho every morning for edescheduled at 8:00 am -TED hose were doctoccurrences out of 16-On 07/01/24, TED he not applied due to "not ap	ose were documented as of in cart."  ose were documented as of available."  ose were documented as of in cart."  ose were documented as aiting on pharmacy."  ose were documented as a policity of a poportunities.  ose were documented as one of a poportunities.  ose were documented as one of in cart."  ose were documented as of in cart."				
	08/15/24 at 4:36pm re	with Resident #11's PCP on evealed she had written an or Resident #11 and it was				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
			A. BOILDING		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LERS WAY		
	T	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE COMPLETE
D 276	Continued From page	92	D 276		
	(HWD) on 08/16/24 a -He remembered mea TED hoseHe sent the measure -He did not know if th delivered by the phan Interview with the Coi 08/20/24 at 4:16pm re -The HWD was responsible to obtain TE -The facility's contract responsible for supply hose to the facility for -It should not take any	ements to the pharmacy. e TED hose were ever macy for Resident #11.  rporate Clinical Specialist on evealed: onsible for measuring ED hose for residents. ted pharmacy was ying the correctly sized TED			
		ns, interviews, and record ned Resident #11 was a not			
	05/13/24 revealed dia	t #9's current FL2 dated agnoses included benign hypertension, dementia, isease.			
	05/29/24 revealed an	9's physician order dated order for knee length TED al legs in the morning and r circulation).			
	Medication Administra revealed: -There was an entry f	or TED hose knee high s in the morning and remove			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		A. BUILDING	A. BOILDING.			
	HAL011361	B. WING		08	R 3/ <b>20/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE			
	41 COBE	BLERS WAY				
HARMONY AT REYNOLDS MOUNTAIN		LLE, NC 28804				
PREFIX (EACH DEFICIENCY MU	MENT OF DEFICIENCIES UST BE PRECEDED BY FULL 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 276 Continued From page 93	3	D 276				
-There was documentation TED hose on 06/03/24 at an an armoved on 06/03/24 at an an armoved on 06/03/24 at an armoved on 06/09/24 at an armoved on 06/14/24 at an armoved on 06/14/24 at an armoved on 06/14/24 at an armoved on 06/18/24 at an armoved on 06/21/24-06. There was documentation armoved on 06/21/24-06. There was documentation armoved on 06/23/24 at an armoved on 06/23/24 at an armoved on 06/25/24 at an armoved on 06/25/24-06. There was documentation armoved on 06/25/24-06. There was documentatio	on the resident refused to 8:00am. on the TED hose were 8:00pm. on the TED hose were 8:00pm. on the TED hose were 8:00pm. tation recorded on the TED hose were 8:00pm. on the TED hose were 8:00pm. on the resident refused to 8:00am. on the TED hose were 8:00pm. tation recorded on the TED hose were 8:00pm. on the TED hose were 8:00pm. on the TED hose were 8:00pm. on the resident refused to 8:00am. on the resident TED hose were 8:00pm. on the resident D hose on 06/26/24 at 8:00pm. on the TED hose were 1/26/24 at 8:00pm. on the TED hose were 1/26/24 at 8:00pm. on the resident D hose on 06/28/24 at 1/20 Dhose Dhose On 06/28/24 at 1/20 Dhose D					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	41 COBB	LERS WAY		
HARIMON	TAI RETNOLDS MOUN	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETE
D 276	Continued From page	e 94	D 276		
	-There was documen administered the TED 8:00amThere was documen removed on 07/07/24 -There was no documen removed on 07/14/24 -There was documen self-administered the 8:00amThere was documen removed on 07/15/24 -There was no documen removed on 07/18/24 -There was documen self-administered the 07/20/24-07/21/24 at -There was documen removed on 07/20/24 -There was documen removed on 07/20/24	tation the resident self D hose on 07/07/24 at  Itation the TED hose were A at 8:00pm. Inentation the TED hose were A at 8:00pm. Itation the resident TED hose on 07/15/24 at  Itation the TED hose were A at 8:00pm. Inentation the TED hose were A at 8:00pm. Itation the resident TED hose on B:00am. Itation the TED hose were A-07/21/24 at 8:00pm. Itation the TED hose were Into 07/26/24 at 8:00am. Itation the TED hose were Into 07/26/24 at 8:00am. Itation the TED hose were Itation the TED hose were Into 07/26/24 at 8:00am. Itation the TED hose were			
	revealed: -There was an entry to (apply to bilateral legated bedtime for circulation at bedtime for circulation).	ntation the resident self D hose 08/07/24 at 8:00am. Itation the TED were			
	revealed: -He used to wear TEI them in a whileHe was not sure the	ent #9 on 08/16/24 at 9:00am  D hose but had not worn  last time he wore them. ere his TED hose were.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMIT LETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	ORESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL	ERS WAY .E, NC 28804		
0(1) 15	STIMMADA ST	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION	IN OVE
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 276	Continued From page	e 95	D 276		
		nytime recently that anyone TED hose or take them off.			
	Observation of Resid 3:14pm revealed:	ent #9 on 08/16/24 at			
	-He was not wearing -Edema to his bilatera observed.	TED hose. al extremities was not			
	Interview with a MA or revealed:	on 08/16/24 at 3:18pm			
	hose on Resident #9	the eMAR that she put TED on 08/16/24 at 8:00am. e put them on himself, but			
	she never checked.	•			
	-Resident #9 was ind his TED hose on him	ependent and wanted to put self.			
	3:10pm revealed:	nd MA on 08/20/24 at			
	independently.	applied his TED hose			
	had put TED hose on	cumented on the eMAR she Resident #9, she would e sure he was wearing them.			
	Interview with a perso 08/16/24 at 3:26pm re	onal care aide (PCA) on			
		ed Resident #9 wearing TED			
	reminders to go to me				
	himself.	s of daily living (ADLs)			
	-She was not sure if hose.	ne could apply his own TED			
		with the facility's contracted er (PCP) on 08/19/24 at			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE	SURVEY LETED
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMP	LETED
		HAL011361	B. WING		l l	R <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE	1 00	
			LERS WAY	,		
HARMON'	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
()(4) ID	SLIMMARY ST	ATEMENT OF DEFICIENCIES	<u> </u>	PROVIDER'S PLAN OF COR	PECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 276	Continued From page	e 96	D 276			
	-Resident #9 suffered -He had swelling in h -She wrote an order of to have TED hoseThe order required in be takenShe was unsure if th doneShe did not think Re hose put on him at al -She wanted him to w not have to be put on -The fluid pills could of lower, resulting in diz -Fluid pills could also the bathroom more fr	d from heart failure. is legs. on 05/13/24 for Resident #9 neasurements of his legs to ne measurements ever got sident #9 was getting TED l. vear TED hose so he would higher doses of fluid pills. cause blood pressure to ziness and falls. cause Resident #9 to go to				
	(HWD) on 08/20/24 a -He expected staff to #9 dailyHe completed the m on 06/10/24He was not sure why measurements when 05/13/24He thought he mayb measurements twiceHe did not know Res TED hose applied da -He did not think Res on himselfIt was the responsible hose to Resident #9It was his responsible	apply TED hose to Resident easurements for TED hose  it took so long to get the order was written on e had to send the but he was unsure. sident #9 was not getting				
		rporate Clinical Specialist				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
711012111	or contraction	BENTI IOMION NOMBER.	A. BUILDING: _		
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	FAIN 41 COBBL	ERS WAY .E, NC 28804		
	OLIMANA DV. OT		1	DDOWDEDIO DI ANI OF CODDECTIO	<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276	Continued From page	97	D 276		
	(CCS) on 08/20/24 at -It was the MA's response were followed a -It was the HWD's res	3:35pm revealed: onsibility to make sure TED s ordered. sponsibility to make sure the d and go behind the MA's to			
	5:46pm revealed: -MAs should make sudailyIt was the HWD's resmake sure MAs had all the should be reported #9 was refusing his Tour -She expected staff to their supervisorsLack of training and all their supervisors.	ministrator on 08/20/24 at a ure TED hose were applied sponsibility to follow up to applied the TED hose. It to the physician if Resident ED hose. The properties of the physician if Resident ED hose to accountability could be TED hose had not been			
		interview with Resident #9's OA) on 08/16/24 at 10:41am om was unsuccessful.			
	dated 05/20/24 revea	3's signed physician's order led an order to check stick blood sugar (FSBS)			
	Review of Resident # dated 07/15/24 revea Resident #3's FSBS t				
	Review of Resident #	3's June 2024 electronic			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` '	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	OF CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING:		COM	ILLILD
		1181 044004	B. WING			R
		HAL011361	3		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE,	ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
		ASHEVII	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENT	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 98	D 276			
D 276	Medication Administrative revealed: -There was an entry to times a day at 8:00ard -There was no document obtained at 8:00am of the FSBSs were doout of 90 opportunities.  Review of Resident # revealed: -There was an entry to a day, with an original 8:00am, 2:00pm and -There was no document obtained on 07/05/24/07/14/24, and 07/15/2/1-There was no document of the revealed of the re	to check a (FSBS) three m, 2:00pm and 8:00pm. mentation FSBSs were m 06/11/24 and 06/12/24. cumented as refused for 2 ms.  dissipation as the state of the state	D 276			
	-There was an entry to day with an original down as obtained 07/16/24 8:00pmThere was no docume obtained on 07/19/24 8:00amThere was no docume obtained on 07/24/24 -The FSBS was documented out of 45 opportunities -	nentation FSBS were at 8:00pm. Immented as "refused" for 4 s 07/01/24 to 07/16/24. Immented as "no test strips" unities. Immented as "no lancets" for 1				

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NAME OF PROVIDER OR SUPPLIER  HARMONY AT REYNOLDS MOUNTAIN  STREET ADDRESS CITY, STATE, ZIP CODE  41 COBBLERS WAY ASHEVILLE, NC 28894  ASHEVILLE, NC 28894  D PROVIDER CHORNORY OR SUD IDENTIFYING INFORMATION)  PREPRIO GRACH DEPICENCY MUST BE PRECEDED BY PULL PREPRIO GRACH DEPICENCY MUST BE PRECEDED BY PULL PREPRIO GRACH DEPICENCY MUST BE PRECEDED BY PULL PREPRIO TAG  D 276  Continued From page 99  unable to check "For 1 out of 45 opportunities. The FSBS was documented as "waiting on the pharmacy" for 1 out of 45 opportunities. Review of Resident #3's August 2024 eMAR revealed: There was an entry to check FSBS two times a day with an original date of 07/16/24 at 8:00am and 8:00pm. The FSBS was documented as "unable to take medication" for 1 out of 28 opportunities.  Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20 lancets and 25 test strips.  Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: There was an order dated 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/16/24 to check Resident #3's FSBS two times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times a day. There was an order dated of 05/20/24 to check Resident #3's FSBS three times times the facility. On 07/20/24, a 33 days supply of 100 lancets, were dispensed to the facility. On 07/20/24, a 50 days supply of 100 lancets, were dispensed to the facility. The lancets and test strips were not on cycle fill and it was the facility responsibility to request remains and test strips were not on	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
HARMONY AT REVOLDS MOUNTAIN    MAY   D   SUMMARY STATEMENT OF DEFICIENCIES   D   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PROVIDERS PLAN OF CORRECTION   PREFIX TAG   PREFIX TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE COMPLETE TAG   PROVIDERS PLAN OF CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  D 276  Continued From page 99  unable to check* for 1 out of 45 opportunities.  -The FSBS was documented as "waiting on the pharmacy" for 1 out of 45 opportunities.  Review of Resident #3's August 2024 eMAR revealed:  -There was an entry to check FSBS two times a day with an original date of 07/16/24 at 8:00am and 8:00pm.  -There was no documentation the FSBS was obtained on 08/12/24 at 8:00am employed and an obtained on 08/12/24 at 8:00am employed provided as "unable to take medication" for 1 out of 28 opportunities.  Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20 lancets and 25 test strips.  Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:  -There was an order dated 07/16/24 to check Resident #3's FSBS two times a day.  -On 05/28/24, a 16 days supply of 50 test strips, were dispensed to the facility.  -On 05/28/24, a 3 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 30 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 30 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 30 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 30 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.			HAL011361	B. WING		08	
Comparison   Com	NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE		
ASHEVILLE, NC 28804    SUMMARY STATEMENT OF DEFICIENCIES   DEFICIENCIES   DEFICIENCY MUST BE PRECEDED BY FULL   TAG			41 COB	BLERS WAY			
PREFIX TAG  CROSS-REFERENCE DTO THE APPROPRIATE  D 276  Continued From page 99  unable to check" for 1 out of 45 opportunitiesThe FSBS was documented as "waiting on the pharmacy" for 1 out of 45 opportunitiesThere was an entry to check FSBS two times a day with an original date of 07/16/24 at 8:00am and 8:00pmThere was no documented as "unable to take medication" for 1 out of 25 opportunities.  Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20 lancets and 25 test strips.  Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed: -There was an order dated 05/20/24 to check Resident #3's FSBS three times a dayThere was an order dated 07/16/24 to check Resident #3's FSBS three times a dayOn 05/28/24, a 15 days supply of 100 lancets, were dispensed to the facilityOn 07/29/24, a 33 days supply of 100 lancets, were dispensed to the facilityOn 07/29/24, a 30 days supply of 100 lest strips, were dispensed to the facilityOn 07/29/24, a 30 days supply of 100 lest strips, were dispensed to the facilityOn 07/29/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/29/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 07/25/24, a 50 days supply of 100 lest strips, were dispensed to the facilityOn 107/25/24, a 50 days supply of 100 lest strips, were dispensed to the facility.	HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVI	LLE, NC 28804			
unable to check" for 1 out of 45 opportunities.  -The FSBS was documented as "waiting on the pharmacy" for 1 out of 45 opportunities.  Review of Resident #3's August 2024 eMAR revealed:  -There was an entry to check FSBS two times a day with an original date of 07/16/24 at 8:00am and 8:00pm.  -There was no documentation the FSBS was obtained on 08/12/24 at 8:00am.  -The FSBS was documented as "unable to take medication" for 1 out of 28 opportunities.  Review of Resident #3's diabetic supplies on 08/20/24 at 11:18am revealed there were 20 lancets and 25 test strips.  Telephone with a Pharmacist from the facility's contracted pharmacy on 08/20/24 at 10:20am revealed:  -There was an order dated 05/20/24 to check Resident #3's FSBS three times a day.  -There was an order dated 07/16/24 to check Resident #3's FSBS two times a day.  -On 05/29/24, a 16 days supply of 50 test strips, were dispensed to the facility.  -On 05/29/24, a 3 days supply of 100 test strips, were dispensed to the facility.  -On 06/06/24, a 3 days supply of 100 lancets, were dispensed to the facility.  -On 07/24/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -On 07/16/24, a 50 days supply of 100 lancets, were dispensed to the facility.  -The lancets and test strips were not on cycle fill and it was the facility's responsibility to request refills.	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE	N SHOULD BE E APPROPRIATE	COMPLETE
-Resident #3 would have been out of lancets 07/07/24 to 07/16/24 used as ordered	D 276	unable to check" for 1-The FSBS was docupharmacy" for 1 out of Review of Resident # revealed: -There was an entry to day with an original dand 8:00pmThere was no documobtained on 08/12/24-The FSBS was documedication" for 1 out Review of Resident # 08/20/24 at 11:18am lancets and 25 test sto Telephone with a Phacontracted pharmacy revealed: -There was an order of Resident #3's FSBS to There was an order of Reside	I out of 45 opportunities. Imented as "waiting on the of 45 opportunities.  It is August 2024 eMAR  It is check FSBS two times a late of 07/16/24 at 8:00am Inentation the FSBS was at 8:00am. Imented as "unable to take of 28 opportunities.  It is diabetic supplies on revealed there were 20 orips.  It is marked to the facility's on 08/20/24 at 10:20am  Indeed 05/20/24 to check three times a day. It is dated 07/16/24 to check three times a day. It is always supply of 50 test strips, the facility. It is always supply of 100 lancets, the facility. It is always supply of 100 lancets, the facility. It is always supply of 100 lancets, the facility. It is always supply of 100 lancets, the facility. It is always supply of 100 lancets, the facility. It is always supply of 100 lancets, the facility. It is responsibility to request the second of lancets.	D 276			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE. ZIP CODE	•
			ERS WAY	,	
HARMON'	Y AT REYNOLDS MOUN	ΓAIN	E, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	N (X5)
PRÉFIX TAG	'	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 100	D 276		
	Director (HWD) to "hi eMAR and let the HW diabetic supplies nee -When she observed two lancets and or str -She was not aware s about refills for diabet 2024 when the PCP to the pharmacy and chwere not available for -She spoke to the RC contact pharmacy or 24 hour report sheet the deskSince late July 2024 pharmacy or physician's book at the hour report sheetIf diabetic supplies we documented the diab cart" on the eMARThird shift staff were diabetic supplies from the medication carts.  Interview with the Recon 08/16/24 at 9:46ar	evealed: the Health and Wellness t" the refill button on the //D and RCD know when ded to be refilled. that supplies were down to rips, she informed the RCD. she could call the pharmacy tic supplies until late July cold her during a visit to call eck on diabetic supplies that Resident #3. D and was then told to PCP, and document it in the and the physician's book at when she notified the n, she documented it in the lee desk and put it on the 24 were not available, she etic supplies were "not in responsible to ensure the n pharmacy were placed in sident Care Director (RCD) m revealed: n the position of RCD for 6-8			
	-The Health and Well responsible for ensur available prior to her	ness Director (HWD) was ing diabetic supplies were being employed by the			
	receiving diabetic sup	ift were responsible for oplies from the pharmacy ne correct medication cart for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
			D. WING		R
		HAL011361	B. WING	<del></del>	08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	ITAIN	LERS WAY		
	I	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 276	Continued From pag	e 101	D 276		
5 2.0	useIf the MAs found tha available, they were feature in the eMARIf the diabetic suppli from the pharmacy, t call the pharmacy to were not deliveredThe MA who workenights in the SCU was a medication cart aus suppliesThe MA was then suresults to the previous-She had not comple	at diabetic supplies were not supposed to use the refill lies did not arrive as expected the MAs were supposed to find out why the supplies did third shift on Monday as responsible for performing dit of all residents' diabetic supposed to turn in the audit as RCD and to her now.			
	08/20/24 at 4:15pm r -If any resident did no available to use, the pharmacy and tell the supplies and bill the -There was no reaso without their diabetic  Interview with the Ad 5:45pm revealed: -She became the Adı -The MAs were responser audits and had for diabetic suppliesThe RCD and Healti (HWD) were responser	ot have diabetic supplies MAs should call the em to send the diabetic facility. In for any resident to be			
	-The RCD and HWD ensuring diabetic sup	were responsible for oplies were available to use. were responsible to report in			

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			A. BOILDING	A. BOILDING.		Б
		HAL011361	B. WING		08	R 3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STAT	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΓΑΙΝ	LERS WAY			
		ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE IE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 102	D 276			
	medication cart auditi-She was responsible found on medication on by the RCD and H-The staff were not be were not held account reasons as to why the were not being comp.  The facility failed to o ordered on 06/10/24 until 08/06/24 for Resfor increased falls and Resident #9 with app hose which resulted in high dosage of medicing his legs which could of due to increased nee	e for ensuring the issues cart audits were followed-up IWD.  eing trained correctly and stable could be one of the emedication cart audits leted.  btain a urine sample as and there was no treatment sident #2, placing him at risk d sepsis and failed to assist lication of thrombo-embolytic in the resident requiring a station to decrease edema in cause dizziness and falls d to urinate. This failure at substantial risk for serious				
	this violation.  CORRECTION DATE	131D-34 on 08/20/24 for				
	05/29/24 revealed dia mellitus type 2, Parkii hypertension, and ba					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL	ERS WAY		
TIARRINGIA	TAT RETROEDS MOOR	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 276	Continued From page	e 103	D 276		
	08/12/24 revealed an deterrent (TED) hose	order for thrombo-embolic knee high, apply to lower d remove at bedtime for			
	administration record -On 08/14/24 at 8am, documented as "not Ir -On 08/14/24 at 8pm, documented as being -On 08/15/24 at 8am, documented as "waiti -On 08/15/24 at 8pm, documented as being -On 08/16/24 at 8pm, documented as being -On 08/16/24 at 8am, documented as being	the TED hose were neer." the TED hose were taken off. the TED hose were ing on pharmacy". the TED hose were taken off. the TED hose were taken off. the TED hose were			
	08/20/24 at 4:16pm re-The Health and Well responsible for meast TED hose for residen -The facility's contract responsible for supply hose to the facility for -It should not take an an order was written those in the facility.  Interview with the Adr 5:46pm revealed:	ness Director (HWD) was uring residents to obtain ts. ted pharmacy was ying the correctly sized TED			
	daily. -It was the HWD's res	sponsibility to follow up to applied the TED hose.			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE		
HARMON'	Y AT REYNOLDS MOUN	TAIN	BLERS WAY			
		ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 276	Continued From page	e 104	D 276			
	#6 was refusing his T -She expected staff to their supervisors. -Lack of training and	It to the physician if Resident TED hose. To report non-compliance to accountability could be TED hose had not been				
D 310	10A NCAC 13F .090 <sup>2</sup> Service	4(e)(4) Nutrition and Food	D 310			
	10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician.					
	This Rule is not met TYPE A1 VIOLATION					
	facility failed to ensur	and record reviews the retherapeutic diets were r 1 of 2 sampled residents iet (Resident #1).				
	The findings are:					
	06/13/19 revealed: -Residents would be dietsSpecial diets to be p included a pureed dietModified diets were the physicianThe facility shall mai current listing of residence.	provided with appropriate provided by Dining Services et. It to be served as ordered by intain an accurate and dents with physician-ordered guidance of food service				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R
		HAL011361	B. WING		08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	FAIN 41 COBBL	ERS WAY		
TIARMON	TAT KETHOLDO MOON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 310	Continued From page	e 105	D 310		
	-All therapeutic diets ordered by the physic	sian.			
	2020 revealed:	nt Diets policy dated May ained on the Physician's			
	-Immediately upon re Diet Order form, a co	ceipt of a new Physician's py would be placed on the			
	Director (DSD) in the				
	-All dining staff were to be trained to check the diet board at the beginning of each shift, as this would alert them to new or diet changes.  -The DSD was responsible for updating the diet card and placing the diet card on the board.  -The DSD was responsible for placing the Physician's Diet Order form in the diet binder kept				
	in the DSD's officeThe DSD was responded Listing which incidesignated area in the	nsible for keeping a Master luded the diet in a e kitchen and staff were to			
	•	ement of the document and staff prior to each meal.			
		1's FL-2 dated 07/03/23 ncluded diabetes, vascular yroidism.			
		1's Resident Register was admitted on 07/03/23.			
		1's signed diet order dated order for a mechanical soft			
		1's signed diet order dated order to change Resident			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C			E SURVEY PLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΓAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 310	O7/12/24 revealed: On the 7:00am to 7: documented Resider throwing up. On the 7:00pm to 7: documented Resider Review of Resident #1 immediately due to ra sequentially over day pneumonia.  Interview with Adult H 08/14/24 at 8:30am r On 08/09/24, she ini serving diets as orde She reviewed the the the dietary board in tl Resident #1's diet w soft diet with thin liqu  Review of the facility' breakfast menu for 0' regular diet of mini ka strawberry baked oat patty, gravy or sauce choice, and bread.  Review of the facility' breakfast menu for 0' regular diet of pureed onion frittata, pureed hot cereal with no lun gravy or sauce of cho choice (no pineapple	200pm section, it was it #1 was coughing and 200am section, it was it #1 died at 7:55pm.  21's death certificate died on 07/12/24 at 7:55pm apid onset of hypoxia and is due to aspiration  20 dome Specialist (AHS) on evealed: tiated the complaint into not red. erapeutic diet list located on the kitchen. as listed as a mechanical ids.  25 Week at a Glance 7/12/24 revealed for a alle caramelized onion frittata, meal hot cereal, sausage of choice, canned fruit of 25 Week at a Glance 7/12/24 revealed for a all mini kale caramelized strawberry baked oatmeal aps, pureed sausage patty, oice, pureed canned fruit of or fruit cocktail) pureed or on nuts, seeds, raisins, or	D 310	DETIGINATION 1		
	Review of the facility' breakfast menu for 0' pureed diet of pureed onion frittata, pureed hot cereal with no lur gravy or sauce of choice (no pineapple slurried soft bread (no	7/12/24 revealed for a I mini kale caramelized strawberry baked oatmeal nps, pureed sausage patty, pice, pureed canned fruit of or fruit cocktail) pureed or o nuts, seeds, raisins, or				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
	list on 08/09/24 at 9:4	umented the speech			
	mechanical soft to pu -The triage note was 07/11/24 at 1:42pm a dietary on 07/11/24.	rreed. documented as faxed on and a copy was given to			
	on 08/15/24 at 12:03 -On 07/12/24, she way Memory Care Unit (No-On 07/12/24, Resided diet, from the serving pureed for breakfast out of it and and start coughing episodes at a she removed the regressident #1 and Resimore until lunchResident #1 was set and she removed it of a she spoke to a Physin the MCU who claris served a pureed diet Room (DM) and the of-About an hour after (PCA) informed her to day room coughing a served a pureed diet to a served a pureed diet Room (DM) and the of-About an hour after (PCA) informed her to day room coughing a served.	as the MA on duty in the MCU), 7:00am to 7:00pm. Ent #1 was served a regular containers, that was not and had maybe a bite or two sed having some heavy and choked.  Gular diet plate from ident #1 did not eat any are she noticed it.  Sical Therapist (PT) that was fied Resident #1 was to be and notified the Dining diet was changed for supper. Junch, a personal care aide that Resident #1 was in the not vomiting.  Toom and found Resident #1			
	9:23am revealed:	with a PT on 08/19/24 at s working with another			

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	ATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA ID PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION		E SURVEY PLETED
			_			В
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	V AT DEVNOI DO MOUNT	41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUNT	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 (EACH CORRECTIVE AC' CROSS-REFERENCED TO	TION SHOULD BE	(X5) COMPLETE DATE
				DEFICIEN	CY)	
D 310	Continued From page	: 108	D 310			
	resident hefore lunch	, when the MA on duty in the				
		ssistance to make sure				
	Resident #1 was "ok"					
		ned that Resident #1 was				
		pureed diet and was served				
		rast and had a choking				
	episode.	-				
		as no Heimlich Maneuver				
		nt #1 that she was aware of.				
	-She called the Speed	,				
		verify the correct diet order.				
		clarified he recommended a				
	-	24 due to a choking episode				
	with Resident #1.	abalaft the MCII right				
		she left the MCU right fied the diet for pureed with				
		id not see what was actually				
	served to Resident #1	-				
	Telephone interview v	vith the facility's contracted				
	ST on 08/19/24 at 4:1	•				
	-On 07/11/24, he rece	eived a call from a physician				
		CP office about Resident #1				
		and a request to change				
	Resident #1's diet to a					
		nt #1's diet was changed				
		to pureed by the PCP the				
		to take the new order to the dd to the therapeutic diet list				
	in the kitchen.	du to the therapeutic diet list				
	-On 07/12/24, the fac	ility's contracted PT				
		choking episode Resident				
		g breakfast due to being				
	served a regular diet.	3				
		ication of the diet order.				
	-He told the PT that R	Resident #1 was to be				
	served a pureed diet.					
		ıld make sure dietary had				
	the correct order.					
	-If Resident #1 was no	ot served a pureed diet.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					l R	
		HAL011361	B. WING		08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	A1 COBBL	ERS WAY			
TIPARAMON	TATRETHOLDO MOON	ASHEVILLI	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	e 109	D 310			
	then Resident #1 cou	ld choke.				
	care provider (PCP) or revealed:  -On 07/09/24, Reside episode, turned blue, required the Heimlich a physician and a che-Resident #1's 07/09/characterized as a "so during which her airw obstructed, resulting it to an inability to coug-When Resident #1 clairflow to her lungs ar breath or talk; her fac she could not breath oxygen flow and then-When Resident #1's at serious risk of decribrain which could lead-It only took 4-6 minuted death to occur after serious filling up with flungs filling up with flungs filling up with flund hypoxia from the saturation, and both clead to death within 3-On 07/11/24, Reside contracted provider a orderedOn 07/12/24, Reside breakfast after being died on the same day -Resident #1 was a grafter choking because	became non-responsive, Maneuver, an evaluation by est xray. 24 choking episode was evere choking" episode ay was completely In loss of consciousness due In loss				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE  A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
HADMON	V AT DEVNOI DE MOUNT	41 COBE	BLERS WAY		
HARMON	Y AT REYNOLDS MOUNT	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 CORREC (EACH CORRECTIVE ACTION SHOI CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D 310		e 110 tary Service Director (DSD)	D 310		
	on 08/19/24 at 4:30pr -When a diet changed received the order was order in the diet order office and the diet order. All dietary staff were the diet board before of new diet orders or -On 07/09/24, the coopreparing the meal act therapeutic diet, which dietThe regular diets we and dished out in the handed to the MCU s -All therapeutic diets and placed on a tray for -There were no dietar therapeutic meals preand sent to the MCUOn 07/11/24, there we book for Resident #1 -On 07/12/24, all meakitchen and transporter-On 07/11/24, he did not received with the dietar therapeutic meals preand sent to the MCU.	In revealed: Id, the dietary staff who are to place the new diet book located in the dietary der board was to be updated er. It responsible for reviewing each meal to alert the staff changes. It was responsible for coording to Resident #1's had was a mechanical soft are sent in large containers kitchen by servers and taff to give to the residents. If were prepared separately for an individual resident, by cards on the separate expared in the main kitchen are an order in the diet order to receive a pureed diet. Its were prepared in the diet order to the MCU dining room. Into know the diet order			
	-On 07/12/24, he did	not know Resident #1 of at breakfast and choked. know there was an issue			
	care of before Reside plate.	et at lunch but it was taken ant #1 received the lunch verify the pureed meal was in the MCU.			
	on 08/16/24 at 9:46ar	sident Care Director (RCD) n revealed: er was received, the MAs			

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			A. BUILDING			
		HAL011361	B. WING		08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON'	Y AT REYNOLDS MOUNT	TAIN 41 COBBL				
	I	ASHEVILLI	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 310	Continued From page	: 111	D 310			
	report and take a cop the dietary manager.  -The dietary staff were out trays according to the kitchen.  -On 07/12/24, for breaseparate pureed diet by the dietary staff and the MAs and PCAs sure the resident received a regular dietary staff.  -On 07/12/24, she did received a regular dietary staff.  -On 07/12/24, she did received a regular dietary staff.  -She was responsible report every morning order or issues to the Manager every morning-She did not know the Resident #1 receiving	writing it in the 24 hour y of the new diet order to be responsible for handing the dietary card posted in akfast, lunch and supper, a was to be made specifically digiven to Resident #1. were responsible for making sived the correct diet from all not know why Resident #1 of for breakfast. For reviewing the 24 hour and reporting the new diet Administrator and Dietary ng in the standup meeting. For was a problem with the wrong therapeutic diet ring breakfast and had a				
	08/16/24 at 2:37pm re -The MAs were responsible and a new diet orderThe RCD was responsible ary Manager had -The RCD was responsible are specified.	nsible for notifying the RCD er. nsible for making sure the a copy of the new order. nsible for reporting all new ning standup meetings to				
	on 08/16/24 at 2:40pr -He was the Administ 07/12/24. -The MAs were respo					

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		HAL011361	B. WING		R 08/20/2024
	ROVIDER OR SUPPLIER Y AT REYNOLDS MOUNT	AIN 41 COBB	DDRESS, CITY, STATI LERS WAY LE, NC 28804	E, ZIP CODE	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 310	hour report every more order to the Administre order was received by take copy of the order processing.  -He did not know the the correct diet on 07.  Attempted telephone Power of Attorney (Power of Attorney) (Power of Attorne	ranible for reviewing the 24 raning and report the new diet ator and if the new diet afore the next meal, then to the DSD for immediate  Resident #1 did not receive /12/24 at breakfast.  Interview with Resident #1's DA) on 08/16/24 at 4:00pm om was unsuccessful.  IA NCAC 13F .0901(c) upervision (Type A1  Perve a pureed diet as 11 who experienced g secondary to a severe aspiration on 07/09/24.  Led a regular diet for and again experienced and died on the day same and serious physical harm and utes a Type A1 Violation.	D 310		
D 358	10A NCAC 13F .1004 Administration	(a) Medication	D 358		
	10A NCAC 13F .1004	Medication Administration			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:		· ,	SURVEY PLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATE	, ZIP CODE	•	
HARMON	Y AT REYNOLDS MOUN	FAIN 41 COBB	LERS WAY			
HARIMON	TAI RETNOLDS MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 113	D 358			
	preparation and admi prescription and non-by staff are in accorda (1) orders by a licens which are maintained (2) rules in this Secti and procedures.  This Rule is not met TYPE A2 VIOLATION  Based on observation reviews, the facility fawere administered as sampled residents (# medications used to tanxiety and elevated medications used to tand fluid retention (#2 urinary incontinence (treat high blood sugar	sed prescribing practitioner in the resident's record; and on and the facility's policies as evidenced by:  Ins, interviews, and record illed to ensure medications ordered for 5 of 13 2, #3, #5, #6, #10) related to reat high blood pressure,				
	The findings are:					
	order dated 05/14/24 furosemide (a medica pressure) 10mg/ml so every morning.	t #3's signed physician's revealed an order for ation to treat high blood blution, take 2mls = 20mg 3's signed physician's order				
		led an order for furosemide				

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	T OF DEFICIENCIES OF CORRECTION					
		HAL011361	B. WING	<del></del>	08	R 3/ <b>20/2024</b>
NAME OF B	ROVIDER OR SUPPLIER	STDEET A	ADDRESS, CITY, STATE	ZIR CODE	•	
NAIVIE OF F	ROVIDER OR SUFFLIER		BLERS WAY	, ZIF CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	ge 114	D 358			
	10mg/ml solution, ta morning.	ke 4ml = 40mg every				
	dated 07/21/24 reve	#3's signed physician's order aled an order for furosemide ke 6ml = 60mg every				
	-There was an entry solution, take 2mls = original date of 05/14-There was no docu was administered or 06/11/24, 06/12/24, 8:00amThe furosemide wa for 5 out of 30 oppor	's June 2024 eMAR revealed: for furosemide 10mg/ml = 20mg every morning with an 4/24 documented at 8:00am. mentation the furosemide n 06/02/24, 06/08/24, 06/15/24 and 06/30/24 at s documented as "refused" tunities. s documented as "waiting on				
	pharmacy" for 1 out  Review Resident #3 -There was an entry solution, take 2mls = original date of 05/1 of 07/22/24 docume -There was no docu was administered or 07/03/24, 07/05/24, 07/19/24 at 8:00am.	of 30 opportunities.  's July 2024 eMAR revealed: for furosemide 10mg/ml = 20mg every morning with an 4/24 and a discontinue date inted at 8:00am. mentation the furosemide in 07/01/24, 07/02/24, 07/08/24, 07/11/24, and  s documented as "refused"				
	-The furosemide wa pharmacy" for 3 out -The furosemide wa take medication" for -There was an entry solution, take "6mls	s documented as "waiting on of 22 opportunities. s documented as "unable to 1 out of 22 opportunities. for furosemide 10mg/ml = 40mg" every morning with 7/22/24 and a discontinue				

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	AND DI AN OF CORRECTION INDENTIFICATION NUMBER.		(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL			
		ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 115	D 358		
D 358	-There was no docum was administered on -The furosemide was "discontinued" for 1 o -There was an entry f solution, take 6mls = original date of 07/30, -There was no docum was administered on -The furosemide was available, RCD follow out of 1 opportunities.  Telephone with a Phacontracted pharmacy revealed: -On 07/21/24, an electraceived from Reside physician (PCP) for futake 4mls = 40mg every -There was a transcriside that was not cautacility staff as of 08/2 furosemide dispensed on the eMAR was for solution, take 6mls = of the 4mls = 40mgSince the furosemide staff could have admited for an increase of a decrease in potassitation. The PCP order docuused for hypertension	nentation the furosemide 07/30/24 at 8:00am. documented as ut of 8 opportunities. for furosemide 10mg/ml 60mg every morning with an 1/24 documented at 8:00am. Inentation the furosemide 07/31/24 at 8:00am. Identation the furosemide 07/31/24 at 8:00am. Identation the facility's on 08/20/24 at 10:20am  Intertact from the facility's on 08/20/24 at 10:20am  Intertact from the pharmacy of the pharmacy staff or 1/20/24 and the label of the 1/20/24 and the facility 1/20/24 and the facility 1/20/24 and the facility 1/20/25 and the facility 1/20/26 and the facilit	D 358		
	furosemide could low pressure more than the	er Resident #3's blood ne intended range.			
	Review of Resident # revealed:	3's August 2024 eMAR for furosemide 10mg/ml			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONS AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		_
		HAL011361	B. WING		R 08/20/2024
NAME OF D	ROVIDER OR SUPPLIER	STREET VL	DDRESS, CITY, STA	TE ZIR CODE	,
NAME OF T	NOVIDEN ON 3011 EIEN		LERS WAY	II.E, ZII CODE	
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	ON (X5)
PREFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
D 358	Continued From page	e 116	D 358		
D 356	solution, take 6mls = original date of 07/30, -There was no docum was administered on 08/06/24, and 08/12/2 -The furosemide was available, RCD follow on cart, refill requeste up with pharmacy", at of 14 opportunities.  Review of Resident # administration on 08/2 there was a bottle of with a label dated 07/ administer 6ml = 60m hypertension with 8m.  Telephone with a Phacontracted pharmacy revealed: -On 05/14/24, there with 10mg/ml solution, take	60mg every morning with an /24 documented at 8:00am. hentation the furosemide 08/03/24, 08/04/24, 24 at 8:00am. documented as "med not red up with pharmacy", "not red by RCD", "RCD followed and "unable to take" for 4 out 3's medications available for 20/24 at 11:18am revealed furosemide 10mg/1ml liquid, 30/24 containing 60mls, to ag every morning for 1s left to administer.	D 336		
		nsed furosemide 10mg/ml day supply on 05/14/24 and			
	-On 07/21/24, there w 10mg/ml solution, tak morning.				
	solution, 120mls, a 30	nsed furosemide 10mg/ml 0 day supply on 07/22/24. was an order for furosemide e 6mls = 60mg every			
	-The pharmacy dispe solution, 180mls, a 30 -Based on dispense h	nsed furosemide 10mg/ml 0 day supply on 07/22/24. nistory, Resident #3 would furosemide 2mls 06/13/24			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
ANDILAN	O CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING: _		COIVII LI	LILD
		HAL011361	B. WING		08/2	0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL	ERS WAY			
	TAT KETHOLDO MOON	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page 117		D 358			
	Primary Care Provide 8:25am revealed: -The furosemide was #3's hypertension by -On 07/21/24, Reside visit for weeping in he swelling and she increaming and there was no door blood pressure (BP) if she went off of June 2 high, and the visit from Resident #3's legs swere ported falls, so she 6mls = 60mg every meaning and she was not aware of 40mg ordered on 07/2 administered as 6mls in July 2024Resident #3 could hap pressure causing fluid and weeping in Resident #3 could increase risk of heart failure.  Interview with a mediaming line was trained by the Director (HWD) to "him in the sweet in the side of the side o	velling and weeping, and no increased the furosemide to norning and sent the order to of the furosemide 4mls = 21/24 was possibly instead of 4mls for 8-9 days have increased blood diretention causing swelling lent #1's legs leading which developing congestive cation aide (MA) on				
	-When she saw that r two doses, she inform					
	about refills for medic	she could call the pharmacy ations until late July 2024 er, during a visit, to call the				

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		(X2) MULTIPLE	(2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPI	LETED
						R
		HAL011361	B. WING		08/	20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
		41 COBB	LERS WAY			
HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVIL	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRE	ECTION	(X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)		COMPLETE DATE
D 358	Continued From page	e 118	D 358			
	not available to admir-She spoke to the RC contact pharmacy or 24 hour report sheet the deskSince late July 2024 pharmacy or physician physician's book at the hour report sheetIf a medication was resulted.	ED and was then told to PCP, and document it in the and the physician's book at when she notified the n, she documented it in the e desk and put it on the 24 not available to administer,				
	<ul> <li>-If a medication was not available to administer, she documented medication "not in cart" on the eMAR.</li> <li>-If a resident's medication ran out prior to the time for batch refill from the pharmacy, the MAs waited on the pharmacy to deliver the medication.</li> <li>-Third shift staff were responsible to ensure the medications from pharmacy were placed in the medication carts.</li> </ul>					
	on 08/16/24 at 9:46ar -She had been in the weeksThe Health and Well responsible for ensur available for administ employed by the facil -The MAs on third shi receiving medications putting the medication cart for administration -If the MAs found a mavailable, they were steature in the eMARIf a medication did not the pharmacy, the MA pharmacy to find out not delivered.	position of RCD for 6-8  ness Director (HWD) was ing medications were ration prior to her being ity.  ift were responsible for a from the pharmacy and in in the correct medication				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLE	
		HAL011361	B. WING		08/2	0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBBL	ERS WAY			
HARWON	TAT RETNOLDS MOON	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETE DATE
D 358	Continued From page	e 119	D 358			
	of all residents' medication. Then, the MA was to the previous RCD, but the audit results in to -She was not sure of responsible for discremedication cart audits at the facilityShe had not complet or reviewed the medication reviewed the medication that the facility.  Interview with the Colon 08/20/24 at 4:15pm realing and resident did not available to administe pharmacy and tell the and bill the facility.	ming a medication cart audit cations.  I turn in the audit results to ut now the MA was to turn her now.  I the process or who was epancies found on the since she began working ared a medication cart audit cation cart audits since she  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the audit results to unit now the MA was to turn her now.  I turn in the MA was to turn her now the MA wa				
	5:45pm revealed: -The MAs were responsed audits and had farmedicationsThe RCD and the He (HWD) were responsed medications identified auditsThe RCD and HWD ensuring medications administerThe RCD and HWD daily standup meeting medication cart audits	ministrator on 08/20/24 at sometime on the medication was been and Wellness Director was a contract of the medication cart where responsible for were available to the was sissues identified on the second of the s				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMP	LETED
		HAL011361	B. WING			R / <b>20/2024</b>
NAME OF D	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE ZID CODE	1 33	
NAME OF T	NOVIDEN ON 3011 EIEN		BLERS WAY	II L, ZII GODL		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 358	Continued From page	e 120	D 358			
	followed-up on by the	PCD and HWD				
		eing trained correctly and				
		ntable could be one of the				
		e medication cart audits				
	were not being comp					
	were not being comp	ictor.				
	b. Review of Residen	nt #3's signed physician's				
	order dated 06/10/24					
	medication used to tr					
	0.5mg/0.5ml to foreal					
	Review of Resident #	43's signed physician's				
		4 for lorazepam gel 1mg/1ml				
		hairless area every night at				
	bedtime.	. •				
	Review of Resident #	<sup>‡</sup> 3's June 2024 eMAR				
	revealed:					
	-There was an entry t	for lorazepam gel				
	0.5mg/0.5ml to forear	rm two times a day with an				
	original date of 06/11	/24 documented as				
	administered on 06/1	3/24 to 06/21/24 at 8:00am				
	and 8:00pm, and 06/2	23/24 to 06/30/24 at 8:00am				
	and 8:00pm.					
	-On 06/11/24 at 8:00a	am, the lorazepam was				
	documented as "not i					
		om, the lorazepam was				
	documented as "med					
		am, the lorazepam was				
	documented as "refus					
	documented as "med	am, the lorazepam was				
		not in cart . not administered for 4 out of				
	60 opportunities.	not administered for 4 out of				
	Review Resident #3's	s July 2024 eMAR revealed:				
	-There was an entry	-				
	_	rm two times a day with an				
	original date of 06/11					
	administered at 8:00a					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			
74101 1544	or connection	IBENTI IO/MIGIN NOMBER	A. BUILDING:			PLETED
		HAL011361	B. WING		0.6	R 3/20/2024
NAME OF F		1		ZID CODE	1 3	<u></u>
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE LERS WAY	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
(X4) ID	SUMMARY S	FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG			PREFIX TAG	(EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	THE APPROPRIATE	COMPLETE DATE
D 358	Continued From pag	e 121	D 358			
	administered on 07// 07/19/24 and 07/26/2 -There was no docur administered on 07// and 07/28/24 at 8:00 -There was an entry to forearm at night w 07/25/24 and a discondocumented at 8:00 -The lorazepam was for 2 out of 60 opportunity -The lorazepam was discontinued for 2 of -The lorazepam was pharmacy" for 1 out of -The lorazepam was pharmacy" for 1 out of -The lorazepam was pharmacy for 1 out of -The lorazepam was	mentation the lorazepam was 15/24, 07/26/24, 07/27/24 pm. for lorazepam gel 1mg/1ml ith an original date of ontinued date of 07/31/24 pm. documented as "not on cart" tunities. documented as "refused" for ties. documented as out of 60 opportunities. documented as "waiting on of 60 opportunities".				
	contracted pharmacy revealed: -On 06/11/24, there was gel 0.5mg/0.5ml to form of the pharmacy dispersion of the pharmacy dispersion of the pharmacy dispersion of the pharmacy was lorazepam 1mg/1ml not compound the magister of the pharmacy was lorazepam 1mg/1ml not compound the magister of the pharmacy discontinued on 07/3-According to their results of the pharmacy was lorazepam 1mg/1ml was not available of the pharmacy	unable to dispense because the pharmacy could edication before it was 1/24. ecords, the lorazepam lable for administration				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
7.1.2.2.1.1		152.111.16/11.16.11.16.11.1	A. BUILDING: _		"	
			B 14#115			R
		HAL011361	B. WING		08	/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	FAIN 41 COBB	LERS WAY			
HAKINION	I AI KETNULDƏ MUUNT	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 358	Continued From page	e 122	D 358			
	. •					
	display increased beh	ed dose the resident could				
	display increased bei	laviors.				
	Telephone interview v	vith a representative from				
	the facility's contracte	•				
	provider on 08/15/24	, ,				
	-The lorazepam was	order for agitation and				
	anxiety.					
		Resident #3 refusing the				
	•	sed him to make medication				
	changesIf the lorazepam was	not administered as				
	•	#3 would have an increase				
		as the reason he had to				
	change the lorazepan					
	07/31/24.					
	Interview with a medic	, ,				
	08/20/24 at 8:00am re	he Health and Wellness				
		t" the refill button when a				
	,	be refilled and notify the				
	HWD and RCD know					
	-When she saw that r	nedications had two doses				
	remaining, she inform					
		she could call the pharmacy				
		ations until late July 2024				
		er, during a visit, to call the				
	pharmacy and check not available to admir	on a medication that was				
		D and was then told to				
	-	PCP, and document it in the				
	·	and the physician's book at				
	the desk.	, 2001. 21				
	-Since late July 2024	when she notified the				
		n, she documented it in the				
		e desk and put it on the 24				
	hour report sheet.					
		not available to administer,				
	she documented med	lication "not in cart" on the	1			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
					R	
		HAL011361	B. WING		08/20/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	AIN 41 COBBL				
	OLIMANDY OT		E, NC 28804	DROWDEDIO DI AN OF CORRECTIO	N	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	: 123	D 358			
	eMAR.  -If a resident's medicator batch refill from the on the pharmacy to de-Third shift staff were medications from pharmedication carts.  Interview with the Reson 08/16/24 at 9:46ar-She had only been in weeks.  -The Health and Welling responsible for ensuring available for administremployed by the facility. The MAs on third shift receiving medications putting the medication cart for administration left the MAs found a mavailable, they were serviced the same and the same and the same and the same are same and the same are same as the same are same as the same are same are same as the same are same are same as the same are same as the same are same ar	ation ran out prior to the time e pharmacy, the MAs waited eliver the medication. responsible to ensure the rmacy were placed in the  sident Care Director (RCD) n revealed: n the position of RCD for 6-8 ness Director (HWD) was ng medications were ration prior to her being ity. ft were responsible for of from the pharmacy and in in the correct medication				
	the pharmacy, the MA pharmacy to find out on the pharmacy to find the ph	pposed to turn in the audit s RCD and to her now. out follow through with during the medication cart ployment as the RCD. ed a medication cart audit				
	discrepancies found of audits prior to her em -She had not complet	during the medication cart ployment as the RCD. ed a medication cart audit cation cart audit				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
						R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
	V 47 DEVAIOL DO MOUN	41 COBE	BLERS WAY			
HARMON	HARMONY AT REYNOLDS MOUNTAIN  ASHEVILI					
(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 C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 124	D 358			
	Interview with the Co 08/20/24 at 4:15pm r-If any resident did not available to administe pharmacy and tell the and bill the facility.  There was no reaso without their medicat.  Interview with the Ad 5:45pm revealed:  -She became the Adu-The MAs were responsible and the cart audits and had famedications.  -The RCD and HWD up on missing medication cart audit.  The RCD and HWD ensuring medications administer.  -The RCD and HWD daily standup meeting medication cart audit.  She was responsible found on medication on by the RCD and H-The staff were not bewere not held accour reasons as to why the were not being composed to treat diabetes 10mls two times a daily to the condensation on the condensation of the condensation	rporate Clinical Specialist on evealed: of have a medication or the MAs should call the em to send the medication on for any resident to be ions.  ministrator on 08/20/24 at ministrator a week ago. onsible for weekly medication ailed to identify missing  were responsible to follow ations identified during the self of the were available to were available to were available to the self or ensuring the issues cart audits were followed-up ations identified on the self or ensuring the issues cart audits were followed-up ations identified on the self or ensuring the issues cart audits were followed-up ations at a signed physician's at the signed physician's for metformin (a medication is) 500mg/5ml, administer by.				
	dated 07/08/24 for m	f3's signed physician's order etformin 500mg/5ml, ce daily with breakfast and				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	ZIP CODE	•	
			BLERS WAY	, 0022		
HARMON	Y AT REYNOLDS MOUN	NTAIN	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	supper to decrease Review Resident #3 -There was an entry solution, administer day, with an original at 8:00am and 8:00p -There was no docu administered on 06/06/12/24, and 06/17 -There was no docu administered on 06/8:00pmThe metformin was 4 out of 60 opportuneThe metformin was for 3 out of 60 opportuneThe metformin was for 1 out of 60 opportune.	gastrointestinal (GI) upset.  's June 2024 eMAR revealed: for metformin 500mg/5ml 10mls = 1000mg two times a date of 05/13/24 documented om. mentation the metformin was 02/24, 06/08/24, 06/11/24, //24 at 8:00am. mentation the metformin was 02/24, and 06/08/24 at  documented as "refused" for ities. documented as "not in cart" tunities. documented as "on order" tunities. three times daily obtained at d 8:00pm, with a range	D 358			
	-There was an entry solution, administer day with an original discontinue date of 8:00am and 8:00pm -There was no docu administered on 07/-There was an entry solution, administer day with meals, brea original date of 07/0 administered at 8:00-There was no docu	mentation the metformin was 02/24 at 8:00am. mentation the metformin was 03/24 at 8:00pm. for metformin 500mg/5ml 5mls = 500mg two times a akfast and supper with an 3/24 documented as				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			A. BUILDING			
		HAL011361	B. WING		R 08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL				
	I	ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPI	LETE
D 358	Continued From page	e 126	D 358			
	07/21/24, and 07/22/2 -There was no docum administered on 07/10 07/20/24 and 07/22/2 -The metformin was of incorrectly or 31 out of -The metformin was of or 7 out of 62 opportunit -The metformin was of take" for 1 out of 62 of -The metformin was of use of take of 1 out of 62 of -The metformin was of continued of 1 of -An entry for FSBS the 07/01/24 to 07/16/24	24 at 8:00am. nentation the metformin was 6/24, 07/17/24, 07/18/24, 4 at 5:00pm. documented as administered of 54 opportunities. documented as "refused" for ies. documented as "not on cart" unities. documented as "unable to opportunities. documented as unable to opportunities. documented as ut of 62 opportunities. ree times daily obtained at 8:00am, 2:00pm and as daily, 07/16/24 to 07/31/24				
	solution, administer 5 day with meals, break original date of 07/03, administered at 8:00a -There was no docum administered on 08/038:00amThere was no docum administered on 08/15:00pmThe metformin was or incorrectly or 24 out of 28 opportunit -The metformin was of take" for 1 out of 28 of the original of the control of 28 opportunit take of 1 out of 28 of the original of 28 o	for metformin 500mg/5ml mls = 500mg two times a kfast and supper with an kfast and 5:00pm. hentation the metformin was kfast and 08/12/24 at hentation the metformin was kfast and 08/13/24 at hentation the metformin was kfast and 08/12/24 at hentation the metformin was kfast and 08/13/24 at hentation the metformin was kf				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
7410 1 1541	or contraction	IBERTII IO/MIGIT NOMBER	A. BUILDING: _	<del></del>	OCIVII ELTED
					R
		HAL011361	B. WING	<del></del>	08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
HADMON	V AT DEVNOI DO MOUNT	41 COBBL	ERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ASHEVILL	.E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Review of Resident # administration on 08/2 there was a bottle of with a label dated 07/administer 5ml = 500 diabetes with 8ml left  Telephone with a Pha contracted pharmacy revealed: -On 06/11/24, there w 500mg/5ml solution, a two times a dayThe pharmacy dispeday supply on 05/25/2-On 07/08/24, there w 500mg/5ml solution, a two times a day with be prevent GI upsetThe pharmacy dispeday supply on 07/08/24 Telephone interview w PCP on 08/19/24 at 8	to times daily, 07/16/24 to between 81 and 301.  3's medications available for 20/24 at 11:18am revealed metformin 500mg/5ml liquid, 22/24 containing 200mls, to mg every morning for to administer.  Immacist from the facility's on 08/20/24 at 10:20am  Impact an order for metformin administer 10mls = 1000mg  Insed metformin 600mls, 30 and 24 and 06/22/24.  Impact and order for metformin administer 10mls = 1000mg  Insed metformin 300mls, 15 and 07/22/24.  Insed metformin 300mls, 15 and 07/22/24.  Insed metformin 300mls, 15 and 07/22/24.  Insed metformin 300mls, 15 and 07/22/24.	D 358		
	-The metformin was of #3's high blood sugar -On 07/03/24, she cha				
	metformin from 8:00a day with breakfast an	m and 8:00pm to twice a d lunch to help with			
	_	dent #3 experienced from			
	-On 07/29/24, she say	w Resident #3 at the facility centation of refusals and cation.			
		of the refusals, tly, or being out of the			

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	or periornoiro		()(0) 1 ** " 7:5: -	CONCEDUCTION	T(v(a) 5 +== 5	NIDVEY
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 '	CONSTRUCTION	(X3) DATE S	
, III L LAN	. JOHNEOHON	DENTI TOTALON NOVIDEN.	A. BUILDING: _			
					F	₹
		HAL011361	B. WING		1	20/2024
					, , ,	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ΓΑΙΝ	LERS WAY			
		ASHEVIL	LE, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	•	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	REGULATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	IXIAIL	5,112
D 358	Continued From page	e 128	D 358			
	-Resident #3's last he	emoglobin A1C drawn on				
		A1C is a test that measures				
	the average of glucos					
	•	8 months, normal 4.8-5.6).				
	F	,				
	Interview with a MA o	n 08/20/24 at 8:00am				
	revealed:					
	-She was trained by I	HWD to "hit" the refill button				
	when a medication needed to be refilled and					
	notify the HWD and F	RCD know.				
	•	medications were down to				
	two doses, she inform	ned the RCD.				
		she could call the pharmacy				
		ations until late July 2024				
		er, during a visit, to call the				
		on a medication that was				
	not available to admir					
		D and was then told to				
	•	PCP, and document it in the				
		and the physician's book at				
	the desk.	. ,				
	-Since late July 2024	when she notified the				
	_	n, she documented it in the				
		ne desk and put it on the 24				
	hour report sheet.	·				
	-If a medication was r	not available to administer,				
	she documented med	lication "not in cart" on the				
	eMAR.					
	-If a resident's medica	ation ran out prior to the time				
		e pharmacy, the MAs waited				
		eliver the medication.				
		responsible to ensure the				
		armacy were placed in the				
	medication carts.	•				
	Interview with the RC	D on 08/16/24 at 9:46am				
	revealed:					
	-She had only been in	n the position of RCD for 6-8				
	weeks.					
	-The HWD was respo	onsible for ensuring				

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NAME OF PROVIDER OR SUPPLIER  HALO11361  STREET ADDRESS, CITY, STATE, ZIP CODE  HARMONY AT REYNOLDS MOUNTAIN  A. BUILDING:  R  08/20/2024	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
NAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY	AND PLAN OF	FCORRECTION	IDENTIFICATION NUMBER.	A. BUILDING:		COMIT LETED	
41 COBBLERS WAY			HAL011361	B. WING		1	024
HADMONY AT REVNOLDS MOUNTAIN	NAME OF PRO	OVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
	HADMONY	AT PEVNOLDS MOUNT	FAIN 41 COBBLI	ERS WAY			
ASHEVILLE, NC 28804	TIARWONT	AT RETHOLDS MICON	ASHEVILLI	E, NC 28804			
	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE C	(X5) COMPLETE DATE
medications were available for administration prior to her being employed by the facility.  -The MAs on third shift were responsible for receiving medications from the pharmacy and putting the medication in the correct medication cart for administration.  -If the MAs found a medication that was not available, they were supposed to use the refill feature in the eMAR.  -If a medication did not arrive as expected from the pharmacy to find out why the medications were not delivered.  -The MA who worked third shift on Monday nights in the SCU was responsible for performing a medication.  -The MA was then supposed to turn in the audit results to the previous RCD and to her now.  -She was not sure about follow through with discrepancies found during the medication cart audits prior to her employment as the RCD.  -She had not completed a medication cart audit or reviewed the medication cart audit or reviewed the medication cart audits since she began working at the facility.  Interview with the Corporate Clinical Specialist on 08/20/24 at 4:15pm revealed:  -If any resident did not have a medication available to administer the MAs should call the pharmacy and tell them to send the medication and bill the facility.  -There was no reason for any resident to be without their medications.  Interview with the Administrator on 08/20/24 at 5:45pm revealed:  -The MAs were responsible for weekly medication cart audits and had failed to identify missing medications.	T	medications were avaprior to her being emp- The MAs on third shi receiving medications putting the medication cart for administration- If the MAs found a mavailable, they were sefeature in the eMAR. If a medication did not the pharmacy, the MAP pharmacy to find out not delivered.  The MA who worked nights in the SCU was a medication cart audit medications.  The MA was then sure sufficiently to the previous she was not sure ab discrepancies found of audits prior to her emposhe had not complet or reviewed the medication audits prior to her emposhe had not complet or reviewed the medication audits prior to her emposhe had not complet or reviewed the medication audits prior to her emposhe had not complet or reviewed the medication and the little pharmacy and tell the and bill the facility.  There was no reason without their medication interview with the Adron 5:45pm revealed:  The MAs were responsant audits and had facility and had	ailable for administration bloyed by the facility. If were responsible for a from the pharmacy and in in the correct medication in. It is in the correct medication that was not supposed to use the refill in the correct as expected from t	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
	V AT DEVAIOL DO MOUNT	41 COBB	LERS WAY		
HARMON	HARMONY AT REYNOLDS MOUNTAIN  ASHEVILI				
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFILIENCY)	D BE COMPLETE
D 358	Continued From page  -The RCD and HWD up on missing medicat medication cart audits -The RCD and HWD ensuring medications administerThe RCD and HWD daily standup meeting medication cart audits -She was responsible found on medication on by the RCD and H -The staff were not be were not held account reasons as to why the were not being comple  2. Review of Residen 11/27/23 revealed dia artery disease and hy a. Review of Residen 11/27/23 revealed the brimonidine (used to 0.2% eye drops instill times daily for eye pre Review of a subseque revealed continue brit one drop in both eyes  Review of Resident # medication administra revealed:	were responsible to follow ations identified on the s. were responsible for were available to were responsible to report in gs issues identified on the s. for ensuring the issues cart audits were followed-up WD. eing trained correctly and table could be one of the emedication cart audits eted.  It #10's current FL2 dated gnoses included coronary repertension.  It #10's current FL2 dated ere was an order for reduce pressure in the eye) one drop in each eye three essure.  ent order dated 05/30/24 monidine 0.2% eye drops is three times daily.	D 358		
	scheduled at 7:00am -The brimonidine was	h eye three times a day , 1:00pm, and 7:00pm. s documented as red for 68 occurrences out			

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SU	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLE	TED
		1141 044004	B. WING		R 08/20/2024	
		HAL011361	B. WING		08/20	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	ΓΕ, ZIP CODE		
			LERS WAY	,		
HARMON'	Y AT REYNOLDS MOUNT	ΓΑΙΝ				
		ASHEVIL	LE, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE		COMPLETE DATE
TAG	REGOLATORT OR E	100 IDEIVIII TIIVO IIVI ORWATION)	TAG	DEFICIENCY)	WAI E	
				,		
D 358	Continued From page	e 131	D 358			
		am, 1:00pm, and 7:00pm,				
	the brimonidine was o	documented as not				
	administered due to "	patient refused medication."				
	-On 06/02/24 at 1:00p	om and 7:00pm, the				
	brimonidine was docu	umented as not administered				
	due to "patient refuse	d medication."				
	-On 06/03/24 at 1:00p	om, the brimonidine was				
	documented as not a	dministered due to "patient				
	refused medication."	·				
	-On 06/04/24 at 1:00p	om and 7:00pm, the				
	·	ımented as not administered				
	due to "patient refuse					
	-On 06/05/24 at 1:00p					
		umented as not administered				
	due to "patient refuse					
	-On 06/06/24 at 1:00p					
		umented as not administered				
	due to "patient refuse					
	-On 06/07/24 at 1:00p					
		ımented as not administered				
	due to "patient refuse					
		om, the brimonidine was				
		dministered due to "patient				
	refused medication."					
		om, the brimonidine was				
		dministered due to "patient				
	refused medication."					
	-On 06/10/24 at 7:00a	•				
		ımented as not administered				
	due to "patient refuse					
	-On 06/11/24 at 7:00a					
	brimonidine was docu	umented as not administered				
	due to "patient refuse	d medication."				
	-On 06/14/24 at 7:00a	am, the brimonidine was				
		dministered due to "patient				
	refused medication."	·				
		am, the brimonidine was				
		dministered due to "patient				

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refused medication."

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AND DUAN OF CORRECTION IDENTIFICATION NUMBER.		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
						R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
			BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	ITAIN 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 ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 132	D 358			
	Review of Resident a revealed:  -There was an entry instill one drop in each scheduled at 7:00 am - The brimonidine was administered as order of 93 opportunities.  -On 07/05/24 at 7:00 documented as not a refused medication."  -On 07/12/24 at 7:00 documented as not a refused medication."  -On 07/13/24 at 7:00 documented as not a refused medication."  -On 07/14/24 at 7:00 documented as not a refused medication."  -On 07/14/24 at 7:00 documented as not a refused medication."  -On 07/14/24 at 1:00 documented as not a refused medication."  -On 07/16/24 at 1:00 documented as not a refused medication."  -On 07/17/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/18/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/19/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/19/24 at 1:00 brimonidine was documented as not a refused medication."  -On 07/19/24 at 1:00 brimonidine was documented as not a refused medication."	for brimonidine 2% eye drop ch eye three times a day n, 1:00pm, and 7:00pm. s documented as ered for 64 occurrences out opm, the brimonidine was administered due to "patient opm and 7:00pm, the sumented as not administered ed medication."  Topm and 7:00pm, the sumented as not administered due died medication."  Topm and 7:00pm, the sumented as not administered ed medication."  Topm and 7:00pm, the sumented as not administered due died medication."  Topm and 7:00pm, the sumented as not administered due died medication."  Topm and 7:00pm, the sumented as not administered due died medication."				

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		. ,	E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING	· · · · · · · · · · · · · · · · · · ·	08	R 3/20/2024
NAME OF D	ROVIDER OR SUPPLIER	etdeet A	DDRESS, CITY, STATE	ZIR CODE	·	
NAME OF P	ROVIDER OR SUPPLIER		BLERS WAY	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LE, NC 28804			
0/10/15	QUMMADV QT	FATEMENT OF DEFICIENCIES		PROVIDER'S PLAN OF	CORRECTION	0/5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From page	e 133	D 358			
	refused medication."					
		am, 1:00pm and 7:00pm, the				
		umented as not administered				
	due to "patient refuse					
	-On 07/26/24 at 7:00	am, 1:00pm and 7:00pm, the				
	brimonidine was doc	umented as not administered				
	due to "patient refuse					
	-On 07/27/24 at 1:00pm, the brimonidine was documented as not administered due to "patient refused medication." -On 07/28/24 at 7:00am and 7:00pm, the brimonidine was documented as not administered due to "patient refused medication."					
		am, 1:00pm and 7:00pm, the				
		umented as not administered				
	due to "patient refuse					
	Paview of Pasident t	#10's August 2024 eMAR				
	from 08/01/24-08/16/					
		for brimonidine 2% eye drop				
	-	ch eye three times a day				
		ı, 1:00pm, and 7:00pm.				
	-The brimonidine was	s documented as				
	administered as orde	ered for 17 occurrences out				
		om 08/01/24 to 08/16/24 at				
	7:00am.					
	-On 08/01/24 at 1:00	•				
		umented as not administered				
	due to "patient refuse					
	-On 08/02/24 at 1:00	umented as not administered				
	due to "patient refuse					
	•	pm, the brimonidine was				
		administered due to "patient				
	refused medication."					
		am, the brimonidine was				
		administered due to "patient				
	refused medication."					
		am, 1:00pm and 7:00pm, the				
	brimonidine was doc	umented as not administered				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL	ERS WAY		
		ASHEVILL	.E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 134	D 358		
D 336	due to "patient refuse -On 08/06/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/08/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/09/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/11/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/12/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 7:00: brimonidine was doct due to "patient refuse -On 08/14/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/15/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct due to "patient refuse -On 08/13/24 at 1:00: brimonidine was doct	and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medication."  am, 1:00pm and 7:00pm, the amented as not administered and medicatio	D 306		
	when the eye drops v	vere initially opened by staff.			
	Telephone interview of from the facility's con				

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-Resident #10's brimonidine eye drops were last

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AND DLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN 41 COBE	BLERS WAY			
TIARMON	TAT KETHOLDO MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	dispensed on 03/26/ 17-day supplyThe brimonidine eye 12/13/23, 01/09/24, 01/17-day supplyThe brimonidine eye up to four weeks after being stored at room -Using the brimonidine temperature after for burning sensation in Telephone interview Nurse (RN) who wor ophthalmologist's off revealed: -Resident #10 was or drops to control the pulf Resident #10 miss of the brimonidine, hincreased pressure increased.  Based on observation review it was determined interviewable.	e drops were also dispensed 02/21/24 each supplying a e drops were safe to use for er the date they were opened a temperature. The eye drops stored at room ar weeks could cause a the eyes.  with the triage Registered exed at Resident #10's fice on 08/19/24 at 11:10am ordered the brimonidine eye pressure in his eyes. Seed a large number of doses the ran a higher risk of in his eyes.	D 358			
	11/27/23 revealed th ketorolac (used to re	ere was an order for educe inflammation and 0.5% instill one drop in each				
	(PCP) order dated 0: -Discontinue ketorola -Start ketorolac 0.4%					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
						R
		HAL011361	B. WING		08	3/20/2024
NAME OF D		OTDEET A	DDDEGG GITY GTATE	7/D 00DF	, ,	
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
	CLIMMADY C				CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	e 136	D 358			
	medication administred revealed: -There was an entry drop into left eye four scheduled at 7:00am 7:00pmThe ketorolac was do for 84 occurrences or -On 06/01/24 at 7:00 7:00pm, the ketorolac administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was do administered due to scheduled at 1:00 the ketorolac was documented at 1:00 the ketorola	for ketorolac 0.4% instill one r times a day while awake, 11:00am, 4:00pm, and ocumented as administered at of 120 opportunities. am, 11:00am, 4:00pm, and c was documented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." pm, the ketorolac was administered due to "patient oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, cumented as not 'patient refused medication." oam, 4:00pm, and 7:00pm, the tented as not administered				
	7:00pm, the ketorola	am, 11:00am, 4:00pm and c was documented as not 'patient refused medication."				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
		41 COBBI	LERS WAY		
HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVILI	_E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 137	D 358		
	-On 06/11/24 at 11:00 ketorolac was docum due to "patient refuse -On 06/12/24 at 11:00 documented as not a refused medication." -On 06/14/24 at 7:00a documented as not a refused medication." -On 06/18/24 at 7:00a ketorolac was docum due to "patient refuse -On 06/21/24 at 11:00 documented as not a refused medication." -On 06/22/24 at 4:00a documented as not a refused medication." -On 06/25/24 at 11:00 documented as not a refused medication." -On 06/25/24 at 11:00	Dam and 7:00pm, the ented as not administered ad medication." Dam, the ketorolac was dministered due to "patient am, the ketorolac was dministered due to "patient am and 11:00am, the ented as not administered			
	refused medication."  Review of Resident #10's July 2024 eMAR revealed:  -There was an entry for ketorolac 0.4% instill one drop into left eye four times a day while awake for conjunctivitis scheduled at 7:00am, 11:00am, 4:00pm, and 7:00pm.  -The ketorolac was documented as administered for 79 occurrences out of 124 opportunities.  -On 07/05/24 at 11:00am and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."  -On 07/09/24 at 4:00pm and 7:00pm, the ketorolac was documented as not administered due to "patient refused medication."  -On 07/12/24 at 7:00am, the ketorolac was documented as not administered due to "patient refused medication."  -On 07/13/24 at 4:00pm and 7:00pm, the				

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPL	ETED
					-	,
		1141 044204	B. WING		F	
		HAL011361	1		08/2	20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	ATE, ZIP CODE		
		41 COBBL	ERS WAY			
HARMON	Y AT REYNOLDS MOUNT	TAIN ASHEVILL	E, NC 28804			
040.15	STIMMADV ST.	ATEMENT OF DEFICIENCIES	1	PROVIDER'S PLAN OF CORRECTION		0/5)
(X4) ID PREFIX		Y MUST BE PRECEDED BY FULL	ID PREFIX	(EACH CORRECTIVE ACTION SHOUL		(X5) COMPLETE
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROI	PRIATE	DATE
				DEFICIENCY)		
D 358	Continued From page	e 138	D 358			
		ented as not administered				
	due to "patient refuse					
	-On 07/14/24 at 7:00a					
		dministered due to "patient				
	refused medication."	41 141				
	-On 07/16/24 at 4:00p					
		dministered due to "patient				
	refused medication."	om 4.00pm and 7.00pm				
	the ketorolac was do	am, 4:00pm and 7:00pm,				
		patient refused medication."				
		•				
	the ketorolac was do	am, 4:00pm and 7:00pm,				
		patient refused medication."				
	-On 07/19/24 at 4:00p	<u> </u>				
		ented as not administered				
	due to "patient refuse					
	-On 07/20/24 at 4:00p					
	·	dministered due to "patient				
	refused medication."	·				
	-On 07/22/24 at 7:00a	am, 11:00am, 4:00pm and				
		was documented as not				
	administered due to "	patient refused medication."				
	-On 07/23/24 at 11:00	)am, 4:00pm, and 7:00pm,				
	the ketorolac was doo	cumented as not				
	administered due to "	patient refused medication."				
	-On 07/24/24 at 11:00	)am, 4:00pm, and 7:00pm,				
	the ketorolac was doo	cumented as not				
	administered due to "	patient refused medication."				
	-On 07/25/24 at 7:00a	am, 11:00am, 4:00pm and				
	7:00pm, the ketorolad	was documented as not				
	administered due to "	patient refused medication."				
	-On 07/26/24 at 7:00a	am, 11:00am, 4:00pm and				
	7:00pm, the ketorolad	was documented as not				
	administered due to "	patient refused medication."				
	-On 07/27/24 at 11:00	am, the ketorolac was				
	documented as not a	dministered due to "patient				
	refused medication."					
	-On 07/27/24 at 4:00p	om, the ketorolac was				

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documented as not administered due to "med not

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
	/ AT DEVALOR DO 1401111	41 COBB	LERS WAY		
HARMON	AT REYNOLDS MOUN	ASHEVIL	LE, NC 28804		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECT	TION (X5)
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETE
D 358	Continued From page	e 139	D 358		
	on my shift."				
		am, 4:00pm and 7:00pm, the			
		ented as not administered			
	due to "patient refuse				
	•	am, 11:00am, 4:00pm and			
		c was documented as not			
	• •	patient refused medication."			
		•			
	Review of Resident #	10's August 2024 eMAR			
	from 08/01/24-08/19/	24 revealed:			
	-There was an entry f	for ketorolac 0.4% instill one			
		times a day while awake for			
		ed at 7:00am, 11:00am,			
	4:00pm, and 7:00pm.				
		ocumented as administered			
	for 24 occurrences or				
		Dam, 4:00pm and 7:00pm,			
	the ketorolac was do				
		patient refused medication."			
	the ketorolac was do	Dam, 4:00pm and 7:00pm,			
		patient refused medication."			
		om, the ketorolac was			
	·	dministered due to "patient			
	refused medication."	diffinistered dde to patient			
		am, the ketorolac was			
		dministered due to "patient			
	refused medication."	'			
	-On 08/05/24 at 7:00a	am, 11:00am, 4:00pm and			
		c was documented as not			
	administered due to "	patient refused medication."			
		am, 11:00am, 4:00pm and			
	• •	c was documented as not			
		patient refused medication."			
		0am, 4:00pm and 7:00pm,			
	the ketorolac was do				
		patient refused medication."			
		am, 11:00am, 4:00pm and			
	•	c was documented as not			
	administered due to "	patient refused medication."			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		1 ' '	(X3) DATE SURVEY COMPLETED	
		A. BOILDING				
	HAL011361	B. WING		08	R / <b>20/2024</b>	
NAME OF PROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE			
HARMONY AT REYNOLDS MOUNTA	41 COBBL	ERS WAY				
TIANMONT AT NETHOEDS MOONTA	ASHEVILL	.E, NC 28804				
PREFIX (EACH DEFICIENCY)	EMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
D 358 Continued From page	140	D 358				
-On 08/10/24 at 4:00pm documented as not addrefused medication." -On 08/11/24 at 7:00am 7:00pm, the ketorolac wadministered due to "pa-On 08/12/24 at 7:00am 7:00pm, the ketorolac wadministered due to "pa-On 08/13/24 at 7:00am 7:00pm, the ketorolac wadministered due to "pa-On 08/14/24 at 11:00a the ketorolac was documented as not addrefused medication." -On 08/15/24 at 11:00a documented as not addrefused medication." -On 08/16/24 at 11:00a ketorolac was documented was documented as not addrefused medication." -On 08/16/24 at 11:00a ketorolac was documented was documented as not addrefused medication." -On 08/16/24 at 11:00a ketorolac was documented was documented was documented to "patient refused -On 08/17/24 at 7:00am ketorolac was documented was documented to "patient refused -On 08/19/24 at 7:00am 7:00pm, the ketorolac wadministered due to "patient refused -On 08/19/24 at 7:00am 7:00pm, the ketorolac wadministered due to "patient refused -On 08/19/24 at 10-There was one open to drops with label direction each eye twice daily with 03/26/24 and no date in -There was one bottle of drops with label direction each eye twice daily with 1 abel direction with label directions with label direction	ministered due to "patient  n, 11:00am, 4:00pm and was documented as not atient refused medication." n, 11:00am, 4:00pm and was documented as not atient refused medication." n, 11:00am, 4:00pm and was documented as not atient refused medication." n, 11:00am, 4:00pm and was documented as not atient refused medication." am, 4:00pm and 7:00pm, amented as not atient refused medication." am, the ketorolac was ministered due to "patient  am, 4:00pm, 7:00pm, the nted as not administered medication." n and 7:00pm, the nted as not administered medication." n, 11:00am, 4:00pm and was documented as not atient refused medication."  at #10's medications on 0:00am revealed: bottle of ketorolac 0.5% eye cons to instill one drop in ith a dispense date of nitially opened by staff. of ketorolac 0.4% eye cons to instill one drop four eye with a dispense date of	D 358				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.		R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBLE	ERS WAY		
TIARRITOR	TATRETHOEDO MOOR	ASHEVILLE	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 141	D 358		
	from the facility's con	tracted pharmacy on revealed the dispense of nidine eye drops on			
	Nurse (RN) who work ophthalmologist's office revealed: -Resident #10 was or eye drops to keep infleyeKeeping inflammatio left eye helped to keep	vith the triage Registered and the triage Registered at Resident #10's are on 08/19/24 at 11:10am and the ketorolac 0.4% ammation down in the left and swelling down in the p the eye pressure within maintain the resident's			
		ns, interviews and record ned that Resident #10 was a			
	c. Review of Resident #10's primary care provider (PCP) order dated 05/30/24 revealed latanoprost (used to reduce pressure in the eye) 0.005% one drop to both eyes once daily.				
	medication administrative revealed: -There was an entry for drop into both eyes at 7:00pmThe latanoprost was administered for 22 of opportunities.	or latanoprost 0.005% one t bedtime scheduled at documented as			
	08/10/24-08/11/24, th				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
		HAL011361	B. WING		08	R 8/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	ITAIN	BLERS WAY			
()(1) ID	SLIMMARYS	TATEMENT OF DEFICIENCIES	ILLE, NC 28804	PROVIDER'S PLAN OF	COPPECTION	(VE)
(X4) ID PREFIX TAG	(EACH DEFICIENC	CY MUST BE PRECEDED BY FULL LISC IDENTIFYING INFORMATION)	ID PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	Continued From pag	je 142	D 358			
	revealed: -There was an entry drop into both eyes a 7:00pmThe latanoprost was administered for 22 opportunitiesOn 07/05/24, 07/09, 07/17/24-07/19/24, the lat as not administered medication."	occurrences out of 29				
	from 08/01/24-08/18 -There was an entry drop into both eyes a 7:00pmThe latanoprost was administered for 4 copportunitiesOn 08/01/24-08/03/08/08/08/24-08/09/24, 0	/24 revealed: for latanoprost 0.005% one at bedtime scheduled at s documented as occurrences out of 18 24, 08/05/24-08/06/24, 08/11/24-08/18/24, the umented as not administered				
	hand on 08/19/24 at one open bottle of la with label directions eyes daily with a distribution the facility's cor 08/19/24 at 10:28am -The latanoprost 0.0	dent #10's medications on 10:00am revealed there was stanoprost 0.005% eye drops to instill one drop to both pense date of 05/30/24.  with a pharmacy technician intracted pharmacy on in revealed: 05% dispensed for Resident is a 25 to 28 day supply of the				

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AND DI AN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
ANDILAN	or connection	IDENTIFICATION NOMBER.	A. BUILDING: _		COMILET	LD
		HAL011361	B. WING		R 08/20/	2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY 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 CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE
D 358	when left at room ter -Using latanoprost af temperature could ca its effectiveness.  Telephone interview Nurse (RN) who wor ophthalmologist's off revealed Resident #* latanoprost 0.005% of pressure down in the glaucoma (when the completely blocks the preventing fluid from causing pressure to it damaging the option  Based on observation review it was determ not interviewable.  Interview with a Med 08/19/24 at 9:52am r -Resident #10 had be eye drops for "about -Resident #10 told he eyes and that's why interview with another revealed: -Resident #10 refuse time." -Resident #10 would drops in his eyes unl right mood."	Id be used for six weeks inperature. Ifter six weeks at room ause the medication to lose with the triage Registered ked at Resident #10's ice on 08/19/24 at 11:10am 10 was ordered the eye drops to keep eye eye to prevent angle closure iris bulges and partially or e eye's drainage angle circulating through the eye increase and potentially herve).  Ins, interviews and record ined that Resident #10 was ication Aide (MA) on revealed:  Idea week."  In the eye drops burned his he refused them.  In the eye drops "all the eye ess they caught him "in the ealth and Wellness Director in the ealth and Wellness Director in the eye drops birector in the ealth and Wellness Director in the eye drops birector in the ealth and Wellness Director in the ealth and Wellness Director in the execution	D 358			
		Resident #10's eye drops				

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Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		(X2) MI II TIDI E	CONSTRUCTION	(X3) DATE SI	IRV/FV		
	OF CORRECTION	IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		COMPLETED	
			A. BOILDING	7. SSIEDING.			
		B. WING		R			
		HAL011361	D. 11110		1 08/20	0/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY				
TIARRION	TAT KETHOLDO MOON	ASHEVII	LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROFIDERICENCY)	D BE	(X5) COMPLETE DATE	
D 358	Continued From page	e 144	D 358				
	were not being admir -He was not aware so drops were not dated -He was responsible MAs conducted week assisted livingHe had not received from the third shift sta cart auditsHe did not know for serecent medication cal -The weekly medicati supposed to include of medications on hand	nistered. ome of Resident #10's eye when opened. for ensuring the third shift tly medication cart audits for any documentation recently aff concerning medication sure if staff had completed rt audits.					
	08/20/24 at 4:15pm re- lt was the responsible weekly medication call the medications were and not expiredThe HWD should ad in awhile to know what- When third shift staff audits, it was the HW	ility of the HWD to perform int audits. Ility of the HWD to ensure available, dated correctly, minister medications "once at was happening."					
	5:45pm revealed: -She became the Adr -She was not aware of Resident #10's medic -The Resident Care If were responsible for available to administe -The RCD and HWD	cations. Director (RCD) and HWD ensuring medications were					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
HADMON	V AT DEVNOI DO MOUN	41 COBB	LERS WAY		
HARMONY AT REYNOLDS MOUNTAIN ASHEV			LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 358	medication cart auditable of the staff had been audits, the problems medications would halt was their policy for medication variance. The variance report with Resident #10 geaches of the HWD was responsible found on medication on by the RCD and half tablet (25mg one tablet eveals of the standard of the was adfacility on 06/05/24.  a. Review of Resider 06/05/24 revealed: Diagnoses included cellulitis, and demenders and facility on 06/05/24.  a. Review of Resider 06/05/24 revealed that the metoprolol (used to the 25mg one tablet eveals of the was an entry one half tablet (25mg at 8:00am and 8:00p before morning dose (BP) was greater that (HR) was less than 60-The metoprolol was administered as order	doing medication cart with Resident #10's ave been found. r the HWD to run a report daily. would have shown issues etting his medications. onsible to go over the issues riance report and actions th the Administrator daily in ng. e for ensuring the issues cart audits were followed-up HWD.  Int #2's current FL2 dated multiple fractures ribs, tia. mitted from a skilled nursing  Int #2's current FL2 dated ere was an order for reat high blood pressure) ry 12 hours.  #2's June 2024 electronic ration record (eMAR) from revealed: for metoprolol 50mg take g) two times a day scheduled m; check blood pressure if systolic blood pressure if systolic blood pressure n 130 and or if heart rate is hold medication.	D 358		

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DIVISION	n nealth Service Negu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			-		_	
					R	
		HAL011361	B. WING	<del></del>	08/20/2024	
NAME OF D	DOVIDED OD SUDDUED	STDEET AD	DDESS CITY STA	TE ZID CODE		
NAIVIE OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	ii e, zip code		
HARMON'	Y AT REYNOLDS MOUNT	ΓΑΙΝ	ERS WAY			
		ASHEVILL	E, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORREC	( - /	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHO		E
TAG	REGULATORY OR L	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPI DEFICIENCY)	OPRIATE	
				52. (6.2.(6.7)		-
D 358	Continued From page	e 146	D 358			
	through 06/30/24 at 8	•				
		0/24, the blood pressure				
	, , ,	60-184/104 and heart rate				
	(HR) range was 54-10	07.				
	-On 06/06/24 at 8:00a	am, there was no				
	documented BP or Hi	R, metoprolol was				
	documented as not a	dministered due to "not in				
	cart."					
	-On 06/06/24 at 8:00p	om, there was no				
	documented BP or Hi					
		dministered due to "bp not in				
	range."					
	-On 06/09/24 at 8:00a	am there was no				
	documented BP or Hi					
		dministered due to "not in				
	cart."	diffinistered due to Tiot in				
		am, the documented BP was				
		as 75, metoprolol was				
		dministered due to "waiting				
	on pharmacy."	uninistered due to waiting				
		and the decimanted DD was				
		om, the documented BP was				
		was 87, metoprolol was				
	order."	dministered due to "held per				
		om there was no				
	-On 06/11/24 at 8:00a	•				
	documented BP or Hi	•				
		dministered due to "not in				
	cart."					
		om, the documented BP was				
		as 86, metoprolol was				
		dministered due to "med not				
	on cart."					
	-On 06/12/24 at 8:00a					
	documented BP or Hi					
		dministered due to "not in				
	cart."					
	-On 06/12/24 at 8:00p	om, the documented BP was				
		as 86, metoprolol was				
		dministered due to "med not				

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on cart."

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` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _	<del></del>		
		HAL011361	B. WING		R	
					08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBL				
			E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 147	D 358			
D 356	-On 06/13/24 at 8:00a documented BP or HI documented as not acart." -On 06/13/24 at 8:00a 140/78 and the HR w documented as not acon cart." -On 06/14/24 at 8:00a documented BP or HI documented as not acart." -On 06/14/24 at 8:00a 145/75 and the HR w documented as not acart." -On 06/15/24 at 8:00a 174/111 and the HR w documented as not acart." -On 06/15/24 at 8:00a 174/111 and the HR w documented BP or HI documented BP or H	am, there was no R, metoprolol was dministered due to "not in om, the documented BP was as 78, metoprolol was dministered due to "med not am, there was no R, metoprolol was dministered due to "not in om, the documented BP was as 105, metoprolol was dministered due to "med not am, the documented BP was as 105, metoprolol was dministered due to "med not om, the documented BP was was 82, metoprolol was dministered due to "not in om, there was no R, metoprolol was dministered due to "not in om, there was no R, metoprolol was dministered due to "not in om, there was no R, metoprolol was dministered due to "not in om, there was no R, metoprolol was dministered due to "not in om, there was no R, metoprolol was dministered due to "not in	D 358			
	163/88 and the HR w	am, the documented BP was as 69, metoprolol was				

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didn't need."

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STATEMENT	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		_	
		HAL011361	B. WING		R 08/20/2024	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HADMON	Y AT REYNOLDS MOUNT	41 COBB	LERS WAY			
HARWON	TAI RETNOLDS MOUNT	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 APPROPF DEFICIENCY)	BE COMPLETE	
D 358	Continued From page	e 148	D 358			
	-On 06/28/24 at 8:00a documented BP or HI documented as not a cart."					
	Review of Resident # revealed: -There was an entry f	•				
	-There was an entry for metoprolol 50mg take one half tablet (25mg) two times a day scheduled at 8:00am and 8:00pm; check blood pressure					
	•	if systolic BP was greater was less than 65 hold				
	-The metoprolol was administered as order of 40 opportunities.	documented as red for 38 occurrences out				
	-From 07/01/24-07/31	I/24, the BP range was e HR range was 57-107.				
	-On 07/01/24 at 8:00p documented BP or HI	om, there was no				
	documented as not a order."	dministered due to "held per				
	-On 07/02/24 at 8:00a documented BP or HI					
	documented as not a refused medication."	dministered due to "patient				
	revealed:	2's August 2024 eMAR				
	one half tablet (25mg	for metoprolol 50mg take ) two times a day scheduled				
	before morning dose	m; check blood pressure if systolic BP was greater was less than 65 hold				
	medication.					
	-The metoprolol was administered as order of 13 opportunities.	documented as red for 12 occurrences out				
	-From 08/01/24-08/14	1/24, the BP range was e HR range was 56-99.				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION		SURVEY PLETED	
			A. BOILDING	, , , , , , , , , , , , , , , , , , ,		
		HAL011361	B. WING	<del></del>	08	R 8/ <b>20/2024</b>
NAME OF D	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E ZIR CODE	,	
TVAIVIL OF T	NOVIDER OR GOLF EIER		BLERS WAY	L, 211 OODL		
HARMON	Y AT REYNOLDS MOUN	TAIN	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIV CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 358	refused medication."  Observation of Resid hand on 08/15/24 at -There was one bubb metoprolol 50mg one tablets remaining with 07/23/24 quantity 30There was a second "bedtime" of metopro with 11 half tablets redate of 07/23/24 quantity 30There was a quantity 50mg dispensed to the -There was a quantity 50mg dispensed to the	am, there was no R, metoprolol was dministered due to "patient ent #2's medications on 11:08am revealed: le pack labeled "morning" of half tablets with nine half in a dispense date of bubble pack labeled lol 50mg one half tablets maining with a dispense ntity 30.  12's repack summary report tracted pharmacy revealed: y of 30 tablets of metoprolol ne facility on 05/24/24. y of 30 tablets of metoprolol ne facility on 06/23/24.  With Resident #2's primary on 08/19/24 at 8:55am in 19/24	D 358	DEFICIENCY		
	not interviewable.	nined that Resident #2 was t #2's current FL2 dated				
	06/05/24 revealed the	ere was an order for				

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING:		
		HAL011361	B. WING		R 08/20/2024
					06/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HARMON'	Y AT REYNOLDS MOUNT	TAIN 41 COBBL			
	Г		E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 150	D 358		
		at high blood pressure)			
	160mg one tablet eve				
	Review of Resident #	2's June 2024 electronic			
	medication administra	ation record (eMAR)			
	revealed:				
		or valsartan 160mg one			
	, , ,	pedtime hold if systolic blood			
	than 60 scheduled at	an 110 or diastolic BP less			
		ocumented as administered			
	as ordered for 13 occ				
	opportunities.	· ·			
		0/24, the BP range was			
	-On 06/10/24, the dod	cumented BP was 140/100;			
	the valsartan was doo				
	administered due to "				
		cumented BP was 144/89;			
	the valsartan was dod				
	administered due to "	med not on cart. cumented BP was 144/89;			
	the valsartan was do				
	administered due to "				
		cumented BP was 140/78;			
	the valsartan was dod				
	administered due to "				
	-On 06/14/24, the doc	cumented BP was 145/75;			
	the valsartan was doo	cumented as not			
	administered due to "	med not on cart."			
		vas no documented BP; the			
		ented as not administered			
	due to "not in cart."	and decomposity LBB #			
	· ·	vas no documented BP; the			
	vaisartan was docum	ented as not administered			
		vas no documented BP; the			
	·	ented as not administered			
	due to "med not on ca				
	oue to "med not on cart." -On 06/18/24, the documented BP was 122/77;				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED		
			7 50.12510.		F	) )
		HAL011361	B. WING		1	0/2024
NAME OF F	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	FAIN 41 COBBL				
		ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE	(X5) COMPLETE DATE
D 358	Continued From page	e 151	D 358			
D 330	the valsartan was do administered due to " -On 06/19/24, the door the valsartan was door administered due to " -On 06/20/24, the door the valsartan was door administered due to " -On 06/21/24, the door the valsartan was door administered due to " -On 06/21/24, the door the valsartan was door administered due to " Review of Resident # revealed: -There was an entry for tablet every night at beliess than 110 or diast scheduled at 8:00pmThe valsartan was do as ordered for 29 occopportunitiesFrom 07/01/24 to 07. 93/73-187/108On 07/01/24, there we valsartan was docum due to "held per order tablet every night at beliess than 110 or diast scheduled at 8:00pmThe valsartan was do as ordered for 7 occupoportunities.	cumented as not med not on cart." cumented BP was 157/109; cumented as not med not in cart." cumented BP was 155/96; cumented as not med not on cart." cumented BP was 151/102; cumented BP was 151/102; cumented as not not in cart."  2's July 2024 eMAR for valsartan 160mg one pedtime hold if systolic BP olic BP less than 60  2's July 2024 eMAR  3's valsartan 160mg was  2's August 2024 eMAR  3's valsartan 160mg one pedtime hold if systolic BP olic BP less than 60  3's Coumented as administered one pedtime hold if systolic BP olic BP less than 60  3's Coumented as administered occumented as administered occumented as administered	D 336			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING	<del></del>	R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBBI	ERS WAY		
HARMON	TAT KETHOEDO MOON	ASHEVILI	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE
D 358	Continued From page	e 152	D 358		
	tablets with a dispens of 30. -The label directions	le pack of valsartan 160mg se date of 07/23/24 quantity were valsartan 160mg one se hold if systolic BP less than			
	Review of Resident #2's repack summary report from the facility's contracted pharmacy revealed: -There was a quantity of 30 tablets of valsartan 160mg dispensed to the facility on 05/24/24There was a quantity of 30 tablets of valsartan 160mg dispensed to the facility on 06/23/24.				
	Telephone interview with Resident #2's primary care provider (PCP) on 08/19/24 at 8:55am revealed: -Resident #2 had a diagnosis of heart failureResident #2 was ordered valsartan to treat high blood pressureMissed doses of the valsartan increased Resident #2's risk of heart attack, stroke, and worsening kidney disease from high blood pressure.				
		ns, interviews, and record nined that Resident #2 was			
	06/05/24 revealed the torsemide (a diuretic from multiple causes	used to reduce swelling and also used to treat high g take one and one-half			
	Review of Resident # medication administrates	2's June 2024 electronic ation record (eMAR)			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION (DENTIFICATION NUMBER:		' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE ZIP CODE	·
NAME OF T	NOVIDEN ON 3011 LIEN		BLERS WAY	TE, Zii GODE	
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page		D 358		
	and one-half tablets (scheduled at 8:00amThe torsemide was a 20 occurrences out of 06/07/24-06/30/24On 06/20/24, torsem administered due to "-On 06/21/24, torsem administered due to "Review of Resident #from the facility's cont-There was a quantity 20mg dispensed to the 1-there was a quantity 20mg dispensed to the 20mg dispensed to the 20mg dispensed to the 20mg dispensed to the 3-there was a quantity 20mg dispensed to the 3-there was a quantity 20mg dispensed to the 3-there was a quantity 3-th	locumented as administered f 22 opportunities from ide was documented as not not in cart." ide was documented as not not in cart."  2's repack summary report tracted pharmacy revealed: of 60 tablets of torsemide re facilty on 05/24/24. of 26 tablets of torsemide re facility on 06/08/24, due to two per day to one and			
	hand on 08/15/24 at an anti-transfer was one bubb tablets with a dispension quantity of 45.  The label directions one and one-half tables.  Telephone interview was a second or continuous tables.	le pack of torsemide 20mg se date of 07/23/24 for a were torsemide 20mg take			
	-It was "very dangero even two doses of the -Missed doses of the	torsemide increased neart attack, stroke, and			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
HARMON	V AT DEVNOLDS MOUN	TAIN 41 COBB	LERS WAY		
HARMONY AT REYNOLDS MOUNTAIN  ASHEVIL			LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE
D 358	D 358 Continued From page 154		D 358		
		ns, interviews, and record nined that Resident #2 was			
	dated 03/18/19 reveal -Community provides medication assistance -All medications for remedication assistance requested to be unit-distributionAny medication provistaff assistance that will be sent to the Copharmacy for repacked agrees to and/or is all regulationsAll medications that and assist with will be electronic medication (MAR) and in according	s medication ordering and e services. esidents receiving e from Community staff are dose packaged prior to  rided to the Community for was not unit-dose packaged mmunity's preferred aging, if the pharmacy ble to repackage per  staff members handle, store, e documented on the a administration record ance with state regulations is preferred pharmacy policy			
	facility's contracted p 1:50pm revealed: -Resident #2's medic to the facility by an or -Resident #2's medic in bottlesResident #2's bottled the facility's contracte repackaged into bubl -The pharmacy sent	ations arrived to the facility  d medications were sent to ed pharmacy and			
	Interview with a medi	•			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7.1.20.125.110.		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE	
		41 COBE	BLERS WAY		
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 358	Continued From page	e 155	D 358		
	08/16/24 at 10:14am	revealed:			
		not available to administer,			
		dication "not in cart" on the			
		edications, she would click on			
		the electronic eMAR.			
	-If a resident's medic	ation ran out prior to the time			
		ne pharmacy, the MAs waited			
		leliver the medication.			
	_	dent #2's medications in			
		de pharmacy and then sent contracted pharmacy to			
		ations into bubble packs.			
		ations arrived in quantities of			
	a three month supply				
		end the entire three month			
	supply to the facility's	s contracted pharmacy and			
		e the medications and send			
		ications back to the facility in			
	quantities of a 30-day				
	the pharmacy by third				
		responsible to ensure the			
	medication carts.	ons were placed in the			
		sident Care Director (RCD)			
	on 08/15/24 at 2:38p				
	-She had been in the weeks.	position of RCD for eight			
	-The Health and Wel	Iness Director (HWD) was			
		ring medications were			
		tration prior to her being			
	employed by the faci				
		ations were delivered to the			
	facility from an outsid				
	-	onsible to send Resident #2's			
		o the facility's contracted			
		aging into bubble packs. onsible for making sure			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
II A DIMONI	V AT DEVALOU DO MOUNT	41 COBBI	ERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ASHEVILI	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	) BE COMPLETE
D 358	Continued From page	= 156	D 358		
D 358	administration.  -If the MAs found a m for administration, the refill feature in the eM -If a demanded medic expected from the fact the MAs were supposfind out why the medication the MAs was responsible medication cart audit -The MA was then suresults to the RCD.  -She was not sure ab discrepancies found of audits prior to her em Interview with the Cot 08/20/24 at 4:15pm refigured.	he facility and available for nedication was not available by were supposed to use the IAR. Cation did not arrive as stility's contracted pharmacy, sed to call the pharmacy to cations were not delivered. If third shift on Monday le for performing a of all residents medications, pposed to turn in the audit out follow through with during the medication cart ployment as the RCD.	D 358		
		n for any resident to be			
	5:45pm revealed: -She became the Adr -The weekly medicati identify Resident #2's -The RCD and Health (HWD) were respons	ministrator on 08/20/24 at ministrator "one week ago." on cart audits had failed to missing medications. n and Wellness Director ible to follow up on missing d on the medication cart were responsible for			
		were responsible to report in			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			E SURVEY PLETED
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF F	PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE	-	
		41 COBE	BLERS WAY	,		
HARMON	Y AT REYNOLDS MOUN	ITAIN ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 358	daily standup meetir medication cart audi-she was responsible found on medication on by the RCD and decomposed of the properties of the pr	ngs issues identified on the ts. le for ensuring the issues a cart audits were followed-up HWD.  Int # 6's current FL2 dated iagnoses included diabetes 2), Parkinson's disease, and balance instability.  If care provider (PCP) order aled there was an order for ower blood sugar) 10mg et by mouth once daily for notify physician if blood sugar  #6's June 2024 electronic ration record (eMAR)  for Jardiance 10mg tablet, nouth once daily at 8:00am for notify physician if blood sugar  08am, the documented FSBS was documented as here was no documentation  21am, the documented FSBS was documented as here was no documentation  24 am, the documented FSBS was documented as here was no documentation	D 358			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
	HAL011361	B. WING			R 8/ <b>20/2024</b>	
ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	, ZIP CODE			
	41 COBE	BLERS WAY				
Y AT REYNOLDS MOUNT	TAIN ASHEVII	LLE, NC 28804				
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Continued From page	e 158	D 358				
administered, and the PCP was notified On 06/30/24 at 8:00 was 156; Jardiance w	ere was no documentation lam, the documented FSBS vas documented as					
medication administrative revealed:  - There was an order take one tablet by modiabetes, hold and nowas less than 200.  -On 07/02/24 at 08:33 was 110; Jardiance was administered, and the PCP was notified.  -On 07/03/24 at 08:24 was 117; Jardiance was	for Jardiance 10mg tablet, buth once daily at 8:00am for biffy physician if blood sugar flam, the documented FSBS are was no documented FSBS are was no documented FSBS are documented as from the documented FSBS are documented FSBS are documented as					
was 102; Jardiance wadministered, and the PCP was notifiedOn 07/05/24 at 9:19a was 133; Jardiance wadministered, and the PCP was notifiedOn 07/07/24 at 7:59a was 130; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:32a was 124; Jardiance wadministered, and the PCP was notifiedOn 07/15/24 at 8:00a	vas documented as ere was no documentation am, the documented FSBS vas documented as ere was no documentation am, the documented FSBS vas documented as ere was no documentation am, the documented FSBS vas documented as ere was no documentation am, the documented FSBS vas documented as ere was no documentation am, the documented FSBS vas documented as ere was no documentation					
	Continued From page administered, and the PCP was notifiedOn 07/03/24 at 08:32 was 110; Jardiance wadministered, and the PCP was notifiedOn 07/03/24 at 08:32 was 133; Jardiance wadministered, and the PCP was notifiedOn 07/05/24 at 08:32 was 133; Jardiance wadministered, and the PCP was notifiedOn 07/05/24 at 08:32 was 17; Jardiance wadministered, and the PCP was notifiedOn 07/04/24 at 10:33 was 102; Jardiance wadministered, and the PCP was notifiedOn 07/05/24 at 9:193 was 133; Jardiance wadministered, and the PCP was notifiedOn 07/07/24 at 7:593 was 130; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 7:593 was 130; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notifiedOn 07/12/24 at 8:323 was 124; Jardiance wadministered, and the PCP was notified.	HALO11361  PROVIDER OR SUPPLIER  Y AT REYNOLDS MOUNTAIN  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 158  administered, and there was no documentation PCP was notified.  On 06/30/24 at 8:00am, the documented FSBS was 156; Jardiance was documented as administered, and there was no documentation PCP was notified.  Review of Resident #6's July electronic medication administration record (eMAR) revealed:  There was an order for Jardiance 10mg tablet, take one tablet by mouth once daily at 8:00am for diabetes, hold and notify physician if blood sugar was less than 200.  On 07/02/24 at 08:31am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/03/24 at 08:24am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/04/24 at 10:32am, the documented FSBS was 102; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/05/24 at 9:19am, the documented FSBS was 103; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/05/24 at 9:19am, the documented FSBS was 133; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/07/24 at 7:59am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/12/24 at 8:32am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified.  On 07/12/24 at 8:32am, the documented FSBS was 124; Jardiance was documented as administered, and there was no documentation PCP was notified.	ROVIDER OR SUPPLIER  **PAT REYNOLDS MOUNTAIN**  **SUMMARY STATEMENT OF DEFICIENCIES** (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  **Continued From page 158** administered, and there was no documentation PCP was notified On 06/30/24 at 8:00am, the documented FSBS was 156; Jardiance was documented as administered, and there was no documentation PCP was notified There was an order for Jardiance 10mg tablet, take one tablet by mouth once daily at 8:00am for diabetes, hold and notify physician if blood sugar was less than 200 On 07/02/24 at 08:31am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/03/24 at 08:24am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/04/24 at 10:32am, the documented FSBS was 10; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/04/24 at 10:32am, the documented FSBS was 10; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/07/24 at 17:59am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/12/24 at 18:32am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/12/4 at 18:32am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/15/24 at 8:32am, the documented FSBS was 124; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/15/24 at 8:30am, the documented FSBS was 124; Jardiance was documented as administered, and there was no documentation PCP was notified.	DENTIFICATION NUMBER:  HALO11361  ROVIDER OR SUPPLIER  TREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY ASHEVILLE, NC 28804  SUMMARY STATEMENT OF DEFICIENCES  [EACH DERICIENCY MUST BE PRECEDED BY PLUL REGULATORY OR LSC DENTIFYING INFORMATION)  COntinued From page 158  administered, and there was no documentation PCP was notified.  Review of Resident #6's July electronic medication administration record (eMAR) revealed: There was an order for Jardiance 10mg tablet, take one tablet by mouth once daily at 8:00am for diabetes, hold and notify physician if blood sugar was less than 200. On 07/02/24 at 08:31am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/03/24 at 08:24am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/03/24 at 08:23am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/03/24 at 10:32am, the documented FSBS was 102; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/05/24 at 9:19am, the documented FSBS was 133; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/05/24 at 7:59am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/12/24 at 8:32am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified. On 07/12/24 at 8:32am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documented as adminis	ROWDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY ASHEVILLE, NC 28804  SUMMARY STATEMENT OF DEFICIENCES (EACH DEFICIENCY MUST BE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION)  CONTINUED From page 158  administered, and there was no documentation PCP was notified On 06/30/24 at 8:00am, the documented FSBS was 169, Jardiance was documented as administered, and there was no documentation PCP was notified On 10/30/24 at 0.31am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/03/24 at 0.32am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 0.32am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 0.32am, the documented FSBS was 110; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 0.32am, the documented FSBS was 117; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 0.93am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 19-19am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 19-19am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 18-29am, the documented FSBS was 130; Jardiance was documented as administered, and there was no documentation PCP was notified On 07/07/24 at 8.32am, the documented FSBS was 141, Jardiance was documented as administered, and there was no documentation PCP was notified On 07/12/24 at 8.32am, the documented FSBS was 141, Jardiance was documented as administered, and there was no documentation PCP was notified.	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NOWIBER.	A. BUILDING: _	A. BUILDING:		LETED
		HAL011361	B. WING		08	R / <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE
D 358	-On 07/20/24 at 7:47; was 119, the Jardian incorrectly, and there was notifiedOn 07/24/24 at 7:53; was "not recorded", there was no docume Review of Resident #medication administrative revealed: -On 08/03/24 at 9:09; was 103; Jardiance vadministered, and the PCP was notifiedOn 08/07/24 at 7:44; was "not recorded", there was no docume -On 08/10/24 at 7:08; was 114; Jardiance vadministered, and the PCP was notified.  Interview with PCP or revealed: -She was not informed JuneShe was not informed administered incorrect though FSBS was undurant of the PCP was notified was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect though FSBS was undurant of the PCP was not informed administered incorrect the PCP was not informe	entation PCP was notified. am, the documented FSBS be was administered was no documentation PCP am, the documented FSBS the Jardiance was held, and entation PCP was notified.  66's August electronic ation record (eMAR) am, the documented FSBS was documented as ere was no documentation am, the documented FSBS the Jardiance was held, and entation PCP was notified. am, the documented FSBS was documented as ere was no documentation and the documented fSBS was documented as ere was no documentation and the documented fSBS was documented as ere was no documentation and of any FSBS under 200 in and the medication was being etly and was given even der 200. sugar issues could result in action Jardiance essential for controlling es. cation aide (MA) on	D 358			
		e for contacting the physician				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		1141 044004	B. WING		R
		HAL011361			08/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	ΓAIN	LERS WAY		
	T	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE COMPLETE
D 358	Continued From page	e 160	D 358		
	missedShe was responsible	eld, administered late, or e for communication with the regarding resident issues.			
	on 08/20/24 at 4:45pi -He was responsible -He was responsible notified of any reside including missed or h -He was responsible pharmacy.	for auditing MARs. for ensuring the PCP was nt related health concerns eld medications. for faxing new orders to the medications were being			
	05/16/24 revealed the gabapentin (used to t tablet, one tablet by r	reat nerve pain) 600mg nouth each day at bedtime. electronic medication			
	tablet, take one table 9:00am. -The gabapentin was	or gabapentin 600 mg t by mouth once daily at			
	o5:00pm revealed: -She noted the gabar administered appropriatention of staffThe gabapentin was administered at bedtiThe time of gabapen addressed by the facture.	supposed to be me.  tin administration was never			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			1 ' '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
			7.1. 20125.110			R	
		HAL011361	B. WING			20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE			
HARMON	Y AT REYNOLDS MOUN	ΓAIN	LERS WAY				
			LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE	
D 358	Continued From page	e 161	D 358				
	increased the resider	abapentin on 06/25/24 as					
	Interview with a MA or revealed:	n 08/16/24 at 10:48am					
	facility management i medication issues.						
	<ul> <li>She was unaware ar administered incorred</li> </ul>						
		edications as shown on the					
	revealed: -He was responsible -He was responsible notified of any reside including missed or h	for ensuring the PCP was nt related health concerns					
	administered incorred	medications were being otly. t #5's current FL2 dated					
	06/10/24 revealed dia depression, sleep app	agnoses included severe nea, adenocarcinoma, d cerebrovascular accident.					
	07/12/24 revealed tar	5's physician's order dated msulosin (used to treat 0.4 mg. 1 tablet once daily; time to bedtime.					
	Medication Administratevealed: -There was an entry f	5's July 2024 electronic ation Record (eMAR) for tamsulosin 0.4 mg, take ne for urinary incontinence.					

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	-
		41 COBB	ERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ASHEVILI	_E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE COMPLETE
D 358	Continued From page	e 162	D 358		
	revealed: -There was an entry fone capsule at bedtim -There was an entry fadminister daily at 9:0 -There was document				
	facility's contracted ph 11:25am revealed: -He received an dated 0.4 mg. to be given at -He was not aware th eMAR. -He was not sure why administration time as 9:00pm. -He changed the time	with the Pharmacist from the narmacy on 08/15/24 at d 07/15/24 for tamsulosin t bedtime for Resident #5. e time did not change on the the eMAR still had the s 9:00am, instead of to be administered on the be given on 08/16/24 at			
	Primary Care Provide 4:35pm revealed: -Resident #5 had adv chronic obstructive pu -She changed the adr tamsulosin 0.4 mg to because it could caus condition that causes	ministration time for			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
ANDILAN	O CONNECTION	IDENTIFICATION NOWIDER.	A. BUILDING: _		COMI ELTED
		HAL011361	B. WING		R 08/20/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	AT REYNOLDS MOUNT	ΓAIN	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE COMPLETE
D 358	the risk of fallingShe was not aware to still being administersShe expected staff in implemented and follow line in the result of the re	alls due to dizziness. bedtime would decrease hat tamsulosin 0.4 mg was ed in the mornings. hake sure orders were bowed through.  cation aide (MA) on evealed: amsulosin 0.4 mg was istered at bedtime. he eMAR said, and it had ster the tamsulosin at  alth and Wellness Director at 11:10am revealed: hing the order for tamsulosin histration time at bedtime. high the order to the  of the administration time for as not changed to bedtime  lity to ensure orders were s.  rvisor on 08/20/24 at e for collecting all new orders and placing it in the HWD's  of an order to change the ation time to be given at  onsible to ensure orders	D 358		
	Interview with the Co	rporate Clinical Specialist			

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	HAI 044264			<b>I</b>	(X3) DATE SURVEY COMPLETED	
	HAL011361	B. WING		08	R / <b>20/2024</b>	
E OF PROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE,	, ZIP CODE			
MONY AT REYNOLDS MOUN	FAIN 41 COBE	BLERS WAY				
INIONT AT RETNOLDS MOUN	ASHEVIL	LE, NC 28804				
EFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETE DATE	
358 Continued From page	e 164	D 358				
-She was not aware t tamsulosin 0.4 mg. w -It was the HWD's res	he administration time for as changed to bedtime. sponsibility to ensure orders					
5:46pm revealed: -She became the Adr -She was not aware t administration time of -She expected orders on eMAR's so the me correctlyNot being trained co could be reasons why checked for accuracy -It was the HWD's res	ninistrator a week ago. amsulosin had the wrong in the eMAR for Resident #5. Is to be up to date and reflect edications would be given rectly or held accountable of eMAR's are not being is sponsibility to make sure					
The facility failed to e order was transcribed and the furosemide wadministration which unnecessarily increas #3 and the resident nas ordered which res swelling and weeping developing congestiv failed to ensure loraz administration for Resident and subsequences.	on)].  nsure that a physician's discourately on the eMAR was available for resulted in the physician sing the dosage for Resident ot receiving the furosemide for the lower extremities and increased her risk of the heart failure. The facility epam was available for sident #3, resulting in usent changes in dosages,					
(CCS) on -She was tamsulosin -It was the were charchanges.  Interview 5:46pm re -She becarson eMAR' correctlyNot being could be richecked from the eMAR's retimes.  [Refer to the Care (Type)  The facility order was and the fundaministration of the expension of the emand of th	08/20/24 at not aware to not aware to not aware to not aware to aware to attend or aware to attend or accuracy to a HWD's researched to easons why for accuracy to HWD's researched to easons who are A1 Violation which arily increase to a subsequence and subsequence and subsequence to a subsequen	08/20/24 at 3:35pm revealed: not aware the administration time for n 0.4 mg. was changed to bedtime. e HWD's responsibility to ensure orders nged on the eMAR to reflect current  with the Administrator on 08/20/24 at evealed: ame the Administrator a week ago. not aware tamsulosin had the wrong ation time on the eMAR for Resident #5. ected orders to be up to date and reflect 's so the medications would be given  g trained correctly or held accountable reasons why eMAR's are not being for accuracy. e HWD's responsibility to make sure effected the correct administration  and 273, 10A NCAC 13F .0902(b) Health the A1 Violation)].  Ty failed to ensure that a physician's to transcribed accurately on the eMAR throsemide was available for ation which resulted in the physician arily increasing the dosage for Resident the resident not receiving the furosemide d which resulted in her lower extremities and weeping and increased her risk of g congestive heart failure. The facility ansure lorazepam was available for ation for Resident #3, resulting in and subsequent changes in dosages, crease to a stronger medication as well	08/20/24 at 3:35pm revealed: not aware the administration time for n 0.4 mg. was changed to bedtime. http://www.exa.changed.ch	D 358  It from page 164  08/20/24 at 3:35pm revealed: not aware the administration time for n 0.4 mg, was changed to bedtime. HWD's responsibility to ensure orders aged on the eMAR to reflect current  with the Administrator on 08/20/24 at evealed: ame the Administrator a week ago. not aware tamsulosin had the wrong ation time on the eMAR for Resident #5. acted orders to be up to date and reflect s so the medications would be given g trained correctly or held accountable reasons why eMAR's are not being for accuracy. HWD's responsibility to make sure effected the correct administration  atag 273, 10A NCAC 13F .0902(b) Health the A1 Violation)].  Ty failed to ensure that a physician's transcribed accurately on the eMAR trosemide was available for ation which resulted in the physician arily increasing the dosage for Resident the resident not receiving the furosemide d which resulted in her lower extremities and weeping and increased her risk of g congestive heart failure. The facility insure lorazepam was available for ation for Resident #3, resulting in and subsequent changes in dosages, crease to a stronger medication as well	d From page 164  08/20/24 at 3:35pm revealed: not aware the administration time for n 0.4 mg. was changed to bedtime. HWD's responsibility to ensure orders nged on the eMAR to reflect current  with the Administrator on 08/20/24 at evealed: ame the Administrator a week ago. not aware tamsulosin had the wrong ation time on the eMAR for Resident #5. ected orders to be up to date and reflect is so the medications would be given g trained correctly or held accountable reasons why eMAR's are not being for accuracy. HWD's responsibility to make sure effected the correct administration  atag 273, 10A NCAC 13F .0902(b) Health the A1 Violation)].  y failed to ensure that a physician's transcribed accurately on the eMAR trosemide was available for ation which resulted in the physician arily increasing the dosage for Resident e resident not receiving the furosemide d which resulted in her lower extremities and weeping and increased her risk of g congestive heart failure. The facility nsure lorazepam was available for ation for Resident #3, resulting in and subsequent changes in dosages, crease to a stronger medication as well	

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED		
		HAL011361	B. WING		R 08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	•	
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	LERS WAY LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROPRIED TO THE APPROPRIED (ENCY)	D BE COMPL	ETE
D 358	ensure the physician with the administratio completed to prevent correct the dosage of FSBSs as high as 36 substantial risk for se neglect and constitute.  The facility provided a accordance with G.S. this violation.	ordered metformin changes in time to 5:00pm was GI upset and failured to metformin resulted in 8. This failure resulted in rious physical harm and es a Type A2 Violation.  a plan of protection in 131D-34 on 08/15/24 for FOR THE TYPE A2 HOT EXCEED SEPTEMBER	D 358			
	(g) The facility shall e administered to reside or one hour after the time unless precluded.  This Rule is not met TYPE B VIOLATION  Based on interviews a facility failed to ensur administered within o after the prescribed ti residents related to a symptoms of Parkins stiffness and tremors	and record reviews, the e medications were ne hour before or one hour me for 2 of 3 sampled medication used to treat				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
ANDILAN	or dortheorion	IDENTIFICATION NOMBER.	A. BUILDING: _		OOMII EETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBBL	ERS WAY		
HARMON	I AI KETHOEDS MOON	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 364	Continued From page	e 166	D 364		
D 364	dated 03/18/19 reveal administered up to or prescribed time, unless specific time.  1. Review of Residen 06/10/24 revealed diadepression, sleep apple accident, systematic likely accident, systematic likely accident, systematic likely accident for carbidopales symptoms of Parkins stiffness and tremors tablets, three times a likely accident # medication administrative accident # medication administrative accident # 25-100 tablet, take 2 8:00am, 12:00pm, and Carbidopalevodopa administered at 9:00a 06/01/24 through 06/2 administered at 8:00a	s Medication Services policy led medications were to be the hour before and after their ses the physician ordered a st #5's current FL2 dated agnoses included severe thea, cerebrovascular supus, and adenocarcinoma.  5's signed physician's revealed there was an evodopa (used to treat on's disease such as 25mg-100mg tablet, take 2 day.  5's June 2024 electronic action record (eMAR)  for carbidopa-levodopa tablets three times daily at d 5:00pm.  was documented as am, 12:00pm, and 5:00pm 21/24 and documented as am on the 06/22/24.	D 364		
	administered on 06/2	was documented as not 2/24 at 12:00pm or 5:00pm			
	due to "leave of abse	nce." was documented as not			
	administered on 06/2				
	12:00pm due to "leav	e of absence."			
	-	was documented as			
	administered on 06/2	•			
		was documented as			
	administered on 6/24 12:00pm, and 5:00pm	/24-06/30/24 at 8:00am, n.			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:		` '	SURVEY PLETED	
		HAL011361	B. WING		08	R 3/20/2024
NAME OF F	PROVIDER OR SUPPLIER		DDRESS, CITY, STATE	ZIP CODE	1 33	
		41 COBB	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY 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) COMPLETE DATE
D 364	Review of Resident # Administration Audit -Carbidopa-levodopa administered outside hour after time frame 84 opportunities with being on 06/30/24 at -There was no entry Administration Audit 8:00am or 12:00pm.  Review of Resident # revealed: -There was an entry 25-100 tab, take 2 ta 8:00am, 12:00pm, ar -Carbidopa-levodopa administered on 07/0 12:00pm, and 5:00pm  Review of Resident # Administration Audit -Carbidopa-levodopa administered outside hour after time frame 91 opportunities with being 07/29/24 at 9:1 -There was no entry Administration Audit 8:00am or 12:00pm.  Review of Resident # -There was an entry 25-100 tablet, take 2 8:00am, 12:00pm, ar -Carbidopa-levodopa administered on 08/0 12:00pm, and 5:00pm	Report revealed:  25-100 tablet was of the one hour before/one for 38 occurrences out of the latest administration 1:15pm. on the June 2024 Medication Report for 06/01/24 at  25's July 2024 eMAR for carbidopa-levodopa blets three times daily at ad 5:00pm. was documented as al/1/3-07/31/24 at 9:00am, n.  25's July 2024 Medication Report revealed: a 25-100 tablet was the one hour before/one for 46 occurrences out of the latest administration 6am. on the July 2024 Medication Report for 07/01/24 at  25's August eMAR revealed: for carbidopa-levodopa tablets three times daily at ad 5:00pm. was documented as al/24-08/13/24 at 8:00am, n. was documented as al/24-08/13/24 at 8:00am, n. was documented as	D 364	DEFICIENT		

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		, ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
					R
	HAL011361	B. WING		08	3/20/2024
NAME OF PROVIDER OR SUPPLIE		TADDRESS, CITY, STATE	, ZIP CODE		
HARMONY AT REYNOLDS I	OUNTAIN	BBLERS WAY VILLE, NC 28804			
PREFIX (EACH DEF	RY STATEMENT OF DEFICIENCIES CIENCY MUST BE PRECEDED BY FULL YOR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
Administration A-Carbidopa-levor administered on hour after time for 39 opportunities being 08/14/24 and the state of the	ent #5's August Medication udit Report revealed: dopa 25-100 tablet was tside the one hour before/one rame for 18 occurrences out of with the latest administration at 9:16am. ntry on the August 2024 inistration Audit Report for am and 12:00pm.  View with the facility's contracted ovider (MHP) on 08/15/24 at d: s started on the opa by another physician. levodopa must be taken at the or day to prevent "wearing off" the symptoms such as difficulty anding, stiff and achy muscles, thements, muscle rigidity, problems on and gait, and difficulty with allowing would reoccur because the dication would be diminished. The constant level of the opa in Resident #5's blood bould cause very painful and obtoms.  medication aide (MA) on pm revealed: she administered Resident #5's opa "late" on multiple occasions. enough staff to assist with	D 364			

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	OF DEFICIENCIES OF CORRECTION	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING:		В	
		HAL011361	B. WING		R 08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
HARMON'	Y AT REYNOLDS MOUNT	AIN 41 COBBL	ERS WAY			
		ASHEVILL	E, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
D 364	Continued From page -He was aware Resid was not administered	ent #5's carbidopa-levodopa	D 364			
	-He thought it was due to sleep late.	e to Resident #5 preference				
	-He did not know Res cabidopa-levodopa w 12:00pm and 5:00pm	as administered late for the				
	-It was his responsibil were administered on	ity to ensure medications time.				
	(CCS) on 08/20/24 at					
	-Medications were co administered within a and after the time the	one-hour window before				
	administered on time.	nedications were not being				
	-The HWD was respo medications were adr					
	5:46pm revealed:	ninistrator on 08/20/24 at				
	multiple occasions.	vas administered late on				
	•	aff to administer medications efore and one hour after				
	-Lack of training and ı	not being held accountable the medications were being				
	-The HWD was respo	nsible for running a time o ensure medications were				
		-				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
AND FLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D 364	a. Review of Resider (PCP) orders dated 0 an order for carbidop (ER) 25-100mg tablet times daily for Parkin stiffness and tremors.  Review of Resident # medication administration administration administration and the second proportion of the seco	the sesident Register on date of 05/14/24.  In #6's primary care provider 05/14/24 revealed there was alevo extended release to take two tablets three son's symptoms such as, of the one-hour of two tablets at 9:00am, on.  #6's June 2024 electronic ation record (eMAR) on entry for carbidopa-levo of two tablets at 9:00am, on.  #6's June 2024 Medication Report revealed for frame for 16 of 86 one-hour of time frame for 16 of 86 one-hour of the one-hour of two tablets at 9:00am, on.  #6's July 2024 eMAR on entry for carbidopa-levo of two tablets at 9:00am, on.  #6's July 2024 Medication Report revealed for 8pm and 9pm.  #6's July 2024 Medication Report revealed for 8pm and 9pm was of the one-hour frame for 30 of 90 one latest administration time der for 8pm and	D 364		
	Review of Resident #	6's August 2024 eMAR			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
			A. BOILBING.			Б
		HAL011361	B. WING	<del></del>	I	R <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STAT	E, 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 LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPE DEFICIENCY)	OULD BE	(X5) COMPLETE DATE
D 364	ER 25-100mg tablets 12:00pm, and 8:00pm Review of Resident Administration Audit I carbidopa-levo ER 25 administered outside before/one-hour after opportunities with the being on 08/04/24 or administered at 2:45pt Interview with a medi 08/16/24 at 10:48am -Medications should before or one hour af administration on the -She was responsible if medications were a ordered timeThis medication requadministration time number could not recall more accurate administration time number could not recall more accurate administration time for diabetes) inject 10 unit/ml (diabetes) inject 10 unit/ml (d	n entry for carbidopa-levo two tablets at 9:00am, n.  #6's August 2024 Medication Report revealed 5mg/100mg was of the one-hour time frame for 21 of 54 elatest administration time der for 12:00pm and 5m.  cation aide (MA) on revealed: to be administered one hour fer the time for eMAR. el for contacting the physician administered outside of the uired more accurate 15 minutes before/after oted on MAR. why the medication required	D 364	DEFICIENCY)		
	Review of Resident #	6's June 2024 Medication				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CO A. BUILDING:			E SURVEY PLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	ZIP CODE	•	
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBE	SLERS WAY			
		ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 364	Administration Audit solostar was administed opportunities with the on 06/27/24 documed 10:33pm, two and a law revealed there was a 100 unit/ml inject 10 for diabetes, hold if be review of Resident administration audit resolostar was administed opportunities with the being on 07/17/24 or administered at 11:52 Review of Resident administered at 10 unit/ml inject 10 for diabetes, hold if be Review of Resident administration audit resolostar was administed opportunities with the being on 08/15/24 or administered on 08/1 Interview with Reside 5:00pm revealed:  She was not informed Solostar was not being one-hour before/one-it difficut to control the solostar was not the solostar was not the solostar was not being one-hour before/one-it difficut to control the solostar was not the solostar was not the solostar was not the solostar was not being one-hour before/one-it difficut to control the solostar was not t	Report revealed Lantus tered outside of the one hour time frame for 1 of 10 e latest administration time inted as administered at half hours late.  66's July 2024 eMAR in entry for Lantus Solostar units every night at 8:00pm lood sugar is less than 100.  66's July 2024 medication report revealed Lantus tered outside of the one hour time frame for 4 of 28 e latest administration time der for 8pm and 2pm.  66's August 2024 eMAR in entry for Lantus Solostar units every night at 8:00pm lood sugar is less than 100.  66's August 2024 eMAR in entry for Lantus Solostar units every night at 8:00pm lood sugar is less than 100.  66's August 2024 medication report revealed Lantus tered outside of the one hour time frame for 2 of 13 e latest administration time der for 8:00pm and 6/24 at 2:00am.  60's PCP on 08/19/20 at ed of Resident #6's Lantus and administered within the chour after timeframe making	D 364			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	AIN 41 COBBI	ERS WAY		
HARMON	TAT RETNOLDS MOUNT	ASHEVILL	.E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	DULD BE COMPLETE
D 364	Continued From page	: 173	D 364		
	Solostar could lead to	uncontrolled blood sugars.			
	before or one hour aft administration on the -She was responsible if medications were a c. Review of Resident	revealed: be administered one hour der the time for			
	an order for entacapo per daily (used in con	ne 200mg tablet three times bination with			
	carbidopa-levodopa to in patients with Parkir	o treat "end of dose" effects nson's disease.			
	Medication Administrative revealed there was an	6's June 2024 electronic ation Record (eMAR) n entry for entacapone nm, 12:00pm, and 8:00pm.			
	Administration Audit F was administered out before/one-after time opportunities with the being on 06/17/24 do				
		6's July 2024 eMAR n entry for entacapone nm, 12:00pm, and 8:00pm.			
	Administration Audit F was administered out before/one-hour after opportunities with the	6's July 2024 Medication Report revealed entacapone side of the one hour time frame for 19 of 90 latest administration time			

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE C A. BUILDING:			SURVEY PLETED	
			A. BOILDING.			Б
		HAL011361	B. WING		08	R 3/20/2024
NAME OF D			DDDEGG GITY GTATE	7/0.0005	1 00	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE BLERS WAY	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LLE, NC 28804			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	COMPLETE DATE
D 364	Continued From page	e 174	D 364			
	at 10:48am, two hour late.	s and forty-eight minutes				
	revealed there was a	6's August 2024 eMAR n entry for entacapone am, 12:00pm, and 8:00pm.				
	Administration Audit I was administered out before/one-hour after opportunities with the	time frame for 8 of 54 latest administration time cumented as administered				
	before or one hour af administration on the	revealed: to be administered one hour ter the time for MAR. e for contacting the physician				
	5:00pm revealed: -Entacapone was use carbidopa-levodopa to in patients with Parkinson's symptom tremorsShe was not aware to administered within the hour after the schedul which, could cause Research.	ent #6's PCP on 08/19/20 at ed in combination with o treat "end of dose" effects as such as, stiffness and the medication was not ne one hour before or one alled administration time desident #6 to experience an and stiffness and increased				
	d. Review of Resider provider's (PCP) orde there was an order fo	er dated 05/29/24 revealed				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			
				B. WING		R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STATE	E, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	LERS WAY LE, NC 28804			
(V4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF (	CORRECTION	(X5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
D 364	Continued From page	e 175	D 364			
	1 -	oer daily (used to treat associated with Parkinson's				
	Medication Administr	f6's June 2024 electronic ation Record (eMAR) n entry for amantadine 1 capsule by mouth three , 1pm, and 7pm for				
	Administration Audit I was administered ou before/one-hour after	time frame for 5 of 89 latest administration time der for 7am and				
		n entry for amantadine 1 capsule by mouth three				
	Administration Audit I was administered out before/one-hour after	time frame for 5 of 91 latest administration time der for 1pm and				
	revealed there was a	6's August 2024 eMAR n entry for amantadine 1 capsule by mouth three , 1pm, and 7pm for				
	Review of Resident #	6's August 2024 Medication				

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	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING:			(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	ΓΑΙΝ	BLERS WAY		
	T	ASHEVIL	LE, NC 28804		T
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
D 364	Continued From page		D 364		
	was administered out before/one-hour after	time frame for 3 of 46 latest administration time der for 1pm and			
	before or one hour af administration on the	revealed:  pe administered one hour ter the time for MAR. e for contacting the physician			
	5:00pm revealed: -Amantadine was use disorders associated -She was not aware a administered within thour after the schedu which, could cause R	with Parkinson's disease.  amantadine was not  ne one hour before or one led administration time esident #6 to experience an nd involuntary movements			
	to treat Parkinson's d within one-hour after Resident #5 and #6 a developing debilitating "wearing-off" effect of debilitating symptoms walking, standing, stiff involuntary movement with coordination and talking and swallowin detrimental to the hea	g symptoms due to ithe medication. The include difficulty with if and achy muscles, its, muscle rigidity, problems gait, and difficulty with g. This failure was			

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	ITE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	ΓΑΙΝ	ERS WAY		
	I		.E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETE
D 364	Continued From page	e 177	D 364		
	this violation.  CORRECTION DATE	131D-34 on 08/20/24 for			
D 451	and Incidents  10A NCAC 13F .1212 Incidents (a) An adult care hon department of social sincident resulting in reaccident or incident reresident requiring references		D 451		
	facility failed to ensure was sent to the depar (DSS) for 3 of 4 samp #6) who required the choking episode (#1), with injuries (#4 and # The findings are:	and record reviews, the e an incident/accident report the the the the the the the the the th			
	Review of the facility's dated 03/18/19 revea	s Medical Emergency policy led:			

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AND DLAN OF CORRECTION IDENTIFICATION NUMBER					ATE SURVEY OMPLETED	
			7. BOILDING			R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	E, ZIP CODE		
<b>П</b> АВМОМ	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
HARIMON	TAI RETNOLDS MOUN	ASHEVII	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 CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE
D 451			D 451			
	and given to the Res (RCD)/Health and W	nt form was to be completed ident Care Director ellness Director (HWD). It report was to be sent to				
		nt #1's FL-2 dated 07/03/23 ncluded diabetes, vascular pyroidism.				
		#1's Resident Register I was admitted on 07/03/23.				
	07/09/24 at 5:28pm r (MA) documented Re episode, turned blue	#1's progress note dated evealed a medication aide esident #1 had a choking in the face and a third party rsing Assistant (CNA)				
	07/17/24 at 8:45pm r -The Health Care Co locked unit documen -On 07/09/24, the sta #1 choked while eati -The HCC for the loc hospice nurse perfor and Resident #1's aii -Afterwards she obse	ordinator (HCC) for the ted a late entry for 07/09/24.  Iff notified her that Resident ng beets.  ked unit was informed that a med the Heimlich Maneuver				
	07/09/24 revealed: -The MA documented episode during the sl	's 24 hour report dated  d Resident #1 had a choking nift due to diet restrictions. nentation 911 was called.				
	Attempted review of	Resident #1's				

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BUILDING		
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		41 COBB	LERS WAY	,	
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	D BE COMPLETE
D 451	Continued From page	e 179	D 451		
		ort dated 07/09/24 revealed /accident report completed ied.			
	at 4:19pm revealed: -On 07/09/24, she wa 7:00pmOn 07/09/24, she wa MA covered the resid eating lunch.	as the MA from 7:00am to as off the floor while another ents when Resident #1 was a incident/accident report A completed one.			
	Memory Care Unit (M choked. -The MAs were respondent/accident repo	revealed: as the MA covering the ICU) when Resident #1 ansible for completing			
	08/14/24 at 8:30am rd -On 07/09/24, Reside which resulted in her the Heimlich Maneuv was no incident/accid	ent #1 had a choking episode loss of consciousness and er was performed and there lent report completed. nt/accident report completed			
	revealed: -On 07/09/24, when F lunch she was in a m -The MA that witness	ed the choking was eting the incident/accident			

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 1	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>	
NAME OF P	ROVIDER OR SUPPLIER	•	DDRESS, CITY, STATE	E. ZIP CODE	1 00	,	
		41 COBE	BLERS WAY	,			
HARMON	Y AT REYNOLDS MOUN	IAIN ASHEVII	LE, NC 28804				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETE DATE	
D 451	lnterview with the Co 08/16/24 at 2:37pm r -On 07/09/24, after R consciousness and the performed, the MA w completing the incide the report to the RCD -The RCD was responsible incident/accident reports and the completed for 07/Resident #1.  Telephone interview Administrator on 08/1 -He was the Administrator on 08/1 -The MA on duty at the incident/accident was sincident/accident was sincident w	e for faxing the ort to DSS. was not completed and she  rporate Clinical Specialist on evealed: esident #1 choked, lost ne Heimlich Maneuver was as responsible for ent/accident report and give or to DSS. Incident/accident report was 109/24 choking episode for with the previous 16/24 at 2:40pm. Errator on 07/09/24 and	D 451				
	RCDThe RCD was respo incident/accident report, the dat -He did not know a in						
	Refer to interview wit 9:46am.	h the RCD on 08/16/24 at					
	Refer to interview wit Specialist on 08/16/2	h the Corporate Clinical 4 at 2:37pm.					
	Refer to telephone in	terview with the previous					

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
ANDILAN	or dortheorion	BENTI IGATION NOMBER.	A. BUILDING: _		OOWII EETED
		HAL011361	B. WING		R 08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
HARMON	Y AT REYNOLDS MOUN	ΓAIN	LERS WAY		
	OUR MAN DV OT		LE, NC 28804	PD0/405000 DLAV 05 0000505	<u></u>
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE COMPLETE
D 451	Continued From page	e 181	D 451		
	Administrator on 08/1	6/24 at 2:40pm.			
	05/13/24 revealed	t #4's current FL2 dated hyperlipidemia and memory			
	Review of Resident # revealed: -She used a walker for -She required extens	4's care plan dated 04/30/24			
	report dated 07/04/24 -Resident #4 was fou bathroom after an un -She stated to staff sl legs hurt.	nd sitting on the floor in her witnessed fall. ne had hit her head, and her of the emergency room (ER). nentation the ort was sent to DSS.			
	revealed: -She was brought to a following a fall during -Resident was assess were foundResident was discharged to 17/04/24.	which she hit her head. sed for injury with no injuries urged to the facility on t #4's incident/accident			
	-She activated her en				

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	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLETED
		HAL011361	B. WING		R <b>08/20/2024</b>
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	ORESS, CITY, STA	TE, ZIP CODE	
HADMON	V AT DEVIOU DE MOUNT	41 COBBL	ERS WAY		
HARMON	Y AT REYNOLDS MOUNT	ASHEVILL	E, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 451	Continued From page	e 182	D 451		
	head and it was bleed -Resident was sent to -There was no docum incident/accident report Review of Resident and dated 07/16/24 reveating a fall where a "closed fracture".	o the emergency room (ER). nentation the ort was sent to DSS.  #4's ER discharge summary led: the emergency room she hit her head.			
		rged back to the facility on			
	report on 07/25/24 re -Resident #4 had an head.	unwitnessed fall and hit her Resident #4 was transported nentation the ort was sent to DSS.			
	(HWD) on 08/20/24 a -The MAs were responsible incident/accident reports and had not fax reports because he was process to make sure	and Wellness Director t 4:45pm revealed: possible for completing the ports and giving them to him. for faxing incident reports to ed the incident/accident vas still working on a better the incident/accident ed and faxed to DSS when			

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	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING:			SURVEY PLETED
			A. BOILBING.			R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	ADDRESS, CITY, STATE	. ZIP CODE	•	
		41 COBI	BLERS WAY	,		
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVI	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 183	D 451			
	Refer to interview wit 9:46am.	h the RCD on 08/16/24 at				
	Refer to interview wit Specialist on 08/16/2	h the Corporate Clinical 4 at 2:37pm.				
	Refer to telephone in Administrator on 08/1	terview with the previous 6/24 at 2:40pm.				
	revealed: -She used a walker for the sequired superviambulating and dress	ision with toileting,				
	-Resident had multipl admission. -Resident had her blo					
	revealed there was n incident/accident reported to the fall when Refer to interview wit	66's incident/accident reports of documentation of an ort completed or sent to DSS on she hit her head.				
	9:46am.  Refer to interview wit Specialist on 08/16/2	h the Corporate Clinical 4 at 2:37pm.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO		, , ,	E SURVEY PLETED
			A. BUILDING:			
		HAL011361	B. WING		08	R 3/ <b>20/2024</b>
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
		41 COBE	BLERS WAY			
HARMON	Y AT REYNOLDS MOUN	TAIN ASHEVII	LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 184	D 451			
	Refer to telephone in Administrator on 08/1	terview with the previous 6/24 at 2:40pm.				
	05/29/24 revealed dia dementia, major depr	at #13's current FL2 dated agnoses included vascular ressive disorder, history of erlipidemia, and carotid				
	05/13/24 revealed: -He required supervis and transfersHe required extensiv bathing and dressing	sion with eating, ambulating, we assistance with toileting, assistance with personal				
	report dated 07/17/24	of a wheelchair and fell to of hip and side pain. was 136/61, pulse 59. nentation the				
	report on 07/28/24 at -He was found by sta laceration above righ: -He had been incontinunwitnessed fallHis blood pressure v -There was no documincident/accident report	ff on the floor with a "small t eye with mild swelling". nent following the was 142/80, pulse 96. nentation the				
	c. Review of Residen report on 08/07/24 at					

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C			SURVEY PLETED
			A. BUILDING:			
			B. WING			R
		HAL011361	B. WING		08	/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN 41 COBE	BLERS WAY			
TIZITINON	TAT KETNOEDO MOON	ASHEVIL	LE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ( (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 451	Continued From page	e 185	D 451			
	tableHe had an abrasion toward his armpitHe was complaining -There was no docum incident/accident report on 08/08/24 at -Staff found the resid the end of the bed whadminister morning numbers.	nentation the ort was sent to DSS.  at #13's incident and accident 5:24am revealed: ent sitting on the floor next nen they came in to nedications. vas 160/94, pulse 90. nentation the				
	revealed: -The MA that witness accident was responsincident/accident representation and the HWD with the incident/accident Interview with the Co 08/16/24 at 2:37pm responsincident/accident representation and the HWDThe MA was responsincident/accident representation and the HWDThe RCD/HWD was incident/accident representations.	cD on 08/16/24 at 9:46am  led a fall, any injury or sible for competing the ort and give it to the rere responsible for faxing reports to DSS.				
	-The MA was respons	with the previous 16/24 at 2:40pm revealed: sible for completing the ort and give the report to the				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CO			SURVEY PLETED
						R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER		ADDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	BLERS WAY LLE, NC 28804			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 451			D 451			
D980	G.S. § 131D-25 Impler		D980			
	this Article shall rest facility. Each facility training to staff to imp	olementing the provisions of with the administrator of the shall provide appropriate olement the declaration of ided in G.S. 131D-21.				
	This Rule is not met TYPE A1 VIOLATION					
	Administrator failed to management, operate procedures of the fact maintained in substautiles and statutes to related to personal care and supersonal care and superso					
	The findings are:					
	through 12/31/24 for residentsThe expiration date 12/31/24.	's license revealed: d was effective 01/01/24 a capacity of up to 99 of the facility's license was as not listed on the license.				

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	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE Co		1 ' '	SURVEY PLETED
			D. WING			R
		HAL011361	B. WING		08	3/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	ΓAIN	BLERS WAY LLE, NC 28804			
			LL, NC 20004			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D980	Continued From page	e 187	D980			
	Review of the Admini 08/14/24 at 10:00am facility revealed the A	hanging on the wall in the				
	(PCA) on 08/14/24 at hired to be a private s facility and no one ga	ncy personal care aide 9:30am revealed she was sitter for the first time at the ve her instructions on what or the capabilities of the				
	12:03pm revealed shape #1 out after a choking	nd MA on 08/15/24 at e wanted to send Resident g episode per the policy but Resident Care Director CCD was the "nurse".				
	mental health provided 2:00pm revealed: -The staff at the facility weights, or vital signs not enough staff to obtain the was at the and Wellness Director to give report on the results.	facility, the RCD or Health r (HWD) were not available				
	Heimlich Maneuver o choking because she if she was allowed to the orientation about as the AD.  -There were two Cert	evealed: cardiopulmonary out did not provide the				

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	FOF DEFICIENCIES DF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE ( A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
					R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
HADMON	Y AT REYNOLDS MOUNT	41 COBB	LERS WAY		
HARMON	TAT RETNOLDS MOUNT	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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETE
D980	Continued From page	: 188	D980		
	Maneuver since three	staff present did not do it.			
	primary care physicia 4:35pm revealed ther staff to process order	vith the facilty's contracted n (PCP) on 08/15/24 at e was not enough trained s, administer medications, notify her about issues or idents.			
	2:31pm revealed: -There was a web base for scheduling that was November 2023The program allowed use the program to see -All staff had access that and request time -The HWD could see extra shifts, staff who when staffing ratios we -The web based prog	If the HWD or designee to bet staff schedules. To their schedules through off. The request for time off, pick up were CPR certified and were not going to be met. The rearm was not being utilized enot trained by the previous			
	revealed: -She started working agoSince she was hired been putting out "fires (MCU) and not able to dutiesIt was hard for her to because she was per admissions to the facigetting her training co	d, everything was a mess			

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DIVISION	n nealth Service Regu	ialion				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLI	ETED
						,
		1101 044004	B. WING		R	
		HAL011361			<sub>1</sub> 08/2	0/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
		41 COBBL				
HARMON	Y AT REYNOLDS MOUNT	TAIN	E, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
PREFIX TAG		SC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPR		DATE
1710		,	1,710	DEFICIENCY)		
			5000			
D980	Continued From page	e 189	D980			
	-When she began wo	rking at the facility there				
		documentation, resident				
	record keeping, facilit					
		and incident accident				
		rders not being filed and				
		livered from the pharmacy				
	that were not put on t					
		electronic documentation				
		osed to be used by her, the				
		s, but she was not given				
		it until 08/15/24 and the				
		e training on 08/16/24.				
	-Staff were not trained	on policies and				
	procedures.					
		ed and not trained on				
	policies and procedur					
		d at the facility, she spoke				
		cal Specialist (CCS) and				
	-	f be trained in CPR because				
	the CCS only wanted					
		only training the MAs in a				
	_	ld result in someone not				
	receiving CPR when t	they needed it.				
	•	vith the facility's contracted				
		T) on 08/19/24 at 9:23am				
	revealed:					
		working with another				
		, when the MA on duty in the				
		ssistance to make sure				
	Resident #1 was ok.					
		ned that Resident #1 was				
		pureed diet and was served				
	a regular diet at break	rfast and had a choking				
	episode.					
	-Her biggest concern	was that staff were not				
		ents out per issue/policy,				
		oncerns, or process orders				
	when written.	,				

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Division of	of Health Service Regu	ilation				
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S	
AND PLAN (	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLI	ETED
					F	<b>.</b>
		HAL011361	B. WING		1	20/2024
		IIALUTIOUT			1 00/2	.0/2024
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STA	TE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUNT	TAIN 41 COBB	LERS WAY			
HARMON	TAT KETHOLDO MIOON	ASHEVIL	LE, NC 28804			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP		COMPLETE DATE
TAG	NEGOLATORT ORT	EGG IDENTIF TING INFORMATION)	TAG	DEFICIENCY)	VIAIL	5,112
			+			
D980	Continued From page	e 190	D980			
	Interview with MA on	08/19/24 at 2:30pm				
	revealed:					
	-There was not enou					
	-There had recently b					
		s on the "memory care" floor				
		eding skilled level of care.				
		ts on the "memory care"				
	floor already need ski	orepared for the level of				
	need.	orepared for the level of				
	-The facility would no	t allow lifts				
		ough staff by any stretch of				
	the imagination".					
		is only 1 MA and 1 PCA on				
	this floor.					
	-Staff had tried to exp	plain this to administration.				
	Interview with the RC	D on 08/20/24 at 10:46am				
	revealed:					
	-She did not feel she					
		the requirements of her job.				
	-She felt staff were to					
	corporate clinical spe	eelings to corporate, and the				
		had any support from upper				
	management.	nad any support nom appor				
	J					
		/D on 08/20/24 at 11:10am				
	revealed:					
		supposed to be making				
	sure weights were do					
		into resident weights to				
	ensure they were get it was an issue.	ting done after he found out				
		it was his responsibility.				
	-140 One nau tolu IIIII	it was the responsibility.				
	Interview with a medi	cation aide (MA) on				
	08/20/24 at 3:10pm re					
		ve time to notify the doctors				
		s or weight refusals due to				

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AND PLAN	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING:	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			201251110.		R
		HAL011361	B. WING		08/20/2024
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	E, ZIP CODE	
HARMON	Y AT REYNOLDS MOUNT	AIN 41 COBB	LERS WAY		
HARWON	TAT KETHOEDS MOON	ASHEVIL	LE, NC 28804		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLETE
D980	Continued From page	: 191	D980		
	she was required to de-A lot of medications of medicating so many representations of medicating so many representations. She was giving medicated and the Adress of the physician, medicated responding in an emerging lementation of order the Department of Source of the Medication of the Medication of Source of the Medication of the Medica	was late because she was esidents and she does not cations out to resident floors, 1st and 3rd floors.  ministrator on 08/20/24 t  the policies. staff not being trained and do in the case of notifying tion management, ergency, staffing, lers, diets and notification to cial Services (DSS).			
	facility failed to provid according to the facility for 1 of 1 sampled resconsciousness and remainder (#1). [Refe. 0901(c) Personal Ca Violation)].  2. Based on observatinterviews, the facility and referral for 8 of 13 #3, #4, #5, #6, #10 & who had two choking of a primary care provided for the facility and research of the control of	ty's policy and procedures sidents who choked, lost			

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MAME OF PROVIDER OR SUPPLIER  STREET ADDRESS, CITY, STATE, ZIP CODE  41 COBBLERS WAY ASHEVILLE, NC 28804    CAN JID   SUMMARY STATEMENT OF DEFICIENCIES   CACH DEFICIENCY MUST BE PRECEDED BY FULL   PREFIX   TAG	STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:			(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER  ### ASHEVILLE, NC 28804  ### ASHEVILLE, NC 28804  ### ASHEVILLE, NC 28804    ASHEVILLE, NC 2804    ASHEVILLE, NC 2804    ASHEVILLE, NC 2804    ASHEVILLE, NC 28004    ASHEVILLE, NC 2804    ASHEVILLE, NC 2804    ASHEVILLE, N			HAI 011361			000	R / <b>20/2024</b>	
ARMONY AT REYNOLDS MOUNTAIN   ASHEVILLE, NC 28804						00	12012024	
ARMONY AT REYNOLDS MOUNTAIN   ASHEVILLE, NC 28804	NAME OF P	PROVIDER OR SUPPLIER			, ZIP CODE			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)   PREFIX TAG   PROVIDER'S PLAN OF CORRECTION SHOULD BY CROSS-REFERENCED TO THE APPROPRIATION OF LIFE APPROPRIATION OF LIF	HARMON	IY AT REYNOLDS MOUN	TAIN					
D980  Continued From page 192  (#2), notification to the primary care provider (PCP) about medications to treat blood pressure, anxiety, and diabetes (#3), about fall with a head injury (#4), weekly weights (#5), a diabetic medication with parameters (#6), a fall with head trauma for a resident on antiplatelet medications (#10) and weekly weights with parameters (#13). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].  3. Based on observations, interviews, and record reviews, the facility failed to implement orders for 5 of 13 sampled residents (#2, #3, #6, #9, and #11) related to urinalysis lab collections (#2 and #11) and application and removal of compression stockings (#2, #6, #9, and #11) and obtaining finger stick blood sugars (#3). [Refer to tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type A2 Violation)].  4. Based on interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents related to a purceed diet (Resident #1). [Refer to tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and								
(#2), notification to the primary care provider (PCP) about medications to treat blood pressure, anxiety, and diabetes (#3), about fall with a head injury (#4), weekly weights (#5), a diabetic medication with parameters (#6), a fall with head trauma for a resident on antiplatelet medications (#10) and weekly weights with parameters (#13). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type A1 Violation)].  3. Based on observations, interviews, and record reviews, the facility failed to implement orders for 5 of 13 sampled residents (#2, #3, #6, #9, and #11) related to urinalysis lab collections (#2 and #11) and application and removal of compression stockings (#2, #6, #9, and #11) and obtaining finger stick blood sugars (#3). [Refer to tag 276, 10A NCAC 13F .0902(c)(3-4) Health Care (Type A2 Violation)].  4. Based on interviews and record reviews the facility failed to ensure therapeutic diets were served as ordered for 1 of 2 sampled residents related to a pureed diet (Resident #1). [Refer to tag 310, 10A NCAC 13F .0904(e)(4) Nutrition and	PREFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACT CROSS-REFERENCED TO T	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE	
Food Service (Type A1 Violation)].  5. Based on observations, interviews, and record	D980	(#2), notification to the (PCP) about medicated anxiety, and diabeted injury (#4), weekly we medication with parastrauma for a resident (#10) and weekly we [Refer to tag 273, 10 Care (Type A1 Violated 3. Based on observation reviews, the facility for 13 sampled resident (#11) related to urinaled #11) and application stockings (#2, #6, #9 finger stick blood sug 10A NCAC 13F .090. A2 Violation)].  4. Based on interview facility failed to ensure served as ordered for related to a pureed diag 310, 10A NCAC Food Service (Type A)	e primary care provider ions to treat blood pressure, (*#3), about fall with a head eights (#5), a diabetic meters (#6), a fall with head on antiplatelet medications ights with parameters (#13). A NCAC 13F .0902(b) Health ion)].  Itions, interviews, and record ailed to implement orders for dents (#2, #3, #6, #9, and yeis lab collections (#2 and and removal of compression, and #11) and obtaining pars (#3). [Refer to tag 276, 2(c)(3-4) Health Care (Type we and record reviews the retherapeutic diets were at 1 of 2 sampled residents iet (Resident #1). [Refer to 13F .0904(e)(4) Nutrition and 13T Violation)].	D980				
reviews, the facility failed to ensure medications were administered as ordered for 5 of 13 sampled residents (#2, #3, #5, #6, #10) related to		reviews, the facility fa were administered as sampled residents (#	alled to ensure medications s ordered for 5 of 13 2, #3, #5, #6, #10) related to					
medications used to treat high blood pressure, anxiety and elevated blood sugar (#3), medications used to treat high blood pressure and fluid retention (#2), medication used to treat urinary incontinence (#5), medications used to treat high blood sugars and nerve pain (#6), and a medication used to reduce increased eye pressure (#10). [Refer to tag 358, 10A NCAC 13G		anxiety and elevated medications used to and fluid retention (# urinary incontinence treat high blood suga a medication used to	blood sugar (#3), treat high blood pressure 2), medication used to treat (#5), medications used to rs and nerve pain (#6), and reduce increased eye					

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, ,		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			- I		R	
		HAL011361	B. WING	<del>-</del>	08/20/2024	
NAME OF P	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	ΓE, ZIP CODE		
HARMON	Y AT REYNOLDS MOUN	TAIN	SLERS WAY LLE, NC 28804			
(VA) ID	SLIMMADV ST		,	PROVIDER'S PLAN OF CORREC	TION	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETE	
D980	D980 Continued From page 193		D980			
	Violation)].					
	facility failed to ensur administered within of after the prescribed to residents related to a symptoms of Parkins stiffness and tremors treat Parkinson's dise [Refer to tag 364, 10.	ne hour before or one hour me for 2 of 3 sampled medication used to treat				
	management and operallowing staff to not represent to not residents' life threate episode where a resident was a 3rd party personate hospital, and a set days later, was not sellater that day (#1), not as ordered resulting if died later that day (#1) the healthcare needs #5, #6, #10 & #13), not oresidents (#2, #3, providing staffing to resupervision needs of	neet the personal care and the residents. This failure serious neglect which				
	neglect which constit  The facility provided	n serious physical harm and utes a Type A1 Violation. a plan of protection in . 131D-34 on 08/20/24 for				

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	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
					R			
		HAL011361	B. WING		08/20/2024			
NAME OF PI	NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE							
HARMON	Y AT REYNOLDS MOUNT	·ΔIN	_ERS WAY _E. NC 28804					
ASHEVILLE, NC 28804  (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION								
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE			
D980	Continued From page	: 194	D980					
	THE CORRECTION I	DATE FOR THIS TYPE A1 IOT EXCEED SEPTEMBER						

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