

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R-C 09/11/2025
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE MEMORY CARE		STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
(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 a follow-up, annual survey and complaint investigation from 09/09/25 to 09/11/25.	D 000	Please see attached POC	
D 049	10A NCAC 13F .0305 (d) Physical Environment 10A NCAC 13F .0305 Physical Environment (d) The requirements for the bedroom are: (1) the number of resident beds set up shall not exceed the licensed capacity of the facility; (2) live-in staff shall be permitted in facilities with a capacity of 7 to 12 residents provided all of the requirements of Section .0600 of these Rules are met; (3) there shall be separate bedrooms for any live-in staff and other persons living in the facility. Residents shall not share bedrooms with live-in staff and other live-in non-residents; (4) live-in staff shall not occupy a licensed bed or live in a licensed bed; (5) residents shall reside in bedrooms with residents of the same sex unless other arrangements are made with each resident's consent; (6) only rooms authorized by the Division of Health Service Regulation as bedrooms shall be used for bedrooms; (7) bedrooms shall be located on an outside wall and off a corridor. A room where access is through a bathroom, kitchen, or another bedroom shall not be approved as a resident's bedroom; (8) private resident bedrooms shall have not less than 100 square feet of occupiable floor area excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "private resident bedroom" is a resident bedroom occupied by one resident; (9) semi-private resident bedrooms shall have	D 049		

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

Armi James

TITLE

Regional Director of Operations

(X6) DATE

10/12/25

STATE FORM

U60K11

Continuation sheet 1 of 15

Reviewed and acknowledged

by

DMS

on 10/17/25

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D 049	Continued From page 1 not less than 80 square feet of occupiable floor area per bed excluding accessory areas such as vestibules, closets, or wardrobes. For the purpose of this Rule, "semi-private resident bedroom" is a resident bedroom occupied by two residents; (10) the total number of residents assigned to a bedroom shall not exceed the number authorized by the Division of Health Service Regulation for that particular bedroom; (11) a bedroom may not be occupied by more than two residents; (12) resident bedrooms shall be designed to accommodate all required furnishings; (13) resident bedrooms shall be ventilated with one or more windows which are maintained operable. The window area shall not be less than eight percent of the floor space and be equipped with insect-proof screens. The window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide. The windows shall be low enough to see outdoors from the bed and chair, with a maximum 36 inch sill height; and (14) Residents' bedrooms shall have one closet or wardrobe per resident. A closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed, approximately two feet deep by three feet wide by eight feet high, of which one-half of this space shall be for hanging with an adjustable height hanging bar. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations and interviews, the facility failed to ensure the window openings in the Special Care Unit (SCU) for 37 of 37 residents' rooms had windows that were operational and	D 049		

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D 049	Continued From page 2 maintained in a fashion to prevent elopement by restricting it to a six inch opening when a resident was able to exit the window and found down the road from the facility. The findings are: Observation of the windows in the SCU on 09/09/25 at 2:50pm revealed: -There were 37 resident rooms with one window in each room. -There were 37 windows with an alarm box attached and were screwed closed with a metal L-shaped bracket and were unable to be opened. Interview with a medication aide (MA) on 09/09/25 at 3:30pm revealed: -Sometime in August 2025, a resident tried to elope through a window in an empty room, but the window alarm alerted the staff, and we were able to prevent him from eloping. -In September 2025, a second resident eloped out of the same window and the window alarm did not alert staff because the window alarm battery was dislodged from the alarm during the elopement. -Yesterday on 09/08/25, the Administrator had the Maintenance Director screw all resident windows shut so that no one could open them to elope. Interview with the Maintenance Director on 09/09/25 at 2:56pm revealed: -On 09/08/25, the Administrator instructed him to install metal L-shaped brackets on all residents' windows in the facility to prevent residents from opening the window and eloping. -On 09/08/25 he fastened the metal L-shaped brackets to all resident windows in the facility so the windows could not be opened. -He did not know the windows should be able to	D 049			

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D 049	Continued From page 3 be opened to at least six inches. Interview with the Administrator on 09/09/25 at 2:55pm revealed: -On 09/03/25, a resident eloped out of a window in a room that was not occupied by a resident because the alarm battery was dislodged and did not alert staff. -The next day, on 09/04/25, he ordered metal L-shaped brackets to secure the windows shut. -On 09/08/25, the metal bracket arrived, and he instructed the Maintenance Director to install them in all resident room's windows to prevent them from opening. -He did not know the windows had to allow at least an opening of at least six inches to comply with the rule. [Refer to tag 0328, 10A NCAC 13F .0906(f)(4) Other Resident Care and Services (Type A1 Violation)]. The facility failed to restrict the residents' windows to at least six inches to prevent an elopement resulting in a resident eloping and being found at end of the road in front of the facility. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/10/25 for this violation. CORRECTION DATE FOR THIS TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2025.	D 049		

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D 273	Continued From page 4	D 273		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 1 of 4 sampled residents (#1) who had a history of dementia and injurious behavior towards others and was not sent to the hospital for an evaluation after he assaulted and injured his roommate. The Findings are: 1. Review of Resident #1's current FL2 dated 08/26/25 revealed: -Diagnoses included Alzheimer's dementia and lung mass. -He was ambulatory and intermittently disoriented. -He had a history of wandering, verbally abusive behavior and injurious to others. -His level of care was Special Care Unit (SCU). Review of Resident #1's Resident Register revealed an admission date of 08/22/25. Review of Resident #1's Care Plan dated 08/26/25 revealed the resident had a history of wandering, becoming verbally abusive and physically abusive. Review of Resident #1's SCU pre-admission	D 273		

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D 273	Continued From page 5 screening dated 08/22/25 revealed: -The pre-admission screening was completed by the Special Care Coordinator (SCC). -Under the behaviors section there was documentation Resident #1 had a history of wandering and a history of aggressive /combative behaviors. Review of Resident #1's SCU Resident Profile dated 08/22/25 revealed: -The SCU Resident Profile was completed by the SCC. -Resident #1 had a history of wandering, becoming verbally and physically abusive, and had a history of agitation and sundowning. -Under the comments section there was documentation of Resident #1 had outbursts at any time, he will hit when upset over money, and a history of changing his clothing and walking during the night. Review of Resident #1's Accident and Incident Report dated 08/23/25 at 11:22pm revealed: -The Accident and Incident report was completed by a medication aide (MA). -Resident #1 assaulted his roommate. -Resident #1's Primary Care Provider (PCP) was notified of assault via email on 08/24/25 at 11:22pm. -Resident #1's Responsible Party (RP) was notified of assault via phone call on 08/24/25 at 11:22pm Review of Resident #1's staff charting note dated 08/23/25 at 11:30pm revealed: -Resident #1 assaulted his roommate this shift. -Staff heard a commotion and ran to see what happened and found Resident #1 on top of his roommate. -Resident #1 and the roommate were separated.	D 273			

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D 273	Continued From page 8 -When the MA notified her that Resident #1 had calmed down, was not injured and the LEO stated they could not do anything, she told the MA not to send Resident #1 out for an evaluation. -Resident #1's PCP had been notified and was going to evaluate the resident at his next visit to the facility. Interview with the Administrator on 09/09/25 at 2:40pm and on 09/11/25 at 1:40pm revealed: -He did not know Resident #1 had not been to the hospital for an evaluation after he assaulted his roommate on 08/23/25. -He expected the MA to send the resident for an evaluation. -He did not know why Resident #1 was not sent out for an evaluation. _____ The facility failed to send Resident #1 out to the hospital for evaluation after an he assaulted and injured his roommate, who sustained a laceration to his left arm and skin tears to his left eye and the left side of his jaw. This failure resulted in serious neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 10, 2025, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 11, 2025.	D 273			
D 328	10A NCAC 13F .0906(f)(4) Other Resident Care and Services	D 328			

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D 273	Continued From page 6 -Staff observed Resident #1's roommate was injured. -Staff monitored Resident #1 every 30 minutes per protocol. Telephone interview with Resident #1's PCP on 09/10/25 at 10:15am revealed: -The facility notified him that Resident #1 assaulted his roommate. -He did not know Resident #1 was not sent to the hospital for an evaluation after assaulting another resident. -He expected the facility to send Resident #1 to the hospital to be evaluated after he assaulted his roommate. Interview with a PCA on 09/10/25 at 4:21pm revealed: -She worked on 08/23/25 when she heard Resident #1's roommate yelling, "help, help!" from his and Resident #1's shared room. -She did not see Resident #1 assault his roommate. -She witnessed Resident #1 holding his roommate down while on Resident #1's bed. -She and another PCA separated Resident #1 and his roommate. -The MA called 911. -This incident happened around 6:00pm to 6:30pm. -She did not know why Resident #1 was not sent to the hospital for an evaluation. Telephone interview with a medication aide (MA) on 09/10/25 at 9:43am revealed: -She was working on 08/23/25 third shift from 11:00pm to 7:00am. -She was made aware of the incident between Resident #1 and his roommate when she arrived on 08/23/25 and was asked to complete the	D 273			

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D 273	Continued From page 7 incident report which was a late entry. -They put Resident #1 in a separate room to monitor him. -Prior to the incident there had been no problems with Resident #1 and his roommate. -Resident #1 would walk the halls all night and on occasion they could get him to bed about 3:00am. Telephone interview with a second MA on 09/10/25 at 3:26pm revealed: -On 08/23/25 she heard a commotion down the hallway in Resident #1's room. -Two PCAs were the first ones to arrive to Resident #1's room before she was able to get there. -She witnessed Resident #1 on top of his roommate on a pile of clothes. -The PCAs separated the residents. -She called 911 for law enforcement assistance. -The local law enforcement officer (LEO) who came to the facility said they could not do anything because of Resident #1's dementia diagnosis. -She notified the SC) who told her to send Resident #1 to the hospital if he was still agitated. -She notified the SCC of what LEO had told her and did not request that Resident #1 be sent out for an evaluation because he had calmed down and was not hurt. -She moved Resident #1 to a different room and completed 30 minutes checks after the incident. Interview with the SCC on 09/09/25 at 4:52pm and on 9/10/25 at 10:46am revealed: -She knew Resident #1 was not sent to the hospital for an evaluation after he assaulted his roommate on 08/23/25. -The MA had notified her of the assault, and she had told the MA to send both residents to the hospital.	D 273		

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D 328	Continued From page 9 10A NCAC 13F .0906 Other Resident Care and Services (f) Visiting: (4) If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the person in charge in the home shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews for 1 of 4 sampled residents (#1), the facility failed to immediately notify local law enforcement when a Special Care Unit (SCU) resident eloped from the facility and was not immediately located. The findings are: Review of Resident #1's current FL2 dated 08/26/25 revealed: -Diagnoses included Alzheimer's dementia and lung mass. -He was ambulatory and intermittently disoriented. -He had a history of wandering, verbally abusive behavior and has been injurious to others. -His level of care was SCU. Review of Resident #1's Resident Register revealed an admission date of 08/22/25. Review of Resident #1's Care Plan dated 08/26/25 revealed the resident had a history of wandering, becoming verbally abusive and	D 328			

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D 328	Continued From page 10 physically abusive. Review of Resident #1's SCU pre-admission screening dated 08/22/25 revealed: -The pre-admission screening was completed by the Special Care Coordinator (SCC). -Under the behaviors section there was documentation Resident #1 had a history of wandering and a history of aggressive /combative behaviors. Review of Resident #1's SCU Resident Profile dated 08/22/25 revealed: -The SCU Resident Profile was completed by the SCC. -Resident #1 had a history of wandering, becoming verbally and physically abusive, and had a history of agitation and sundowning. -Under the comments section there was documentation of Resident #1 had outbursts at any time, he will hit when upset over money, and a history of changing his clothing and walking throughout the home at night. Review of Resident #1's Accident and Incident Report dated 09/04/25 at 12:45am revealed: -Resident #1 had been wandering the halls of the facility stating he had somewhere to be and asked medication aide (MA) for directions. -After assisting another resident while Resident #1 continued to wander the halls, the MA noticed the resident had left the building out of a window located in a vacant resident room. -Resident #1's Primary Care Provider (PCP) was notified via email on 09/04/25 at 1:00am of the elopement. -Staff left two voicemails with Resident #1's responsible party (RP) on 09/04/25 at 1:30am and at 1:50am.	D 328			

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D 328	Continued From page 11 Review of Resident #1's staff charting note dated 09/04/25 at 1:15am revealed: -Resident #1 had been wandering the halls in an agitated manner when he asked MA about the area and asked how to get to certain streets. -When the MA returned from assisting another resident, she noticed Resident #1 was no longer wandering the halls or in his room. -The MA and other staff began to search the facility for the resident. -Local law enforcement (LLE) called the facility to notify staff that Resident #1 had been found and gave staff the location of the resident. -Staff reached out to the SCC and the Administrator while on the way to Resident #1's location. -Staff identified Resident #1 and he was transported back to the facility by LLE. -Resident was transported by emergency medical services (EMS) to the local hospital for evaluation. Review of LLE investigation report dated 09/04/25 revealed: -A call was received on 09/04/25 at 12:45am from a concerned citizen that an older man came to their house, stating he had been robbed but was not making a lot of sense. -LLE called the facility at 12:57am to ask if the facility had a resident missing. -The facility stated the resident was missing from the facility and they had been looking for him. -The facility did not call to make a report, and unknown time for how long the resident had been missing. -LLE transported Resident #1 back to the facility on 09/04/25 at 1:14am. -EMS was dispatched on 09/04/25 at 1:17am and arrived at the facility at 1:30am. -Resident #1 was transported via EMS to the	D 328			

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D 328	Continued From page 12 local hospital on 09/04/25 at 1:45am. Review of the facility video recording of Resident #1 on 09/04/25 revealed: -On 09/04/25 at 12:11am Resident #1 was observed stepping through a window located directly beside the main entrance and exit door located on the left side of the facility, where the side parking lot was located. -Resident #1 was observed walking through the facility parking lot located on the left side of the building (if facing the facility), towards the road. Observation of Resident #1's GPS route revealed resident #1 walked a total of 0.7 mile on a two lane, no outlet road, to the location of the concerned citizens residence. Telephone interview with Resident #1's PCP on 09/10/25 at 10:15am revealed: -The facility did notify him of Resident #1 eloping from the facility. -He did not know the facility had not contacted 911 when staff realized Resident #1 was missing. -He expected the facility to contact 911 immediately when a resident was missing. Telephone interview with the medication aide (MA) on 09/10/25 at 11:30am revealed: -Resident #1 had asked her about street names while he had been wandering up and down the halls. -When she did not see Resident #1 walking in the hallway after assisting another resident, she checked the bathroom and Resident #1's room but did not find him. -She and other staff started going through all residents' rooms and bathrooms looking for Resident #1. -When she arrived at the last room to be	D 328			

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(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 328	Continued From page 13 checked, she noticed the window was open. -LLE called the facility around 12:45am on 09/04/25 stating they had found Resident #1. -She was asked by LLE to come to the location Resident #1 had been found to identify him. -She identified Resident #1, and he was transported back to the facility by LLE. -When she realized Resident #1 was missing, LLE had already called the facility and she stated, "I didn't have a chance to call 911 but if this were to happen again, I would immediately call 911." -When asked how long she thought Resident #1 had been missing, she stated, "maybe 30 minutes." -She should have called 911 immediately when Resident #1 was not immediately located but did not. -Resident #1 was brought back to the facility by LLE and EMS came shortly after to transport him to the hospital. Interview with the SCC on 09/10/25 at 10:46am revealed: -She was notified by the MA on 09/04/25 that Resident #1 had eloped through a window located in a vacant resident room. -She knew LLE had called the facility when the resident had been found down the road. -She expected the MA to call 911 immediately once they realized the resident was missing. Interview with the Administrator on 09/10/25 at 9:30am and on 09/11/25 at 1:40pm revealed: -He arrived at the facility on 09/04/25 around 2:00am after being notified by staff that Resident #1 had eloped from the facility. -The MA should have immediately called 911 once they realized the resident was missing. Attempted telephone interview with a LLE Officer	D 328		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL049036	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R-C 09/11/2025
NAME OF PROVIDER OR SUPPLIER HARMONY HOUSE MEMORY CARE			STREET ADDRESS, CITY, STATE, ZIP CODE 1372 EUFOLA ROAD STATESVILLE, NC 28677		
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D 328	Continued From page 14 on 09/10/25 at 8:52am was unsuccessful. Attempted telephone interview with a personal care aide (PCA) on 09/11/25 at 11:17am was unsuccessful. Attempted telephone interview with a second PCA on 09/11/25 at 11:23am was unsuccessful. _____ The facility failed to notify local law enforcement immediately after Resident #1 was confirmed as missing which resulted in the resident traveling approximately 0.7 mile away from the facility after 12:11am when a concerned citizen called local law enforcement after Resident #1 came to their house stating he had been robbed, which lead to a local law enforcement officer conducting a welfare check and contacting the facility to notify them of their missing resident. This failure resulted in serious neglect to the resident and constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on September 10, 2025, for this violation. THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 11, 2025.	D 328			

The following is the Plan of Correction for Harmony House Memory Care regarding the Statement of Deficiencies dated September 11, 2025. This Plan of Correction is not to be construed as an admission of or agreement with the findings and conclusions in the Statement of Deficiencies, or any related sanction or fine. Rather, it is submitted as confirmation of our ongoing efforts to comply with statutory and regulatory requirements. In this document, we have outlined specific actions in response to identified issues. We have not provided a detailed response to each allegation or finding, nor have we identified mitigating factors. We remain committed to the delivery of quality health care services and will continue to make changes and improvements to satisfy that objective.

10A NCAC 13F .0902 (b) Health Care

Type A1

The community shall ensure referral and follow-up to meet the routine and acute health care needs of the residents. In the event that there is resident on resident abuse the community will ensure that the residents are sent to the hospital for evaluation. Including contacting the family, local law enforcement and the Primary Care Physician. The community will all request a behavioral health evaluation is completed.

All staff have been re-trained by the current Executive Director/Regional Director of Operations, on the correct procedures to follow in the event of resident-on-resident abuse. To assist with ongoing compliance, as well with any new hires the Resident Care Director will be discussing referrals and follow -up with all staff weekly during shift change for the next 3 months.

Completion Date: October 11, 2025

10A NCAC 13F .0906(f)(4) Other Resident Care and Services

Type A1

If the whereabouts of a resident are unknown and there is reason to be concerned about his safety, the Supervisor in charge in the community shall immediately notify the resident's responsible person, the appropriate law enforcement agency and the county department of social services.

The community has had an in-service with all staff on missing resident policy and procedures. All staff have been trained on what to do if a resident goes missing. Staff will search inside and outside of community if not located within 10 minutes, Supervisor will

notify police and family. The management will notify the county department of social services. The community will hold monthly elopement drills and document all staff that attended.

Completion Date: October 11, 2025

10A NCAC 13F .0305(d) Physical Environment

Type B

The requirements for the bedroom are the window opening may be restricted to a six-inch opening to inhibit resident elopement or suicide.

The community has installed brackets to all windows of the community and ensured that they do not raise more than 6 inches when opening the windows. The community has held an in-service with all staff to educate per the rules of windows in memory care. The management team or designee will audit windows monthly to ensure compliance restrictions.

Completion Date: October 11,2025