STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345078	A. Building B. Wing	08/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Highland Farms	200 Tabernacle Road Black Mountain, NC 28711

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0559 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to share a room with spouse or roommate of choice and receive written notice before a change is made. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and responsible party (RP) and staff interviews, the facility failed to notify the Responsible Party in advance of a room change for 1 of 1 resident reviewed for transfer to a new room in the facility (Resident #4).The findings included:Resident #4 was admitted to the facility on [DATE].The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #4 was moderately cognitively impaired. Review of a note written by the Social Service Director dated 5/20/2025 revealed the Social Service Director called and left the Responsible Party (RP) a voice mail informing them of the room change for Resident #4 and an email was sent. There was no documentation in the social service notes that indicated notification to the residents or RP of reason for the room change.A review of an email sent on 5/20/2025 at 10:23 AM by the Social Service Director to the Responsible Party revealed the email was delivered on 5/20/2025 and indicated that a voice mail was left for the RP that Resident #4 would be moving to another room due to various reasons. The email further stated the reason was because Resident #4 struggled with having short term roommates coming and going and would get mean. Review of Resident #4 electronic medical record (EMR) indicated that Resident #4 was moved to a different room on 5/20/2025.A telephone interview was conducted on 8/11/2025 at 3:21 PM with the RP of Resident #4. The RP stated Resident #4 was in her room for over a year that was at the window, and she was able to view the RP's place of work. The RP stated that Resident #4 had refused to move to another room. The RP indicated she was notified of the room change after the room change occurred. An interview was conducted with the interim Social Service Director on 8/13/2025 at 2:42 PM. The interim Social Service Director stated she was not employed at facility at the time of Resident #4's room change. The Social service Director explained there was general discussion about room changes in the morning management staff meeting. The interim Social Service Director stated sometimes she called the RP about a room change. An interview conducted with the MDS Coordinator on 8/13/2025 at 2:42 PM revealed the facility's policy for room change was the resident that caused the conflict in the room was the resident that changed rooms. The MDS Coordinator stated that the facility did not need permission to change the resident's room.An interview was conducted on 8/14/2025 at 2:24 PM with the Director of Nursing (DON) who stated the room change was discussed during the morning meeting. She was not aware of Resident #4 declining to move to a different room. The DON indicated the facility needed to come up with a different solution for those residents who refused to move rooms.An interview with the Administrator on 8/14/2025 at 8:02 AM revealed the RP was notified of Resident #4's room change by email. The Administrator indicated that she had not spoken to the RP or received a response from the RP about the move. Her understanding was she had to only notify the RP of the room change and she was not aware that Resident #4 had voiced she did not want to move.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, Security Officer interview, Independent Living (IL) Resident interview, and staff interviews, the facility failed to supervise a severely cognitively impaired resident who was known to wander and used a wander guard so staff could monitor whereabouts. On 5/25/2025, Nurse #3 disarmed the service hallway exit doors and overrode the wander guard system. Resident #3 exited the healthcare center and entered a service hallway to the old assembly room area in the independent living area of the continuing care retirement community without staff supervision. Resident #3 was returned to the healthcare center by an IL Resident and the Lead [NAME] without injury. This deficient practice affected 1 of 5 residents reviewed for accidents (Resident #3).The findings included:Resident #3 was admitted to the facility on [DATE] with a diagnosis of senile degeneration of the brain, dementia, and history of falling.Resident #3's care plan dated 2/08/2025 revealed a care plan for wander guard related to diagnosis of dementia and occasional wandering and risk for wandering and injury. Interventions included education to the staff, approach in a calm, gentle manner; assure resident is safe, redirect resident from other resident rooms or if entering unsafe areas, or leaving health center unescorted, use familiar objects to reorient to residents room, seek to reassure and redirect, seek to redirect with an activity task as agreeable, asses for physiological needs or pain when wandering and advise nurse as needed, fall into step with resident and determine where resident is going, validate need to find something or something as appropriate, apply wander guard to right wrist, and monitor whereabouts when wandering.Resident #3's quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #3 as severely cognitively impaired. The MDS indicated Resident #3 exhibited wandering behavior daily. The MDS further indicated Resident #3 used a walker and could walk 50 feet with supervision or touching assistance and used a wheelchair for mobility throughout the facility.Resident #3's physician orders in May 2025 and current physician orders revealed a wander guard order dated 5/15/2025 to be checked twice daily in the morning and at night for placement and function. The order further revealed the wander guard to be placed on the right wrist. A telephone interview conducted on 8/14/2025 at 11:23 AM with Nurse #4 revealed she was assigned to Resident #3 on 5/24/2025 from 7:00 PM until the morning of 5/25/2025 7:00 AM. Nurse #4 stated Resident #3 was lying in her bed at approximately 6:30 AM. Nurse #4 indicated when she left the faciity on 5/25/2025 around 7:15 AM she did not see Resident #3 in the hallway. A telephone interview was conducted with Nurse Aide (NA) #5 on 8/15/2025 at 1:48 PM which revealed NA #5 was assigned to Resident #3 on the night of 5/24/2025 until the morning of 5/25/2025 at 7:00 AM. NA #5 stated she was unable to recall any events on 5/25/2025 nor the last time she had checked on Resident #3. NA #5 stated she normally would get Resident #3 up and out of bed and assist with dressing around 6:30 AM. NA #5 stated sometimes the resident would walk to the dining room or to the front lobby but would come back to her room. NA #5 confirmed she had seen Resident #3 attempt to go out the service entry doors in the past, but because they were locked, she would turn around and come back to her room. NA #5 stated she believed the wander guard for Resident #3 was on her ankle.Elopement event documentation written by Nurse #1 for Resident #3 from 5/25/2025 was reviewed. The documentation revealed there was evidence of an elopement event, notification to the attending physician and resident representative, and written education with staff. There was no evidence of injury to Resident #3 as a skin check was performed upon return to the healthcare center.An interview was conducted with Nurse #1 on 8/12/2025 at 3:30 PM. Nurse #1 stated the event dated 5/25/2025 occurred in the early morning at approximately 7:39 AM after reviewing the healthcare center surveillance footage. Nurse #1 was able to recall the events of the elopement event after the review of the healthcare center surveillance footage. Nurse #1 stated Resident #3 was sitting in the front lobby in her wheelchair near the double doors that lead to the service hallway when Nurse #1 came into work. There was another nurse (Nurse #3) that came into the healthcare center to clock out using the front entrance. Nurse #3 proceeded to the service hallway entry doors and entered the code on the keypad disarming the service hallway entry doors as well as overriding the wander guard system. Nurse #3 was able to proceed through the double doors and clock out. When Nurse #3 finished clocking out, Nurse #3 entered the code on the keypad disarming the service hallway exit doors as well as overriding the wander guard system. Nurse #3 came back through the service hallway entry doors and did not ensure the doors were closed all the way. Resident #3 was still sitting in her wheelchair and was able to self-propel in her wheelchair to exit from the healthcare center through the service hallway entry doors. Nurse #1 did not recall the alarm sounding on the

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews the facility failed to label and date leftover food stored for use in 1 of 1 walk in cooler and 1 of 1 walk-in freezer and failed to discard expired food items in 1 of 1 dry goods storage room. These practices had the potential to affect food served to residents. The findings included:a. During an initial observation of the facility's kitchen with the Dietary Manager (DM) on 08/11/2025 at 10:37AM the walk-in cooler was noted to have the following concerns:- An open to air and unlabeled ripped plastic bag of cooked chicken fillets on a shelf available for use.- An opened and unlabeled plastic wrapped bag of thin sliced potatoes on a shelf available for use. b. During an initial observation of the facility's kitchen with the Dietary Manager (DM) on 08/11/2025 at 10:43AM the walk-in freezer was noted to have frozen angel food cake on a tray wrapped in plastic, labeled 7/1 use by 7/21 on a shelf, available for use. c. The dry goods storage room was observed in the presence of the Dietary Manager on 08/11/2025 at 11:03AM with the following concerns:- Two plastic bags of cornflakes labeled 5/5 use by 8/5 on a shelf, available for use.- A plastic bin with off-white powder labeled poultry gravy powder dated 4/23 use by 7/23 on a shelf, available for use.An interview with the Dietary Manager on 08/11/2025 at 10:54AM revealed that he understood that items were not stored correctly. The Dietary Manager disposed of food items. He continued by showing the FDA Refrigerator and Freezer Storage Chart posted outside the walk-in freezer and stated he would have to train the staff to get labels properly created. The Dietary Manager stated labels and dates on opened food items should be checked weekly.An interview with the campus Food Service Director on 08/14/2025 at 10:14AM revealed the Dietary Manager should check dates and labels every day that he worked. He further stated the kitchen was in transition and some duties had been assigned to others to assist in the management of the kitchen. The Food Service Director stated staff received education related to proper labeling, storing and dating in June 2025. An interview with the Administrator on 08/14/2025 at 3:00PM revealed that kitchen staff should follow food safety standards and policies.