

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

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345414	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/02/2026
NAME OF PROVIDER OR SUPPLIER Haymount Rehabilitation & Nursing Center, Inc.		STREET ADDRESS, CITY, STATE, ZIP CODE 2346 Barrington Circle Fayetteville, NC 28303	
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 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 ensure uncovered cooked food was not stored next to a partially closed trashcan with trash in it. The facility also failed to label and date a resident's personal food item and discard an expired food item stored in 1 of 2 nourishment refrigerators (Rehabilitation Unit refrigerator). These practices had the potential to affect food served to residents. Findings included: a. An observation of the kitchen with the Food Services Director on 6/30/26 at 1:50 PM revealed a pan of uncovered cooked rice, a pan of uncovered mashed potatoes and a pan of uncovered cooked spinach on a cart next to a partially closed large kitchen trashcan that had trash in it and was approximately 1/3 full. No flies were observed in the trashcan or around the trashcan. During this observation on 6/30/26 at 1:50 PM, the Food Services Director stated that the food items were left over from lunch and were supposed to be cooled down before being stored to be utilized within 3 days of storage. The Food Services Director inquired from the kitchen staff who had placed the food items next to the trashcan and [NAME] #1 reported he had placed it there. During an interview on 6/30/26 at 1:51 PM with [NAME] #1, he reported that he had moved the food approximately 5 minutes prior to the observation from the line tray area to the area where the food was observed (next to the trashcan) in preparation for cooling and storage. During an interview on 6/30/26 at 1:56 PM with the Food Services Director, he explained that the food should have been covered and placed in shallow pans for cooling prior to storage, away from an uncovered trashcan to prevent foodborne illnesses. b. Observation of the Rehabilitation Unit nourishment room refrigerator with the Food Services Director on 6/30/26 at 2:09 PM revealed the following: -A carton of milk with an expiration date of 6/21/26.-An unidentified greenish substance in a plastic container covered with a napkin with an unidentifiable date. The Food Services Director, who was present during the observation, placed the items in the trashcan. The Food Services Director explained that nursing staff were supposed to ensure the food items were labeled and dated before being placed in the refrigerator and dietary staff were responsible for checking the refrigerator daily and discarding any expired food items. An interview was conducted on 7/1/26 at 4:40 PM with the Administrator. She indicated that she expected staff to date and label all food items, check the refrigerator daily and discard expired food items. The Administrator also stated that she expected dietary staff to handle food under sanitary conditions and that she expected food to be kept in a designated area away from the trashcans.		

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 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. Based on observations and staff interviews, the facility failed to protect private health information by leaving confidential medical information visible and accessible to the public on an unattended medication cart for 1 of 4 medication carts (Unit 6 hallway medication cart). (Resident #17 and Resident #54) Findings included: A continuous observation of an unattended medication cart on Unit 6 hallway was conducted on 07/02/2026 from 8:53 AM to 9:05 AM. Nurse #2 left Resident #17's medication bottle of Lactulose oral solution, on top of the cart. Resident #17's identifiable information included the residents' name, medication and why the medication was administered. Nurse #2 then left the cart, leaving the computer screen visible while she retrieved vital signs and administered medications to Resident #54 in the resident's room. Resident #54's face sheet (a summary sheet containing medical information) was visible on the computer screen. Visitors, residents, and staff were present in the hallway during this observation. During an interview conducted on 07/02/2026 at 9:05 AM, Nurse #2 stated she had left the computer screen unattended in the hallway while retrieving vital signs and administering medications to Resident #54. She acknowledged that she forgot to close the electronic medical record before leaving the cart and stated she should have locked the screen to prevent Resident #54's medical information from being visible to others. She also reported that she should not have left Resident #17's medication bottle with identifiable information on the cart. She explained she intended to reorder the medication and forgot to discard the bottle, which should have been emptied in the medication room and placed in the destroyer container after removing identifiers. Instead, she placed the bottle in the cart's trash can, stating she would discard it properly in the medication room. An observation on 07/02/2026 at 10:47 AM of the Unit 6 medication cart parked at the nurse's station revealed that Resident #17's medication bottle, still containing identifiable information, remained in the cart's trash can. The Director of Nursing (DON) was notified. An interview with the DON was conducted on 07/02/2026 at 10:56 AM. She stated Nurse #2 should not have left Resident #17's medication bottle with identifying information on the cart. She explained that the bottle should not have been disposed of in the cart's trash, and any remaining liquid should have been poured out, resident identifiers removed, and the bottle placed in the destroyer. She also stated Nurse #2 should not have left the computer screen visible when entering Resident #54's room, emphasizing that nurses are responsible for protecting residents' medical information from unauthorized visibility. During an interview on 07/02/2026 at 2:37 PM, the facility Administrator stated that private health information should never be left visible to the public.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, staff and physician interviews, the facility failed to administer oxygen at the prescribed rate for 1 of 3 residents reviewed for respiratory care (Resident #36). The findings included: Resident #36 was admitted to the facility on [DATE]. Her diagnoses included chronic diastolic congestive heart failure, dependence on supplemental oxygen and chronic obstructive pulmonary disease (COPD). A physician order dated 6/30/25 indicated administer oxygen via nasal cannula at 2 liters per minute continuously for COPD. Resident #36's medication administration record (MAR) indicated check oxygen level every shift to maintain oxygen saturations above 92 %. A quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #36 was moderately cognitively impaired and was dependent on staff for all activities of daily living (ADL) to include turning left and right in bed and transfers. Her diagnoses included COPD and dependence on supplemental oxygen. She was coded for shortness of breath or trouble breathing when lying flat. Resident #36's care plan last revised 6/22/26 had a care focus area that indicated Resident #36 required use of oxygen continuously via nasal cannula related to COPD. Interventions included ensuring oxygen was titrated to appropriate setting as ordered by physician. During an observation on 6/29/26 at 11:00 AM Resident #36 was observed with the oxygen nasal cannula in place. Resident #36's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. During an observation on 6/30/26 at 2:20 PM with Nurse #1 present, Resident #36 was observed with the oxygen nasal cannula in place. Resident #36's oxygen regulator on the concentrator was set at 3 liters per minute when viewed horizontally at eye level. Resident #36's oxygen regulator was verified with Nurse #1 to be set at 3 liters per minute. During an interview on 6/30/26 at 2:22 PM with Nurse #1 who was assigned to care for Resident #36 during the day shift on 6/30/26 (7:00 AM - 7:00 PM) she revealed that she frequently cared for Resident #36 and that Resident #36 had a physician order for oxygen at 2 liters per minute via nasal cannula. She further explained she would normally check the setting on the oxygen concentrator when she went to Resident #36's room, but she had not checked it earlier that morning when she went to Resident #36's room to administer her morning medication. Nurse #1 reported that she had last checked Resident #36's oxygen during her previous shift. Attempts to interview the nurse who was assigned to care for Resident #36 on night shift 6/29/26 at 7:00 PM to 6/30/26 at 7:00 AM were unsuccessful. An interview was conducted on 7/1/26 at 4:40 PM with the Director of nursing (DON). The DON explained Nurse #1 should have verified the oxygen concentrator upon entering Resident #36's room during morning medication administration and throughout her shift to ensure it was set per the doctor's orders. She stated nurses were to follow physician's orders and obtain another order if they needed to titrate the oxygen rate. An interview was conducted on 7/2/26 at 9:51 AM with the facility Physician. She stated Resident #36 was receiving oxygen for COPD. The Physician stated nursing staff were to follow physician orders as given and to call the physician if they needed to titrate the oxygen rate. During an interview on 7/2/26 at 3:02 PM with the Administrator, she stated she expected nurses to administer oxygen to residents according to physician orders.		

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. Based on observations, staff interviews, and record reviews, the facility failed to maintain a medication error rate of less than 5%, as evidenced by 2 medication errors out of 30 opportunities, resulting in a medication error rate of 6.67% for 1 of 4 residents observed during medication administration (Resident #54). Findings included: A review of Resident #54's physician orders revealed orders for Aspirin 81 milligrams (mg) delayed-release tablet daily for atherosclerotic heart disease, and for estrogen 0.625 mg tablet daily. On 07/02/2026 at 8:44 AM, an observation of a medication pass was conducted for Nurse #2 while she was administering medications to Resident #54. Nurse #2 was observed removing one 81 mg chewable aspirin tablet from a stock bottle and placing it into a medication cup she was preparing for Resident #54. She then administered the chewable aspirin tablet to the resident that was not delayed release. During the same observation, Nurse #2 did not administer the estrogen tablet. At 8:50 AM on 07/02/2026, an interview was conducted with Nurse #2. She stated she did not realize the aspirin tablet was chewable rather than delayed-release. She also stated she did not administer the conjugated estrogen tablet because it had not been ordered on time and that she would call the physician. An interview was conducted on 07/02/2026 at 11:49 AM with the Director of Nursing (DON). The DON stated she expected nurses to administer medications exactly as ordered by the physician. She reported that the physician was notified and the resident was assessed, with no issues resulting from the administration of the chewable aspirin. She also stated that staff are required to order medications according to the medication card to prevent missed doses.		