

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: 345010	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/15/2026
NAME OF PROVIDER OR SUPPLIER Bear Mountain Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 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 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, facility activity calendar, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 7 of 9 residents reviewed for activities (Residents #10, #41, #11, #57, #8, #56, #9). The residents expressed not being able to leave the facility made them feel sad and sometimes depressed and angry. The findings included: A review of the activity calendars from May 10, 2025 to July 2026 revealed activities were scheduled inside of the facility during the week and on the weekends. There was one outside of the facility activity scheduled on 2/5/26. Observation of the facility location on 7/13/26 at 8:00 AM revealed it was located in a rural area that was within an 8-to-10-minute driving distance to numerous local and commercial shops, grocery stores, fast food, and sit-down restaurants. a. Resident #10 was admitted to the facility on [DATE]. An Annual Minimum Data Set (MDS) dated [DATE] indicated Resident #10 felt that it was very important to have activities that included going outside of the facility and doing things in a group setting. The assessment further indicated Resident #10 was cognitively intact. An interview conducted with Resident #10 (Resident Council President) on 7/13/26 at 3:00 PM during the Resident Council meeting revealed there had been no scheduled activities outside of the facility in a very long time with the exception of when two other residents were chosen to go out to eat a few months ago. She stated she felt it was unfair that only two residents got to go and no other outside activities had been scheduled for anyone else. Resident #10 reported they had discussed with the Activities Director about scheduling activities outside of the facility and she believed the Activities Director had spoken with the Administration about it, but they currently only had one van that held two people in wheelchairs, so they didn't have enough transportation to accommodate everyone and the van was always tied up with doctor's appointments. Resident #10 stated not having the opportunity to participate in activities outside of the facility made her feel sad and sometimes depressed. She revealed she felt like the facility could do something to assist with them being able to leave the facility on a group activity even once every other month. Resident #10 stated she would like to be able to go to a restaurant and order her own meals and socialize with other people, or go to the store shopping. b. Resident #41 was admitted to the facility on [DATE]. An Annual MDS dated [DATE] indicated Resident #41 felt that it was very important to have activities that included going outside of the facility and somewhat important doing things in a group setting. The assessment further indicated Resident #41 was cognitively intact. An interview conducted with Resident #41 on 7/13/26 at 3:00 PM during a Resident Council meeting revealed there had been no scheduled activities outside of the facility in over a year. He reported that he knew the facility's van was small and only held a couple of wheelchairs and was always tied up with doctor's appointments, but he would be happy if he could just ride along some days to those appointments in order to get out (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	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, Responsible Party, resident and staff 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 starting them for 2 of 5 residents reviewed for unnecessary medications (Resident #12 and Resident #3). The findings included: 1. Resident #12 was admitted to the facility on [DATE] with diagnoses that included anxiety disorder. A review of the physician's orders in Resident #12's medical record indicated an active order which started on 7/15/25 for Buspirone (an anti-anxiety medication) oral tablet 10 milligrams &ndash; give 1 tablet by mouth two times a day for agitation/restlessness. This order was entered into Resident #12's medical record by Unit Manager #1. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #12 was rarely/never understood and had severely impaired cognitive skills for daily decision making. Resident #12 had no behavioral symptoms, and received antianxiety medications. Further review of Resident #12's medical record indicated no information whether Resident #12's Responsible Party (RP) was informed in advance of the risks and benefits of initiating Buspirone. A phone interview with Resident #12's RP on 7/15/26 at 9:21 AM revealed that a nurse called him on 7/14/26 and told him that they just wanted to check if he was fine with Resident #12 receiving Buspirone. Resident #12's RP stated prior to 7/14/26, he had not been informed by the facility that Resident #12 had been receiving Buspirone and they had not obtained his consent for Resident #12 to receive this medication. He added that the hospice nurse was the one who told him that Resident #12 had been receiving Buspirone. Resident #12's RP further stated that he was fine with Resident #12 receiving Buspirone as long as she was not getting other medications which worked the same way. An interview with Unit Manager #1 on 7/14/26 at 2:39 PM revealed she remembered receiving the order for Resident #12 to start on Buspirone and she entered this order in her medical record on 7/15/25. Unit Manager #1 stated that she knew they were supposed to notify Resident #12's RP and obtain consent for Resident #12 to receive this medication, but the Director of Nursing was responsible for obtaining consents. Unit Manager #1 stated that she did not know why there was no consent for Buspirone in Resident #12's medical record. An interview with the Director of Nursing (DON) on 7/15/26 at 1:42 PM revealed she was responsible for obtaining the psychotropic medication consents and she usually did this whenever there were new orders for psychotropic medications. The DON stated that she reviewed all new orders daily and she would have obtained consents if there were new orders for psychotropic medications. The DON further stated that she would have called the guardian or Responsible Party for residents who were unable to give consents, and in Resident #12's case, it was just missed and she took full (continued on next page)		

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	responsibility for not obtaining consent for Resident #12 to receive Buspirone. 2. Resident #3 was admitted to the facility on [DATE] with diagnoses that included depression and anxiety disorder. A review of physician's orders in Resident #3's medical record indicated an active order which started on 1/21/26 for Duloxetine (an anti-depression medication) oral capsule delayed release particles 30 milligrams (mg) - give 1 capsule by mouth two times a day for depression. The medical record also revealed an active order dated 4/23/26 for Buspirone (an anti-anxiety medication) oral tablet 15 mg &ndash; give 1 tablet by mouth three times a day for anxiety. The significant change Minimum Data Set (MDS) assessment dated [DATE] showed that Resident #3 was cognitively intact, had no behavioral symptoms, and received medications for depression and anxiety disorder. Further review of Resident #3's medical record revealed no consent form to indicate whether she had been informed in advance of the risks and benefits of taking Duloxetine and Buspirone. In an interview on 7/15/26 at 12:13 PM with Resident #3, she stated she had spoken to staff earlier in the year about her depression and knew they had started Duloxetine but didn't remember talking about risks and benefits or signing a consent form. Resident #3 further stated sometime after that she had asked for something more for anxiety and had known they started Buspirone but didn't remember talking about risks and benefits or signing a consent form. On 7/15/26 at 1:42 PM an interview was conducted with the Director of Nursing (DON) who explained the process for obtaining consent for psychotropic medications. The DON stated she reviewed all new resident orders and if there was a new order for a psychotropic or antipsychotic medication she would physically go to the resident, explain the risks and benefits and get their signed consent. She revealed if the resident couldn't understand she would call their Responsible Party (RP) to explain and get their consent to start the medication. The DON explained she didn't remember why Resident #3 did not have consent forms for Duloxetine and Buspirone, and they had just gotten missed. During an interview with the Administrator on 7/15/26 at 1:49 PM she stated the expectation was that all new resident orders for medications were to be reviewed and written consent obtained for psychotropic medications. She explained the facility had a process in place for this that included daily review of all new medication orders, explaining the risks and benefits of psychotropic medications, and getting written consent from the resident or their RP. The Administrator further explained if residents or responsible parties had not consented to psychotropic medication use it would have put them at risk for not knowing why they were on these medications or understanding the medication's risks and benefits.		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation and staff interviews, the facility failed to discard an expired medication from 1 of 2 medication carts (West-Front Hall) reviewed for medication labeling and storage. The findings included: On 07/14/26 at 8:54 AM, an observation was made of the West-Front hall medication cart with Unit Manager #1. The third drawer on the right side, which was a locked drawer, held a plastic bag that contained an unopened package of two naloxone nasal spray bottles (medication used in emergencies to reverse the effects of a life-threatening opioid emergency). The bag had a pharmacy label with the name of a resident no longer at the facility with a date dispensed of 5/7/22 and a manufacturer's expiration date of 6/30/24. In an interview with the Unit Manager #1 on 7/14/26 at 8:55 AM she stated she had worked on that cart many times but never saw the naloxone package before. She explained that the controlled medications were kept in the second drawer on the right side which was also a locked drawer, and the third drawer was an extra locked drawer in case they had an overflow of controlled medications which rarely happened on that cart. Unit Manager #1 further explained because the drawer didn't get used much this medication package must have been overlooked by nurses and Medication Aides when checking their carts. The Director of Nursing (DON) was interviewed on 7/14/26 at 9:27 AM and confirmed the third drawer on the West-Front hall was for extra controlled medication storage and used infrequently. The DON stated nurses and Medication Aides working on the medication carts were supposed to check carts at the beginning of their shift to ensure that discontinued or expired medications were removed and disposed of or returned to pharmacy. The DON explained Unit Managers would also periodically check the carts for discontinued or expired medications, but this naloxone package had been overlooked and should have been removed from the cart when that resident had been discharged. In an interview with the Administrator on 7/14/26 at 2:26 PM she stated residents should have current medications as dispensed by the pharmacy and there should not be any discontinued or expired medications on the carts because they could cause a mix up or be given to residents when no longer effective.		