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	05/09/2025

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review and staff interviews, the facility failed to promote care in a dignified manner for 1 of 2 residents who were assisted with meals (Resident #2). Staff were observed standing beside the resident's bed while feeding assistance was provided. The finding included: Resident #2 was admitted to the facility on [DATE] with diagnoses including dysphagia and malnutrition. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #2 with intact cognition. The assessment indicated Resident #2 was dependent on staff for eating and receiving a mechanically altered diet. During a continuous breakfast observation on 05/07/25 from 9:01 AM to 9:10 AM, Resident #2 was observed seated at approximately 45-degree angle in her bed. Her breakfast tray was brought into the room by Nurse Aide (NA) #1 and placed on top of the overbed table in front of Resident #2. NA #1 stood on the left side of the bed. She set up the tray and started feeding Resident #2 while she was standing and not at eye level with Resident #2. A folding chair was available in the room and NA #1 did not use it. An interview was conducted with Resident #2 on 05/07/25 at 9:20 AM. She stated that she did not like the staff to stand over her when receiving feeding assistance. During an interview conducted on 05/07/25 at 9:30 AM, Unit Manager #1 (UM) stated all the NAs had received training in feeding and it was her expectation for the NAs to sit at eye levels with the residents when providing feeding assistance. She could not explain why it happened but stated she would notify the Administrator immediately. An interview was conducted with NA #1 on 05/07/25 at 10:11 AM. She explained she had worked at different nursing facilities and received conflicting trainings related to feeding assistance, and it confused her. She did not know it was a dignity issue by not sitting at eye level beside the resident while providing feeding or eating assistance. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/07/25 at 10:51 AM, the Administrator expected nursing staff to pay attention to residents' dignity when providing care or feeding assistance. The Administrator indicated she would re-train all the nursing staff to ensure all dependent residents who needed feeding assistance would receive it with dignity. An interview was conducted with the Director of Nursing (DON) on 05/8/25 at 10:59 AM. She expected all nursing staff to focus on dignity issues when providing care or feeding assistance.

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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 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code Minimum Data Set (MDS) assessments in the areas of Preadmission Screening and Resident Review (PASARR) and high-risk drug classes usage that involved anticoagulant, antipsychotic, and opioid medications for 3 of the 7 sampled residents (Residents #11, #24, and #52). Findings included: a. Resident #11 was admitted to the facility on [DATE] with diagnoses that included high blood pressure and peripheral vascular disease. A review of the Medication Administration Records (MAR) for January 2025 revealed Resident #11 did not receive any anticoagulant throughout the month. Instead, the MAR indicated that he received 1 tablet of enteric-coated aspirin 81 milligrams (mg) by mouth once daily since 01/20/25. The quarterly MDS assessment dated [DATE] coded Resident #11 with intact cognition. The Medication section of the MDS indicated Resident #11 had received anticoagulant during the 7-day assessment periods. b. Resident #24 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction and bipolar disorder. Resident #24's medical record revealed he had completed PASARR Level II assessment on 03/25/24. A review of the annual MDS assessment dated [DATE] revealed the Identifying Information section indicated Resident #24 had not been evaluated by PASARR Level II and determined to have a serious mental illness and/or mental retardation or a related condition. The quarterly MDS assessment dated [DATE] assessed Resident #24 with intact cognition. The Medication section indicated Resident #24 had received anticoagulant, antipsychotic, and opioid during the 7-day assessment periods. A review of the MAR for February 2025 revealed Resident #24 did not have any order to receive anticoagulant, antipsychotic, or opioid throughout the month. c. Resident #52 was admitted to the facility on [DATE] with diagnoses which included cerebrovascular accident. Review of Resident #52's physician's orders revealed an order dated 9/27/24 for Aspirin 81 mg by mouth daily. Resident #52 significant change Minimum Data Set (MDS)assessment dated [DATE] indicated she had severe cognitive impairment and was dependent on staff for most activities of daily living. The MDS coded Resident # 52 for high-risk drug class for anticoagulant use. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/06/25 at 1:18 PM, the MDS Coordinator acknowledged that the coding of anticoagulant for Resident #11, Resident #24, and Resident #52 were incorrect. She explained it was due to her perception of considering aspirin as an anticoagulant, and it was her oversight. She confirmed Resident #24 had completed a PASARR Level II assessment on 03/25/24. She could not explain why she coded Resident #24 as never been evaluated by Level II PASARR in the annual MDS assessment dated [DATE]. She added it was an error to code Resident #24 as receiving anticoagulant, antipsychotic, and opioid for the quarterly MDS assessment dated [DATE] as he was not receiving any of the above medications during the 7-day assessment periods. During an interview conducted on 05/08/25 at 10:59 AM, the Director of Nursing (DON) stated it was her expectation for all the MDS assessments to be coded accurately according to the established medication categories. An interview was conducted with the Administrator on 05/07/25 at 10:51 AM. She stated it was her expectation for the MDS Coordinator to code all MDS assessments correctly before submission.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on staff interview and medical record review, the facility failed to refer a resident with newly diagnosed serious mental illnesses for Pre-admission Screening and Annual Resident Review (PASARR) Level II screening for 1 of 2 residents reviewed for PASARR (Resident #36). The findings included: A review of Resident #36's medical records revealed he had a PASRR Level I evaluation completed in 2023. Resident #36 was admitted to the facility on [DATE] with diagnoses including bipolar disorder. A review of Resident #36's list of cumulative diagnoses revealed a new diagnosis of bipolar disorder with an onset date of 03/13/24 was documented in his medical record. A review of physician's order dated 03/14/24 revealed Resident #36 had an order to receive 1 tablet of Depakote 500 milligrams (mg) delayed release by mouth 2 times daily for mood symptoms related to bipolar disorder. The annual Minimum Data Set (MDS) assessment dated [DATE] coded Resident #36 with intact cognition. The Section A1500 indicated he was not currently considered by the state PASARR Level II process to have a serious mental illness and/or intellectual disability or a related condition. During an interview conducted on 05/06/25 at 9:16 AM, the MDS Coordinator confirmed the facility had failed to refer Resident #36 for a PASARR Level II evaluation according to the annual MDS assessment dated [DATE]. She stated Resident #36 was diagnosed with bipolar disorder during admission and should have a PASARR Level II evaluation. She added the referral was typically handled by the Social Services Director (SSD). An interview was conducted with the SSD on 05/06/25 at 11:03 AM. She confirmed she was responsible for reviewing medical records of newly admitted residents and making a referral for PASARR evaluation as indicated. She acknowledged that Resident #36 should have a referral for PASARR Level II screening as he was diagnosed with bipolar disorder during admission. She could not explain why Resident #36 was overlooked and attributed the error as an oversight. During an interview conducted on 05/06/25 at 11:48 AM, the Corporate MDS Director stated Resident #36 was admitted with bipolar disorder should be referred for a PASARR Level II evaluation. It was his expectation for the SSD to follow the regulation guidance to ensure a referral for PASARR Level II evaluation was in place as indicated. An interview was conducted with the Administrator on 05/07/25 at 10:51 AM. She stated the regulation guidance should be followed and a request for a PASRR Level II evaluation should be made when a resident was diagnosed with a new serious mental health condition such as bipolar disorder. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/08/25 at 10:59 AM, the Director of Nursing (DON) expected the SSD to follow the established guidelines to coordinate PASARR Level II as indicated in a timely manner.

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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	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and Medical Director (MD), resident and staff interviews, the facility failed to readjust medication orders after those orders had been updated which resulted in the resident missing one dose of five medications for 1 of 1 resident reviewed for pharmacy services (Resident #36). The finding included: Resident #36 was admitted to the facility on [DATE] with diagnoses including stroke, insomnia, and bipolar disorder. The quarterly Minimum Data Set (MDS) assessment dated [DATE] coded Resident #36 with intact cognition. The assessment indicated Resident #36 had adequate hearing and vision with clear speech. During the initial interview conducted with Resident #36 on 05/05/25 at 1:13 PM, he stated he disliked nursing staff waking him up around midnight at times to administer his medications. A review of medication administration records (MAR) on 05/05/25 revealed Resident #36 had the following 5 active physician's orders to receive medications once daily at either 8:00 PM or 10:00 PM: 1. Atorvastatin 20 milligrams (mg), 1 tablet by mouth once daily at 10 PM for cholesterol. 2. Depakote delay release 500 mg, 2 tablets by mouth once daily at 10 PM for bipolar disorder. 3. Ezetimibe 10 mg, 1 tablet by mouth once daily at 10 PM for cholesterol control. 4. Melatonin 3 mg, 3 tablets by mouth once daily at 10 PM for insomnia. 5. Trazodone 50 mg, 2 tablet by mouth once daily at 8 PM for sleep. An interview was conducted with Unit Manager #2 (UM) on 05/06/25 at 2:58 PM. She stated Resident #36 voiced a complaint that morning about getting his medications late at night. After she had submitted his concerns in the doctor's communication log, the physician had approved to switch most of Resident #36's evening medications to around 6:00 PM and the orders had been updated. A subsequent review of MAR on 05/07/25 revealed the above 5 active evening medication orders had been discontinued on 05/06/25 at around 10:30 AM. New orders for each of the 5 evening medication were in place and they would be started 05/07/25 at 6:00 PM. Resident #36 received the last dose of the above 5 medications on 05/05/25 at 8:00 PM and 10:00 PM respectively before the discontinuation, but did not receive any of the above 5 medications on 05/06/25 at 6:00 PM. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview conducted on 05/07/25 at 5:45 AM, Resident #36 stated he had received some medications around 6:30 PM on 05/06/25. After that, he did not receive any more medications, and he went to sleep. He could not confirm whether he had received atorvastatin, depakote, trazodone, melatonin, or ezetimibe on 05/06/25 in the evening as he always took the pills without looking at them during medication pass. Resident #36 denied feeling any difference since 05/06/25 evening and stated he slept well on the night of 05/06/25. He added nursing staff notified him that they had changed his evening medications to an earlier hour, and he was very pleased with the changes. During the interview, Resident #36 appeared to be alert and oriented without showing any signs and symptoms of pain, distress, or other behavioral issues. An interview was conducted on 05/07/25 at 5:48 AM with the Medication Aide #1 (MA) who provided care for Resident #36 from 7:00 PM on 05/06/25 to 7:00 AM on 05/07/25. She did not recall administering depakote, melatonin, trazodone, ezetimibe, or atorvastatin to Resident #36 as those medications did not appear on the computer during the evening medication pass on 05/06/25. During an interview conducted on 05/07/25 at 5:55 AM, Nurse #1 confirmed Resident #36 did not receive depakote, melatonin, trazodone, ezetimibe, or atorvastatin on 05/06/25 in the evening. She stated those orders did not appear on the computer as they had been deleted, and the new orders would not be started until a day later on 05/07/25 in the evening. Nurse #1 indicated the new orders should be restarted on the same day on 05/06/25. Otherwise, those orders would not appear on the computer during the evening medication pass on 05/06/25. During an interview conducted on 05/07/25 at 9:57 PM, Nurse #2 stated that he worked on 05/06/25 from 7 AM to 7 PM and confirmed he did not administer Depakote, melatonin, trazodone, ezetimibe, or atorvastatin to Resident #36 on 05/06/25 in the evening as those orders did not appear on the computer during the evening medication pass. An interview was conducted with the Director of Nursing (DON) on 05/07/25 at 7:01 AM. She acknowledged that she was the nursing staff who had updated Resident #36's medication orders on 05/06/25 after she was made aware of the concerns brought up by Resident #36. She stated when she updated the orders, the computer would start the new orders on the next day as a default. She forgot to readjust those orders to avoid a gap after the new orders were in place on 05/06/25. She attributed the errors to her oversight. An interview was conducted with the MD on 05/8/25 at 3:35 PM. She stated missing just one dose of depakote for bipolar disorder along with trazodone, ezetimibe, atorvastatin, and melatonin would not have any significant impact to Resident #36 behavior. It was her expectation for nursing staff to change or update approved medication orders correctly. During an interview conducted on 05/07/25 at 10:51 AM, the Administrator expected nursing staff to stay focus and make readjustment as needed when changing or updating medication orders to avoid creating any gaps in medication administration.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and staff interviews, the facility failed to intervene effectively when two residents became agitated and were yelling at each other in a common area. Resident #44 was cognitively impaired and had a history of violent behaviors caused Resident #229 to sustain a skin tear by hitting her on the hand with a cellphone. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #229). The findings included: Resident #44 was admitted to the facility on [DATE] with diagnoses that included: hemiplegia (muscle weakness or partial paralysis on one side of the body) following cerebral infarction (stroke) affecting right dominant side, schizophrenia (psychiatric disorder), vascular dementia with mood disturbance, aphasia (brain disorder that affects the ability to communicate) following cerebral infarction, bipolar disorder (mood disorder), anxiety disorder, violent behaviors. Resident #44 was a current resident at the facility. The quarterly minimum data set (MDS) dated [DATE] revealed Resident #44 had moderate cognitive impairment. The MDS documented she had no behavior or rejection of care. Resident #44 had a care plan dated 8/27/23 and last revised on 7/28/24 that read: [Resident #44] has potential to be physically aggressive related to dementia, history of harm to others, and poor impulse control. A care plan intervention dated 8/28/23 read, when Resident #44 becomes agitated intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, if response is aggressive staff to walk calmly away and approach later. Resident #229 was admitted to the facility on [DATE] with diagnoses that included: hemiplegia following cerebral infarction affecting left non dominant side, adjustment disorder with mixed anxiety and depressed mood (psychiatric disorder). Resident #229 was discharged from the facility to another care facility on 1/24/25. The quarterly minimum data set (MDS) dated [DATE] revealed Resident #229 was cognitively intact. The MDS documented that she had no behaviors or rejection of care. Resident #229 had the following care plans in place: -A care plan dated 10/19/23 that read, Resident #229 has potential to be verbally aggressive related to cognitive deficits. The care plan interventions included assessing her understanding of the situation, allowing time for her to express self and feelings towards the situation. -A behavior problem care plan related to making false accusations dated 12/20/23. The behavior care plan interventions included intervening as necessary to protect the rights and safety of others, approach/speak in a calm manner, divert attention, remove from situation and take to an alternative location as needed. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- A care plan dated 9/11/24 that read Resident #229 has the potential to be physically aggressive r/t anger, poor impulse control, she will throw things such as cups and dishes when trying to get attention. The care plan interventions included providing physical and verbal cues to alleviate anxiety, giving positive feedback, assist verbalization of source of agitation, assist to set goals for more pleasant behavior, encourage seeking out of staff member when agitated. Additional care plan interventions included when Resident #229 becomes agitated to intervene before agitation escalates, guide away from source of distress, engage calmly in conversation, If response is aggressive, staff to walk calmly away, and approach later. Review of a facility incident reported dated 7/28/24 completed by the Director of Nursing (DON) for Resident #229 revealed she had received a skin tear from another resident. The incident report indicated the other resident had a cell phone in her hand and struck Resident #229 on the right hand after Resident #229 had said don't open the door. The report indicated there was a misunderstanding and the other resident had thought Resident #229 was saying not to let her boyfriend in. The incident report revealed first aid was provided to Resident #229's right hand skin tear and both residents were separated. An order dated 7/28/24 for Resident #229 read: Right hand, clean with normal saline, apply antibiotic ointment and cover with band aid daily until resolved for skin tear. An interview was conducted on 5/5/25 at 11:04 AM with Resident #44. Resident #44 was asked if she recalled ever having any issues or an altercation with another resident at the facility. Resident #44 answered by shaking her head no. Resident #44 declined to answer further questions. Resident #229 was unable to be contacted for interview. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview with Nurse Aid (NA) #1 was conducted on 5/7/25 at 1:27 PM. NA #1 recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. She reported there had been bears outside the facility main entrance door and several residents were gathered in the lobby watching the bears. NA #1 recalled she thought there had been a total of four residents in the lobby including Resident #44 and Resident #229. NA #1 reported she and NA #2 had been in the lobby also watching the bears at the time of the incident. She stated Resident #44 had been standing at the facility entrance glass door in the lobby with her boyfriend. NA #1 recalled Resident #229 had been sitting in her wheelchair at the back corner of the lobby diagonally to where Resident #44 was standing looking out the main door watching the bears. NA #1 explained Resident #229 had been agitated and scared of the bears. She recalled Resident #229 was yelling loudly the bears were going to get inside and eat everybody. NA #1 reported Resident #44 yelled shut up at Resident #229, then Resident #229 yelled shut up back at Resident #44. She reported Resident #229 then continued to yell about the bears and Resident #44 yelled shut up again. NA #1 stated Resident #44 did not really talk but had a select vocabulary of words she could say and shut up was one of them. NA #1 recalled Resident #44 turned and began walking toward the back of the lobby, NA #1 stated she had thought Resident #44 was leaving and going back to her room. NA #1 stated that instead Resident #44 approached Resident #229 and swung at her using her left hand that was holding her cell phone. She reported Resident #229 put her hand up to protect her face and Resident #44 struck Resident #229 on the hand with the cell phone. NA #1 stated another staff member came and separated Resident #44 and Resident #229, but she could not remember who the staff was. NA #1 reported she was aware Resident #44 had a history of aggressive behaviors and becoming easily agitated when someone did something she did not like or if she was provoked. NA #1 stated she thought Resident #229 yelling shut up at Resident #44 would be provoking. NA #1 reported everyone in the lobby was focused on the bears and excited about the bears at the time of the incident. NA #1 agreed she could have intervened when Resident #229 and Resident #44 had shown signs of agitation by yelling shut up, by verbally redirecting them, or removing Resident #229 who was scared and anxious about the bears. NA #1 reported she had been focused on the bears at the time like everyone else in the lobby because the bears were so close to the facility entrance and there were baby bears that she had not thought about it at the time. An interview was conducted with NA #2 on 5/8/24 at 10:54 AM. NA #2 stated she recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. She reported she had been in the lobby when the incident happened but did not see the incident happen. She recalled there had been maybe four Residents in the lobby at the time gathered and watching the bears that were outside the main facility entrance doors. She recalled there had been another staff member in the lobby and another staff member that had walked by the lobby, but she could not remember who the staff members were. NA #2 reported she heard Resident #44 and Resident #229 yell shut up back and forth. She thought they had said shut twice before the incident happened. She stated she could not remember all the details of the incident. NA #2 recalled Resident #44 walking toward the back of the lobby where Resident #229 had been sitting. NA #2 explained she had thought Resident #44 was going back to her room but instead she must have hit Resident #229. She stated she had not seen Resident #44 hit Resident #229 but heard Resident #229 say she [Resident #44] hit me. NA #2 said she was not sure who had separated Resident #44 and Resident #229 after the incident, she reported it had been a staff member but did not remember who the staff member was. NA #2 stated she had never seen or heard of Resident #44 hit anyone before and did not know she was going to hit Resident #229. She reported at the time of the incident she had not worked at the facility long. NA #2 said she had heard Resident #44 say shut up up before but was not aware of Resident #44 having a history of aggressive or violent behaviors. She could not recall where Resident #44 had hit Resident #229. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #4 on 5/8/25 at 1:30 PM. He recalled the incident from 7/28/24 with Resident #44 and Resident #229. He remembered an NA came and got him from the nursing station and told him the two residents were arguing in the lobby about the bears or letting someone in or out of the building. Nurse #4 recalled the NA told him Resident #44 had put hands on Resident #229 and that it was an altercation they believed was physical. Nurse #4 said when he went to the lobby, he separated Resident #44 and Resident #229. Nurse #4 stated he assessed Resident #229 after the incident; he did not remember the skin tear on her hand. He said he just remembered Resident #229 was stuck on the bears and explaining the incident was not her fault. He recalled Resident #229 calmed down with reassurance. Nurse #4 explained he was aware of Resident #44's history of being easily agitated and having aggressive behaviors. He further explained Resident #44 was usually calm unless she was provoked. Nurse #4 said Resident #44 was provoked by direct confrontation such as someone cursing or arguing with her. He stated he had not seen Resident #44 on her own be the first aggressor without provocation. Nurse #4 indicated he reported the incident to the Director of Nursing (DON) and Resident #44 was placed on one-on-one staff supervision after the incident. An interview was conducted on 5/7/25 at 3:44 PM with the DON. She recalled the incident between Resident #44 and Resident #229 that occurred on 7/28/24. The DON stated a staff member called her and reported the incident when it happened. She did not remember who the staff member was who called her. The DON remembered staff had called and told her bears had been outside the front entrance of the building. She said the staff told her Resident #44's boyfriend was outside and trying to get in through the main door. She explained the staff had said Resident #229 was yelling about the bears and had said don't open the door and that was when Resident #44 hit Resident #229 her with cell phone on the hand. The DON stated Resident #44 had become agitated when Resident #229 started yelling shut the door because Resident #229 maybe had thought her boyfriend was going to get eaten by the bears. The DON explained staff separated Resident #44 and Resident #229 after the incident and Resident #229 was placed on one-on-one staff supervision. An interview was conducted with the Administrator and the [NAME] President of Operations (VPO) on 5/8/25 at 5:10 PM. The VPO reported everyone in the building was aware of Resident #44's behaviors. She stated Resident #44 was very quick and she felt like the staff responded quickly and were intervening from what staff had told them. The Administrator said shut up was a common phrase Resident #44 would use when she was agitated. The Administrator said maybe staff should have separated them but that she was not sure because they had been watching the bears. The Administrator said Resident #229 had a very minor injury after the incident on her hand that was superficial. She reported Resident #44 was placed on one-on one supervision after the incident, then monitoring was stepped down to every 15 minutes and then stepped down to every 30 minutes based on her having no further behaviors of incidents.

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	05/09/2025

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff interviews, the facility failed to keep a urinary catheter bag and drainage spout from touching the floor to reduce the risk of infection for 1 of 1 resident (Resident #62). This deficient practice occurred for 1 of 1 resident reviewed with a urinary catheter. Findings included: Resident #62 was admitted to the facility on [DATE] and had been re-admitted to the facility on [DATE]. His diagnoses included chronic obstructive uropathy. A significant change Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #62 was never/rarely understood and his cognitive skills for daily decisions making were severely impaired. He was documented on the MDS as having an indwelling catheter. Resident #62 had a care plan dated 6/14/24 for long term indwelling catheter. The care plan interventions included positioning the catheter bag and tubing below the level of the bladder and away from the entrance room door. An order dated 4/3/25 read, indwelling urinary catheter related to chronic obstructive uropathy. An observation was conducted on 5/5/25 at 11:15 AM of Resident #62 in his room in bed. He was observed to have an indwelling urinary catheter draining to a bedside drainage bag. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The drainage valve of the catheter bag was observed to be unsecured and resting on the floor. A follow up observation was conducted on 5/5/25 at 12:51 PM of Resident #62's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The drainage valve of the catheter bag was observed to be unsecured and resting on the floor. An additional observation was conducted on 5/5/25 at 3:04 PM of Resident #62's indwelling urinary catheter drainage system. The bedside drainage bag was observed positioned below bladder level and hanging on the bottom rail of the bed frame. The catheter bag was observed on the floor beside the bed with the drainage valve unsecured and on the floor. An interview was conducted with Nurse Aide (NA) #3 on 5/5/25 at 3:20 PM. She said she was assigned to care for Resident #62 today. She reported she typically checked on his catheter throughout the shift but that it had been a busy day. NA #3 said she had not specifically checked his catheter bag today. She explained she had been in his room to provide care but had not looked at his catheter bag and had not noticed it had been on the ground or that the drainage valve was loose and on the ground. NA #3 stated she was taught urinary catheter drainage bags should be hung on the bed frame and positioned below the level of the bladder so urine could drain properly. NA #3 said the catheter drainage bag and the drainage valve should not be on the floor because it was unsanitary. (continued on next page)

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	345010	A. Building B. Wing	05/09/2025

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse #3 on 5/5/25 at 13:35 PM. Nurse #3 reported he was Resident #62's assigned nurse today. He was not aware Resident #62's catheter drainage bag and drainage valve were on the floor. Nurse #3 said catheter bags and the drainage valve should not be on the floor because of contamination. An interview was conducted with the Director of Nursing on 5/7/25 at 3:37 PM. The DON stated urinary catheter bags, and the drainage valve should be kept off the floor because of germs and to prevent contamination. The DON explained that urinary catheter bags should be hung on the side of the bed below the level of the bladder when a resident was in bed and the drainage valve should be secured. An interview was conducted with the Administrator on 5/8/25 at 5:10 PM. The Administrator reported urinary catheter drainage bags, and the drainage valve should not be on the floor for infection control reasons. She explained the urinary drainage bag should be hung on the bed frame and positioned below the level of the bladder but should not be touching the floor.