

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345078	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/31/2026
NAME OF PROVIDER OR SUPPLIER Highland Farms		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are fully informed and understand their health status, care and treatments. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, Psychiatric Nurse Practitioner and Medical Director interviews, the facility failed to obtain consent and inform the resident or Resident Representative in advance of the risks and benefits of psychotropic medications prior to the initiation of medication for 3 of 5 residents reviewed for unnecessary medications (Resident #43, Resident #4, Resident #16).The findings included:a. Resident #43 was admitted on [DATE] with diagnosis that included generalized anxiety disorder and major depressive disorder.Resident #43's physician's orders revealed an active order dated 9/15/2025 for buspirone (an anti-anxiety medication used to treat generalized anxiety disorder) 10 milligrams (mg) take one tablet twice daily for anxiety disorder. Resident #43's physician's orders revealed a discontinued order dated 9/15/2025 for escitalopram (an anti-depressant medication used to treat major depressive disorder and generalized anxiety disorder) 10mg take one table daily for depression. This order was discontinued on 5/6/2026 due to an increase in the dosage.A review of Resident #43's medical record revealed no information indicating if Resident #43 was informed in advance of the risks and benefits of buspirone and escitalopram when she was admitted to the facility. Review of Resident #43's Medication Administration Record (MAR) from September 2025 to July of 2026 revealed buspirone and escitalopram was administered as ordered.Review of the admission Minimum Data Set (MDS) dated [DATE] revealed Resident #43 was cognitively intact and indicated Resident #43 received an anti-anxiety and antidepressant during the 7-day look back period. b. Resident #4 was admitted on [DATE] with diagnosis that included adjustment disorder with mixed anxiety and depressed mood, generalized anxiety disorder.Resident #4's physician's orders revealed an active order dated 4/21/2026 for mirtazapine (an antidepressant medication) 15 mg tablet take one by mouth at bedtime for depression.A review of Resident #4's medical record revealed no signed consent indicating Resident #4 was informed in advance of the risks and benefits of mirtazapine when she was admitted to the facility.Review of Resident #4's MAR from April 2026 to July 2026 revealed mirtazapine was administered as ordered.Resident #4's admission MDS dated [DATE] revealed Resident #4 was cognitively intact and indicated Resident #4 received an antidepressant during the 7-day lookback period. c. Resident #16 was admitted on [DATE] with diagnosis that included major depressive disorder.Resident #16's physician's orders revealed an active order dated 6/23/2026 for sertraline (an antidepressant medication) 25mg take one tablet by mouth twice daily for depression.A review of Resident #16's medical record revealed no information indicating if Resident #4 was informed in advance of the risks and benefits of sertraline.Review of Resident #16's MAR from June and July 2026 revealed sertraline was administered as ordered.Resident #16's admission MDS dated [DATE] revealed Resident #16 was moderately cognitively impaired and indicated Resident #16 received antidepressant medication during the 7-day lookback. An interview was conducted with Nurse #1 on 6/24/2026 at 10:30 AM. Nurse #1 stated a psychotropic medication consent form was (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	supposed to be completed for any resident that received a psychotropic medication. Nurse #1 reported the psychotropic consent form was supposed to be completed when a psychotropic medication was initiated and when the dose was increased and that included when residents were admitted on a psychotropic. A telephone interview was conducted on 6/25/2026 at 1:05 PM with the Psychiatric Nurse Practitioner (NP), who stated the facility was responsible for obtaining psychotropic medication consents for residents who were admitted with orders for psychotropic medication, if a new psychotropic medication was started or increased. An interview was conducted with the Medical Director on 6/25/2026 at 12:05 PM. Medical Director agreed all psychotropic medications required a consent to be completed prior to starting or increased dosage of psychotropic medication. An interview was conducted on 6/25/2026 at 11:29 AM with the Director of Nursing (DON) who stated a psychotropic consent form was required any time a resident started a psychotropic medication and when a psychotropic medication dose was increased. The DON revealed the floor nurses were responsible for completing the consent form prior to administration of the first dose, and if a resident had an order for a psychotropic medication the form should be completed by the nurse completing the admission paperwork. The DON stated the psychotropic consent form in the electronic charting program had mistakenly not been set up to automatically be completed for new residents on admission, and it had been overlooked and not completed when residents were admitted to the facility. An interview was conducted on 6/25/2026 at 2:00 PM with the Administrator who stated she was aware psychotropic medication consent forms were required when any psychotropic medication was initiated or the dose was increased. The Administrator reported she thought psychotropic medication consents had been completed during admission paperwork for new admits, but when she searched for the consent forms for Resident #43, Resident #4, and Resident #16, she discovered the electronic psychotropic consent form in the facility charting system had not been selected as an automatic form to be completed on admission. The Administrator explained due to this oversight the psychotropic medication consent forms had not been completed when residents were admitted to the facility on psychotropic medication. The Administrator indicated she expected psychotropic medication consents to be completed for all residents that were admitted on psychotropic medication, if a new psychotropic medication was initiated or a dose was increased.		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures to prevent abuse, neglect, and theft. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to implement their abuse policy in the areas of investigation and reporting after an allegation of staff-to-resident abuse for 1 of 3 residents reviewed for abuse (Resident #58). The findings included: The facility's undated policy titled, Abuse Prohibition Policy stated in part: the facility ensures timely, thorough, and objective investigation of all allegations of abuse. All reported abuse allegations will be reported to the state agency and to all other agencies as per regulations. Resident #58 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder and insomnia. A review of Resident #58's admission minimum data set (MDS) assessment dated [DATE] revealed she was cognitively intact. A review of the facility submitted initial report dated 07/05/26 completed by the Director of Nursing (DON) specified an allegation of abuse by Resident #58. Nurse #1 reported to the DON on 07/04/26 at 4:08 PM that Resident #58 reported to Nurse #2 that Nurse Aide (NA) #1 had grabbed and bruised her. Bruising in various stages of healing were noted to Resident #58's bilateral arms upon physical assessment. NA #1 was not present in the facility at the time the allegations were made and was not allowed to return pending investigation. The facility submitted the initial report to the Division of Health Service Regulation (DHSR) on 07/05/26 at 9:32 AM. Law enforcement was documented as notified 07/05/26 at 10:14 AM. There was no documentation of notification of Adult Protective Services/Department of Social Services (APS/DSS) on the initial report. A review of the facility submitted 5-day investigation report dated 07/09/26 completed by the DON revealed the facility submitted the 5-day investigation report to DHSR on 07/09/26 at 12:43 PM. A summary of the investigation was as follows: On 07/04/26 at 4:08 PM, Resident #58 disclosed to Nurse #2 that NA #1 grabbed her and yanked her gown off causing bruises. Resident #58 was described as having mental anguish when on the afternoon of 07/04/26 she was noted to be crying when family came to visit as she was telling them about the incident. Resident #58 was noted to have bruising on her arm. NA #1 was unassigned from the facility and made a do not return through the agency he worked for. The facility substantiated the allegation of abuse. An undated, unsigned skin assessment for Resident #58 noted multiple bruises to bilateral upper and lower arms and right hand in various stages of healing. The investigation did not include a written or signed statement completed by Resident #58. An emailed statement dated 07/07/26 at 11:05 AM from Nurse #2 to the DON stated in part: Resident #58 reported to her that This morning he was rough getting me out of bed and jerked my gown off leaving bruises on my arms. An interview with Nurse #2 was conducted on 07/28/26 at 12:45 PM. Nurse #2 stated that she worked from 7:00 AM to 7:00 PM on 07/04/26. Resident #58 stopped her in the hall at 3:45 PM on 07/04/26 and reported to her that NA #1 was rough with her and jerked her gown off causing bruises on her arm. Nurse #2 stated that she and Nurse #4 entered the room to speak to Resident #58. A skin assessment was completed by Nurse #4 on Resident #58 immediately after she reported the allegation. The bruising present on her arms did not appear new to Nurse #2 and had been visualized by Nurse #2 previously. No other injury was noted. Nurse #2 reported the allegation to Nurse #1 who was the assigned supervisor. A typed statement signed by Nurse #4 stated in part: Resident #58 reported NA #1 yanked her gown off and caused bruises. An interview with Nurse #4 was conducted on 07/28/26 at 1:05 PM. Nurse #4 stated that she worked 07/04/26 7:00 AM to 7:00 PM and went into Resident #58's room with Nurse #2 on 07/04/26 around 4:30 PM. Resident #58 reported to Nurse #2 that NA #1 yanked her gown off which caused bruises. Nurse #4 explained Resident #58 stated to them that NA #1 was rowdy and when NA #1 came to get her up that morning, (continued on next page)		

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F 0607 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	he yanked off her gown and caused bruises to her arms. Nurse #4 performed a skin assessment at that time and noted bruising to bilateral arms. Nurse #4 stated the bruising appeared older with yellow and brown coloring and a skin assessment completed a day or two prior documented the same bruising present at that time. An undated unsigned typed statement by Nurse #1 reported that at 4:00 PM Resident #58 reported to Nurse #2 that NA #1 grabbed and bruised her when moving her. An interview with Nurse #1 was conducted on 07/30/26 10:02 AM. Nurse #1 stated that she was the shift supervisor on 07/04/26. Nurse #2 reported to her that NA #1 grabbed Resident #58 which caused bruising. Nurse #1 verbalized she reported the allegation to the DON who instructed her to begin an investigation. A written statement by NA #1's was not included as part of this investigation. A telephone interview with NA #1 was conducted on 07/28/26 at 2:11 PM. NA #1 denied the allegation of abuse. NA #1 verbalized he never yanked off Resident #58's gown, but it was a snap gown so maybe she had perceived it that way. In the morning, he got her up and got her dressed. She did not appear afraid or voice any concerns at that time. NA #1 reported that he was never asked to complete a statement or interviewed by anyone at the facility, his agency, or law enforcement about what occurred. A statement from Nurse #3 who worked 07/03/26 to 07/04/26 from 7:00 PM to 7:00 AM made no mention of NA #1's interactions with Resident #58. A telephone interview with Nurse #3 was conducted on 07/29/26 at 3:54 PM. Nurse #3 worked with NA #1 on the night of 07/03/26 to 07/04/26 from 7:00 PM to 7:00 AM. Nurse #3 reported that Resident #58 never reported any concerns to her about care that NA #1 provided. The investigation did not include documented interviews from other cognitively intact residents who NA #1 worked with prior to 07/04/26 and did not include residents who resided on other halls. The investigation did not include documented skin assessments for all moderate and severely cognitively impaired residents in the facility who NA #1 worked with prior to 07/04/26 and did not include residents who resided on other halls. An interview with the DON was conducted on 07/30/26 at 2:07 PM. The DON revealed she received a text message on 07/04/26 at 4:08 from Nurse #1 who reported that Resident #58 had disclosed that NA #1 yanked off her gown causing bruising to her arms. The DON verbalized that Nurse #1 was the shift supervisor and was instructed to obtain interviews and skin assessments limited to the one hall. The DON arrived later that evening to complete the investigation. The DON indicated she never attempted to interview NA #1 or request a statement from him. The DON explained that she had never completed an abuse investigation before and she should have obtained and documented statements from NA #1, all staff involved, interview all alert and oriented residents in the facility, and complete skin assessments on all cognitively impaired residents in the facility not just one hall. The DON acknowledged that a more thorough investigation could have been completed. The DON stated that she was responsible for reporting abuse allegations to the applicable local and state agencies in accordance with the facility policy and procedure. The DON stated that APS/DSS was not on the initial investigation form she completed and she had not realized APS was supposed to be notified within 24 hours. An interview with the Administrator was conducted on 07/31/26 at 2:19 PM. The Administrator stated that she would expect the DON to follow the reporting regulations and complete a thorough investigation of possible abuse before substantiating the allegations.		

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, Resident, Responsible Party, and staff interviews, the facility failed to complete a comprehensive trauma screening assessment on a newly admitted resident. Failure to identify a history of trauma leaves residents vulnerable to re-traumatization from unknown triggers. This affected 1 of 3 residents reviewed for abuse (Resident #58). The findings included: Resident #58 was admitted to the facility on [DATE] with diagnoses which included anxiety disorder and insomnia. A review of Resident #58's admission minimum data set (MDS) assessment dated [DATE] revealed she was cognitively intact. A review of Resident #58's personalized care plan revealed no plan for trauma informed care. An interview with Resident #58's Responsible Party was conducted on 07/28/26 at 11:45 AM. The Responsible Party verbalized that Resident #58 had a history of domestic violence. An interview with Resident #58 was conducted on 07/31/26 at 10:21 AM. Resident #58 verbalized that she had a history of domestic violence. Resident #58 reported that she could not recall any questions about her history of domestic violence or other evaluation for past trauma being asked. A review of Resident #58's medical record revealed no comprehensive trauma screening had been completed upon admission. An interview with the Director of Nursing (DON) was conducted on 07/30/26 at 2:08 PM. The DON stated that a comprehensive trauma assessment should have been completed on all residents by the Social Worker upon admission and quarterly. The DON indicated that any history of trauma would be care planned for the residents. The DON verbalized that Resident #58's history of domestic violence was unknown because an assessment was never completed. The DON stated that Resident #58 would have been care planned for no male caregivers had they known about her trauma history. The DON indicated that the assessments were overlooked due to a charting system change. An interview with the Medical Director was conducted on 07/31/26 at 9:40 AM. The Medical Director stated that the Provider did not conduct any form of trauma screening on new admissions. A telephone interview with the previous facility Social Worker was conducted 07/31/26 at 12:59 PM. The Social Worker stated that she had not completed any trauma screenings on newly admitted residents or as part of their ongoing assessments. An interview with the Administrator was conducted on 07/31/26 at 2:19 PM. The Administrator verbalized that a comprehensive trauma assessment should have been completed by the Social Worker or designee on each resident to evaluate them for history of trauma and identify possible triggers.		