STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011361	A. BUILDING: _____ B. WING _____	R 01/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HARMONY AT REYNOLDS MOUNTAIN	41 COBBLERS WAY ASHEVILLE, NC 28804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section and the Buncombe County Department of Social Services conducted a follow up survey and a complaint investigation on 01/14/25 and 01/15/25.	D 000		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 5 sampled residents (#2) related to a vitamin supplement. The findings are: Review of Resident #2's current FL2 dated 05/29/24 revealed diagnoses included high blood pressure and balance instability. Review of Resident #2's physician's orders dated 12/04/24 revealed vitamin B-12 500mcg (treats vitamin B-12 deficiency) daily.	D 358		

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D 358	Continued From page 1	D 358		

Review of Resident #2's electronic Medication Administration Record (eMAR) for December 2024 revealed:
-There was an entry for vitamin B-12 500mcg daily with an administration time of 8:00am.
-There was documentation the vitamin B-12 500mcg was not administered at 8:00am on 12/26/24 - 12/29/24 and on 12/31/24 due to vitamin B-12 "not in the medication cart".

Review of Resident #2's eMAR for 01/01/25 - 01/14/25 revealed:
-There was an entry for vitamin B-12 500mcg daily with an administration time of 8:00am.
-There was documentation the vitamin B-12 500mcg was not administered at 8:00am on 01/01/25 - 01/07/25, 01/10/25, and 01/12/25 - 01/13/25 due to vitamin B12 "not in the medication cart".

Observation of Resident #2's medications available for administration on 01/15/25 at 8:44am revealed:
-There was one bubble pack labeled vitamin B-12 500mcg take 1 tablet daily with a printed dispense date of 01/15/25.
-There were 31 tablets dispensed and 28 tablets remained in the bubble pack.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 01/15/25 at 9:00am revealed:
-The pharmacy received an electronic physician's order for vitamin B12 500mcg daily for Resident #2 on 12/04/24.
-The pharmacy dispensed 11 tablets on 12/04/24, 30 tablets on 12/11/24, and 30 tablets on 01/08/25 and it was still an active order.
-The dispense date of 01/15/25 on the bubble pack is the date when the medication should be

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D 358	Continued From page 2	D 358		

started from that bubble pack.
-The pharmacy did not have any documentation that the facility requested a refill electronically or telephoned the pharmacy for the vitamin B12.

Telephone interview with a medication aide (MA) on 01/15/25 at 9:42am revealed:
-She could not locate the vitamin B12 in the medication cart.
-She would electronically request a refill when a medication could not be located, and the pharmacy would deliver the medications that evening.
-She did not remember if she electronically requested a refill of the vitamin B12.
-She did not telephone the pharmacy about the vitamin B12 and did not know why.

Interview with a second MA on 01/15/25 at 10:47am revealed:
-The vitamin B12 was in the medication cart but when she scanned the bubble pack, she received an alert that the vitamin was discontinued even though the computer alerted that it was to be administered at 8:00am.
-She did not contact the pharmacy about the issue.
-She did not contact the HWD about the issue.

Telephone interview with the facility's contracted Nurse Practitioner (NP) on 01/15/25 at 9:50am revealed:
-Resident #2 was prescribed vitamin B12 for a vitamin B12 deficiency.
-The vitamin B12 was not discontinued and she expected it to be administered as ordered.

Interview with Resident #2 on 01/15/25 at 9:15am revealed she did not know if she was administered vitamin B12 or not.

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D 358	Continued From page 3 Interview with the HWD on 01/15/25 at 10:05am revealed: -She did not know Resident #2 was not administered the vitamin B12. -The MAs were responsible to electronically request a refill and telephone the pharmacy if a medication was not in the medication cart. -If the MAs informed her that the vitamin B12 was not available she would have instructed them to telephone the pharmacy because she was "far too busy and that is a MA duty". -The third shift MA was responsible for medication cart audits to ensure medications were available. -She was responsible for monitoring to ensure all residents were administered their medications. Interview with the Administrator 01/15/25 at 10:00am revealed: -The MAs were responsible to notify the pharmacy when a medication was not in the medication cart. -She did not know why the MAs did not notify the pharmacy or the HWD. -A pharmacy consultant recently conducted an audit and did not find any issues. -She knew that there were times when the pharmacy documented the delivery of medications and the medications were not in the facility.	D 358		