STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345010	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain Health and Rehabilitation	500 Beaverdam Road Asheville, NC 28804

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. (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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0658 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 record review, staff, Pharmacist, and Medical Director interview, the facility failed to transcribe and implement orders for diabetes care according to the hospital discharge summary for a resident with diabetes. The hospital discharge summary ordered sitagliptin/metformin (Janumet extended release). The facility instead entered and administered metformin, omitting the sitagliptin component and the extended-release formulation. This deficient practice occurred for 1 of 3 residents reviewed for providing care according to professional standards (Resident #1).Findings included:A hospital Discharge summary dated [DATE] included the following medication order: metformin-sitagliptin (Janumet extended release (XR) 100 milligram (mg)-1000 mg oral tablet, 1 tablet by mouth daily for diabetes. According to manufacturer's information, metformin-sitagliptin is a combination of two medications and is marketed under the brand name of Janumet extended release XR.Resident #1 was admitted to the facility on [DATE]. Her diagnoses included Type-2 diabetes mellitus.A physician order dated 8/28/25 entered by Nurse #1 read, metformin 1000 mg tablet give one tablet by mouth once a day.Resident #1's August 2025 and September 2025 medication administration record (MAR) included an order that read, metformin oral tablet 1000 mg give one tablet by mouth one time a day for diabetes mellitus. The start date of the medication on the MAR was 8/29/25. The MAR documented she received the medication on 8/30/25, 8/31/25, 9/1/25, 9/2/25, 9/3/25, 9/4/25, 9/5/25, 9/6/25, and 9/7/25. The MAR documented the medication was discontinued on 9/8/25.Nurse #1 was unavailable for interview.An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severe cognitive impairment. The MDS documented that she received hypoglycemic medication.An interview was conducted with Pharmacist #1 on 12/29/25 at 4:12 PM. Pharmacist #1 stated an order was received from the facility on 8/28/25 for metformin 1000 mg. daily. The Pharmacist said there was not an order for Janumet for Resident #1 from the facility. The Pharmacist reported metformin and Janumet were not the same medication. She explained Janumet XR was a combination medication containing sitagliptin and metformin and was an extended-release medication. She said extended-release medication lasted longer because it was released slowly over a 24-hour period. She stated the order the pharmacy had received from the facility was for metformin immediate release. The Pharmacist explained extended-release medication was absorbed over time so it lasted longer and said immediate release medication should be given every 12 hours. Pharmacist #1 said Resident #1 would not get as much glycemic control (management of blood glucose levels) over time if she was only taking immediate release metformin one time a day. The pharmacist felt it was a significant medication error because Resident #1 was only getting the metformin which was only half of the combination medication (Janumet) she was supposed to be getting.An interview was conducted with the Medical Director on 12/29/25 at 4:43 PM. The Medical Director said if Resident #1 had poor oral intake, then she did not need the Janumet and said metformin would be a better choice for her. She said it was a medication error but that she did not think it had negative effect or hurt Resident #1.An interview was conducted with the Director of Nursing (DON) on 12/30/25 at 12:17 PM the DON stated Janumet XR was ordered for Resident #1 on her hospital discharge summary. She said Nurse #1 entered the wrong medication for Resident #1 in the electronic computer system. She reported one nurse was supposed to enter the admission orders into the electronic computer system and then a second nurse was supposed to review and confirm the orders to make the orders active. The DON explained Nurse #1 had entered and confirmed the admission orders for Resident #1 and the orders had not been checked by a second nurse. The DON stated she thought the error would have been caught if the orders had been checked by a second nurse.An interview was conducted with the Administrator on 12/30/25 at 4:19 PM. The Administrator said orders should be put in according to the hospital discharge summary and entered accurately into the electronic computer system. She stated from her knowledge there was a two-step process for putting in and checking admission orders. The Administrator explained Nurse #1 was a new nurse and thought she may not have known the facility process.

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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 0773 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide or obtain laboratory tests/services when ordered and promptly tell the ordering practitioner of the results. (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 0773 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 record review, and staff, Clinical Practice Manager, and Physician Assistant (PA) interviews, the facility failed to notify the medical provider of abnormal laboratory results for 1 of 1 resident reviewed for notification of laboratory results (Resident #1).Findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included Type-2 diabetes mellitus, hypertension (high blood pressure), long-term use of anticoagulants (blood thinning medication), metabolic encephalopathy (confusion caused by chemical imbalances in the body), malignant neoplasm of the pancreas (pancreatic cancer), hypo-osmolality (excess water relative to solutes such as electrolytes) and hyponatremia (low sodium level), anemia (low red blood cells), hypothyroidism (thyroid disorder), and a disorder of urea cycle metabolism (body cannot properly remove ammonia from the body).An admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severe cognitive impairment.A physician order dated 9/4/25 entered by the PA read, comprehensive metabolic panel (CMP) (lab that checks electrolytes, blood sugar, protein levels, kidney, and liver function) with estimated glomerular filtration rate (GFR) (checks kidney function), complete blood count (CBC) with differential (lab that counts different blood cells in the body to help diagnose infections, anemia, and other conditions). The order specified the labs were scheduled for 9/5/25.Resident #1's electronic medical record contained laboratory results for a CMP with GFR and a CBC with differential. The lab report showed that the samples were collected on 9/5/25 at 1:06 PM and received at the lab on 9/5/25 at 10:24 PM. The report indicated the lab reported date (date the laboratory results were sent to the facility) was 9/6/25 at 1:00 AM. The record documented that the PA reviewed the results on 9/9/25 at 10:43 AM.-The CMP lab results dated 9/5/25 showed that Resident #1's sodium level was 150 (135-145 normal range, high sodium blood levels indicate dehydration). Her chloride level was 117 (95-107 normal range, high chloride level in the blood indicates dehydration, kidney disease, or acid-base imbalances). Her non-fasting glucose level was 190 (normal range 70-139). Her alkaline phosphatase level (liver function lab) was 679 (normal range 40-142) and her Aspartate Aminotransferase AST level (liver function lab) was 61 (normal range 9-40)-The CBC lab results dated 9/5/25 showed Resident #1 had a high white blood cell count of 13 (normal range 4-11, a high white blood cell count is an indicator of possible infection). Her hemoglobin (red blood cells that carry oxygen) was 9.8 (12-16 normal range) and her hematocrit (percentage of your total blood volume that is made up of red blood cells) was 28.5 (normal range 36-48).There was no documentation in Resident #1's electronic medical record from 9/5/25 through 9/8/25 indicating that staff had notified the medical provider of the lab results.An interview was conducted with Nurse #2 on 12/30/25 at 2:09 PM. Nurse #2 worked the night shift (7:00 PM-7:00 AM) on 9/5/25 and 9/6/25. She could not recall if in September 2025 labs were uploaded electronically into the resident's electronic medical record or if lab results were faxed to the facility. She explained that the process of receiving lab results had changed at some point and that the results were now faxed to the facility, but she could not remember when it changed. Nurse #2 stated that when the lab results were automatically uploaded electronically into the resident record it was passed on in the shift change report that the oncoming nurse needed to look for lab results on that shift. She did not recall receiving lab results for Resident #1 or notifying a provider about any results on 9/5/25 or 9/6/25. She stated that if she had received the labs during her shift, she would have documented that she received them and identified the provider she notified. Nurse #2 stated when lab results came back, they were supposed to be called to the provider immediately if there were abnormal or critical results. Nurse #2 stated if there was nothing documented in Resident #1's electronic medical record by her then she did not receive the lab results or contact a medical provider. An interview was conducted with Nurse #3 on 12/30/25 at 3:10 PM. Nurse #3 worked the day shift (7:00 AM-7:00 PM) on 9/6/25. He did not recall any lab work for Resident #1 or calling the provider to report any abnormal labs for Resident #1 on 9/6/25. He stated that if he had called the provider or received orders, he would have made a note about it in Resident #1's electronic medical record. Nurse #3 explained it was standard practice to call lab results to the provider if there were abnormal results. He stated it was typically passed on in the shift change report if they were waiting on lab results for a resident or the Director of Nursing (DON) would tell him to look out for labs if they were waiting on lab results. Nurse #3 said otherwise he would not know who had lab results pending unless he went into each resident's individual electronic medical record and opened the results tab to look for results. Nurse #3 stated unless he opened every resident's individual lab result tab in the electronic medical record every shift