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-C 07/24/2025

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 conducted an annual and follow-up survey on 07/22/25-07/24/25.	D 000		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 1 sampled resident (#6) had a physician's order to self-administer calcium carbonate (used to treat heartburn), albuterol sulfate (used to treat lung disease), fluconazole (used to treat yeast infections), acetaminophen (used to treat pain), and Humalog (injectable insulin used to treat diabetes). The findings are: Observation of Resident #6's bedroom on 07/22/24 at 9:36am revealed she had multiple	D 375		

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-C 07/24/2025

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 375	Continued From page 1	D 375		

medications in an unlocked, clear storage box on the table beside her recliner where she was seated.

Interview with Resident #6 on 07/22/24 at 9:36am revealed:
-She kept several medications in her room to take when she needed them.
-She self-administered as needed medications and insulin when she was at home so she chose to continue to self-administer when she entered the facility since she would be returning to her home after her recovery.
-She did not self-administer medications daily.
-She did have a glucometer and conducted a finger stick blood sugar (FSBS) once or twice a day.
-She had been eating a lot of candy on 07/21/25 and her FSBS was just over 200 so she self-injected 2 units of insulin last night.
-This was the first time (07/21/25) she had given herself insulin at the facility since her admission in June 2025.
-The facility staff did not know she had a glucometer or kept her insulin and the as needed medications in her room.
-"I don't want them to have control over my insulin."

Review of Resident #6's current FL2 dated 06/19/25 revealed:
-Diagnoses included diabetes and heart failure.
-There was no orientation status listed.

Review of Resident #6's physician orders dated 06/19/25 revealed:
-There was not an order for calcium carbonate, albuterol sulfate, fluconazole, acetaminophen or Humalog.

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-C 07/24/2025

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 375	Continued From page 2	D 375		

Review of Resident #6's electronic medication administration record (eMAR) for June 2025 revealed there was no documentation of administration of calcium carbonate, albuterol sulfate, fluconazole, acetaminophen or Humalog.

Review of Resident #6's electronic medication administration record (eMAR) for July 2025 revealed there was no documentation of administration of calcium carbonate, albuterol sulfate, fluconazole, acetaminophen or Humalog.

Staff interview with the medication aide (MA) on 07/22/25 at 2:52pm revealed:
-Resident #6 did not self-administer her medications.
-Resident #6 did not have physician's orders to self-administer any of her medications.
-She administered morning medications to Resident #6 on 07/22/25.
-She did not observe medications in the clear storage box at the table beside her recliner.

Staff interview with the Health Director Assistant on 07/22/25 at 2:54pm revealed:
-She was not aware Resident #6 had any medications in her room.
-Resident #6 did not have an order to self-administer any of her medications.

Observation of the medications the Health Director Assistant removed from Resident #6's room at 3:00pm revealed:
-Calcium carbonate 1000mg tablet - one full bottle of 72 tablets and one opened bottle with six tablets remaining.
-Albuterol sulfate one to two puffs every four to six hours as needed for shortness of breath printed on the pharmacy label with 17 sprays left.
-Fluconazole 100mg tablet twice daily printed on

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-C 07/24/2025

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 375	Continued From page 3	D 375		

the pharmacy label with one tablet remaining.
-Acetaminophen extra strength 500mg tablets with less than ½ of the bottle remaining.
-Humalog Kwik Pen with two 3ml prefilled pens.

Interview with the Healthcare Director on 07/22/25 at 3:23pm revealed:
-Residents were told upon admission if they had an order to self-administer medications, the medication still had to be inventoried and placed on the eMAR.
-The staff were not aware Resident #6 was self-administering medications.
-There should have been a physician's order to self-administer medications, an assessment to verify Resident #6 could safely self-administer medications and a locked area for Resident #6 to keep her medications in her room.

Telephone interview with the primary care provider (PCP) on 07/22/25 at 3:27pm revealed:
-She was not aware Resident #6 was self-administering medications.
-Resident #6 did not have any cognitive impairment and had been administering her own medications including her insulin before her admission to the facility in June 2025.
-Resident #6 was capable of self-administration of her medications, but she needed to write an order for each medication that she self-administered.
Interview with the Administrator on 07/24/25 at 10:17am revealed:
-She was unaware Resident #6 had medications in her room and was self-administering them.
-Medications were not to be self-administered by a resident without a physician's order, an assessment to determine self-administration could be done safely, and a locked container or area the medications could be kept in.

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-C 07/24/2025

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