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

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HIGHLAND FARMS	200 TABERNACLE ROAD , BLACK MOUNTAIN, North Carolina, 28711

(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) COMPLETION DATE
E0000	Initial Comments An unannounced recertification survey was conducted from 08/11/25 through 08/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 1D3181-H1	E0000		
F0000	INITIAL COMMENTS A recertification survey was conducted from 08/11/25 through 08/15/25. Event ID# 1D3181-H1	F0000		
F0559 SS = D	Choose/Be Notified of Room/Roommate Change CFR(s): 483.10(e)(4)-(6) §483.10(e)(4) The right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement. §483.10(e)(5) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement. §483.10(e)(6) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed. This REQUIREMENT is NOT MET as evidenced by: 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 5/7/2024. The Minimum Data Set (MDS) quarterly assessment dated 7/16/2025 revealed Resident #4 was moderately cognitively impaired.	F0559		

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 reverse for further 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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F0559 SS = D	Continued from page 1 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	F0559		

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F0559 SS = D	Continued from page 2 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.	F0559		
F0689 SS = D	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: 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 Cook 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 3/25/2022 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	F0689		

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F0689 SS = D	Continued from page 3 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 3/28/2025 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 facility 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	F0689		

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F0689 SS = D	Continued from page 4 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 doors for the wander guard due to the keypad overriding the wander guard system. Nurse #1 expressed Resident #3 was heading in the direction of the beauty shop through the service hallway that leads to the Independent Living section of the campus. Resident #3 was returned to the healthcare center by an IL Resident and Lead Cook. Nurse #1 explained she became aware Resident #3 was missing from the facility when Resident #3 was returned to the healthcare center. Upon Resident #3's return, Nurse #1 stated she notified the representative, completed a skin check on the resident, and called Resident #3's provider. A telephone interview was conducted with Nurse #3 on 8/13/2025 at 3:36 PM. Nurse #3 stated she was clocking out from working night shift on 5/25/2025 and saw Resident #3 sleeping in her wheelchair in the front lobby by the service hallway entry doors. Nurse #3 stated she thought she was sitting there waiting on her son for church. Nurse #3 explained she did not watch the doors of the service hallway close all the way and	F0689		

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F0689 SS = D	Continued from page 5 Resident #3 was able to get through the doors and into the service hallway entry way. Nurse #3 revealed she was shown the video surveillance footage and was able to see Resident #3 getting into the service hallway. An interview with an Independent Living (IL) Resident was completed on 8/13/2025 at 1:43 PM. The IL Resident stated he was outside walking his dog on 5/25/2025 approximately 7:30 AM. He stated he saw Resident #3 in the enclosed glass vestibule area outside of the doors leading into the old assembly room (this section of the campus was located on the other end of the service hallway that leads to the beauty shop in Independent Living). He stated Resident #3 was turning around trying to get back through the doors of the old assembly room. The IL Resident stated the doors were closing on her, so he went and helped her through the doors. He stated she was in her wheelchair, and she began propelling herself very quickly down the hallway near the beauty shop. The IL Resident went back home and dropped his dog off and came back approximately 5 to 6 minutes later to check on Resident #3. The IL Resident stated Resident #3 was in the same area he brought her back in (old assembly room area) and did not make it back to the healthcare center. The IL Resident then took Resident #3 down the service hallway to the doors that lead to the healthcare center. The IL Resident began knocking on the door. He said the Lead Cook came to the door from the kitchen which was off the service hallway, and the IL Resident asked the Lead Cook if he knew Resident #3. The Lead Cook confirmed that he did. The IL Resident stated both he and the Lead Cook brought Resident #3 back to a nurse in the healthcare center. The IL Resident did not recall the time he returned Resident #3 to the healthcare center. An interview conducted with Lead Cook on 8/13/2025 at 10:24 AM revealed the IL Resident was coming through the service hallway with Resident #3 and asked him if he knew Resident #3. The Lead Cook stated the IL Resident stated he saw Resident #3 caught in between the outside doors of the old assembly room. The Lead Cook assisted Resident #3 to a nurse on duty. The Lead Cook could not recall the time, or which nurse he returned Resident #3 to in the healthcare center. The Lead Cook was unable to state whether Resident #3 had any injury. The Lead Cook verified Resident #3 was cooperative with returning to the healthcare center on 5/25/2025. Resident #3's electronic medical record revealed no current elopement assessment prior to the elopement event on 5/25/2025.	F0689		

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F0689 SS = D	Continued from page 6 An interview was conducted with the Director of Nursing (DON) on 8/14/2025 at 2:10 PM. The DON stated the initial reason for the wander guard for Resident #3 was she had wandered into areas outside of the healthcare center since placement in the facility. The DON explained the elopement assessments were not completed from January 2025 to May 2025 due to change over in team members and the electronic medical record system. She stated the assessments were not populating for completion in the old electronic medical record system. An observation was conducted on 8/12/2025 at 2:45 PM of Resident #3 in her room. Resident #3 was observed to be wearing a wander guard bracelet to her right wrist. An interview was conducted with Nurse #2 on 8/12/2025 at 2:45 PM. The Nurse indicated she was responsible for Resident #3 today (8/12/2025). Nurse #2 stated Resident #3 wore elbow protectors due to rubbing her elbows and the wander guard was probably underneath the elbow pads this morning. Nurse #2 indicated Resident #3 would walk occasionally. Nurse #2 voiced Resident #3 would either walk with walker independently or self-propel her wheelchair and sit in the front lobby. Nurse #2 further indicated the wander guard on Resident #3 was checked every shift. Nurse #2 communicated she was provided with education on wandering and elopement but did not work the morning shift on the day of the incident. An interview with the Administrator regarding the video surveillance of 5/25/2025, on 8/13/2025 at 9:54 AM revealed the video surveillance was maintained for a 30-day timeframe. After 30 days, the video surveillance was recorded over for the next 30-day cycle. An interview with the Security Officer of the campus on 8/13/2025 at 10:01 AM revealed he was able to view the video when Resident #3 exited the health care center on 5/25/2025. He stated Nurse #3 went to clock out at the time clock and Resident #3 slipped in between the doors. He stated he could not view anything else. The Security Officer did verify the doors were on a timer locking system at night. The Security Officer verified there was a magnetic system in place for the facility doors as well as a timer for the doors at night for residents and staff safety. The Security Officer provided documentation that the video was unable to be captured from the elopement event on 5/25/2025, and the footage had been recorded over as it was over the 30-day timeframe. The Wander Management System facility protocol provided by the Maintenance Supervisor revealed the facility used two parts in their system. All doors leading in	F0689		

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F0689 SS = D	Continued from page 7 and out of the healthcare center have a wander guard alarm system that made an audible alarm. The second form of protection was a magnetic lock (utilizes a magnetic force to secure a door) system. All doors were locked with a magnetic lock system 24 hours a day except for the two doors visible from the reception desk which remain unlocked between 8:00 AM and 8:00 PM daily, then locked from 8:00 PM until 8:00 AM. An observation was conducted on 8/14/2025 at 1:35 PM with the Maintenance Technician. He demonstrated the activation of the wander guard system on the service hallway entry doors with a wander guard. The Maintenance Technician stated the service hallway entry doors would lock when reaching within six feet of the service hallway entry doors. There was an audible sound when the wander guard was close to the service hallway entry doors. The Maintenance Technician further demonstrated the disabling of the wander guard alarm by activating the keypad code on both sides of the service hallway entry doors and with a wander guard showing entry into the service hallway. A joint interview was conducted with the Administrator and the Director of Nursing (DON) on 8/14/2025 at 2:10 PM. They both verified every resident received an elopement assessment upon admission determining the risk for elopement. They stated this was a standard of care and practice. Each resident would then receive a quarterly review. The DON stated the loss of some team members, and receiving a new updated electronic medical record system caused some assessments to be missed. The DON stated elopement assessments were to be completed upon admission for each resident, quarterly, and as indicated. The DON further stated she believed Resident #3 left through the service hallway entry because the staff were allowing Resident #3 to sit up front four days prior, so they no longer allowed Resident #3 to sit in the front lobby. An interview conducted with the Administrator on 8/14/2025 at 2:10 PM revealed the Receptionist was responsible for monitoring the service hallway entry doors while on duty (8:00 AM to 5:00 PM). The Administrator stated the Receptionist would make sure a resident did not get through the service hallway entry doors. The Administrator confirmed the wander guard alarm for the service hallway entry doors did not alarm on 5/25/2025 for Resident #3 because the keypad had been overridden by Nurse #3 when she exited the service hallway after clocking out for work and re-entering the healthcare center. The Administrator confirmed Nurse #3 did not ensure the doors were closed completely after exiting the service hallway and proceeding to exit the	F0689		

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F0689 SS = D	Continued from page 8 front of the healthcare center on 5/25/2025 leading to the elopement event for Resident #3.	F0689		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: 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.	F0812		

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F0812 SS = E	Continued from page 9 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.	F0812		