STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. Building B. Wing	10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Ridge Health and Rehab	611 Old US Highway 70 East Black Mountain, NC 28711

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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. (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 0684 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff, Medical Director, Emergency Medical Services (EMS) Supervisor, Physician Assistant and emergency room Physician, the facility failed to leave Resident #1 in place on the floor after a headfirst fall from a mechanical lift while being transferred by Nurse Aide (NA) #1 and NA #2 on [DATE]. The resident was prescribed two medications that increased the risk of bleeding. Resident #1 reported head and neck pain to Nurse #1 when she was assessed immediately after the fall. Resident #1 was lying on her back and was turned onto the mechanical lift pad and returned to her bed using the mechanical lift prior to an evaluation by Emergency Medical Services (EMS). Emergency Medical Services (EMS) was called and when they arrived, they were told Resident #1 fell from the mechanical lift, struck her head and complained of neck pain. EMS placed a cervical collar (neck brace used to stabilize the neck/head during emergencies) before sliding her over to the stretcher and transferred Resident #1 to the emergency room (ER) where she was diagnosed with a C1 ring fracture (first cervical vertebra, where the skull and neck meet). Resident #1 was evaluated by surgery who determined that she was not a suitable surgical candidate, and she was placed in an Aspen collar (brand name for a rigid cervical collar used to immobilize and support the neck after an injury or surgery). She was discharged to an acute hospice facility on [DATE] and expired on [DATE]. When someone sustains a headfirst injury the head and neck should be protected from moving and they should be left on the floor until EMS completes an assessment. Moving a person with a suspected head and neck injury could cause more damage like shifting of bony fractures, severing of the spinal cord, paralysis, and death. Any movement with a C1 fracture is likely to cause additional harm and moving the person can make the C1 fracture worse, and this can cause irreparable damage to the spinal cord, affect respirations, and/or death. Resident #1's Certificate of Death dated [DATE] indicated Resident #1 was pronounced dead on [DATE] at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #1).Immediate jeopardy began on [DATE] when Resident #1 who had a witnessed headfirst fall to the floor was transferred back to bed by staff using the mechanical lift before she was assessed by EMS. Immediate jeopardy was removed on [DATE] when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.The findings included:Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), normal pressure hydrocephalus (excessive accumulation of cerebrospinal fluid in the brain), aphasia (language disorder that affects a person's ability to communicate), hemiplegia and hemiparesis (paralysis and weakness) affecting the left and right side, contracture of the right upper arm, osteoarthritis, osteoporosis, wedge compression fracture of thoracic vertebra 11 to thoracic vertebra 12 and lumbar vertebra and history of left foot drop.The Significant Change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was moderately cognitively impaired, had no behavioral symptoms, and had range of motion impairment on both sides of either upper or lower extremities. She was dependent on staff assistance with chair/bed-to-chair transfer. The MDS further indicated that Resident #1 had no falls since prior assessment and received hospice care while a resident at the facility.Resident #1's care plan last reviewed on [DATE] indicated Resident had an activities of daily living self-care performance deficit related to muscle weakness and left and right sided hemiparesis/hemiplegia due to stroke. Interventions included the resident required total assist by two staff to move between surfaces as necessary using a mechanical lift.A review of Resident #1's Medication Administration Record for [DATE] indicated she received Aspirin 81 milligrams one tablet by mouth one time a day (Aspirin's adverse effects include an increased risk of bleeding due to its antiplatelet properties) and Clopidogrel (antiplatelet medication used to prevent clots) one tablet by mouth one time a day. (The most common adverse effects of Clopidogrel are bleeding and bruising more easily).A review of an Incident Report dated [DATE] at 11:05 AM by Nurse #1 indicated a witnessed fall involving Resident #1. The nurse aide yelled out in the hall for the nurse to come to (Resident #1's room) quickly. Upon entering the room, (the nurse) found Resident #1 lying supine (lying on back with face upward) in the floor with head nearest the door and legs facing the bed, partially underneath the bed. Bed was in a raised position. Noted mechanical lift beside Resident #1 with lift pad remaining on equipment. The nurse aide stated Resident #1

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (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 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observation, and interviews with staff and the Medical Director, the facility failed to provide a safe transfer of Resident #1 using a mechanical lift. Resident #1 had left foot drop, hemiplegia (paralysis) and hemiparesis (weakness) on both sides and was prescribed an anti-platelet medication. Resident #1 was transferred with a mechanical lift by Nurse Aide (NA) #1 and NA #2 on 10/4/25 and they failed to ensure that Resident #1's feet (with shoes on) cleared the bed while in the mechanical lift. Resident #1's feet got caught on the mattress and as the lift was moved, the force of Resident #1's feet coming loose caused Resident #1 to swing and fall headfirst out of the sling that was approximately 4 feet in the air. Resident #1 landed on the floor and complained of pain in her head/neck area and was transferred to the Emergency Department (ED) for evaluation. Resident #1 was diagnosed with a C1 ring fracture (first cervical vertebra, where the skull and neck meet), and was placed in a cervical collar. She was determined to be not a suitable surgical candidate and transitioned to an acute hospice facility on 10/6/25. Resident #1's Certificate of Death dated 10/15/25 indicated Resident #1 was pronounced dead on 10/15/25 at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1).Immediate jeopardy began on 10/4/25 when Resident #1 was unsafely transferred using a mechanical lift and fell out of the sling to the floor headfirst. Immediate jeopardy was removed on 10/18/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.The findings included:A review of the manufacturer's instruction manual for the mechanical lift used by the facility read in part: Special care MUST be taken with people with disabilities who cannot cooperate while being lifted. The patient should be elevated high enough to clear the bed and their weight supported by the lift. When the patient is lifted from the bed (with the patient's head supported), he/she will be raised to a sitting position. When patient is clear of the bed surface, swing their feet off the bed by either aiding or guiding the patient. Illustrations were included of a second person supporting the legs of the patient while being aided or guided to swing their feet off the bed. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the patient lift. Open control valve lowering patient so that his feet rest on or over the base of the lift, straddling the mast. Close control valve. NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to pull or push. Pull the patient lift away from the bed and push from behind with both hands. Illustrations were included detailing a second person supporting the patient from behind while the lift was being pulled away from the bed.A review of the facility's undated Safe Resident Handling/Transfers policy indicated two facility staff members will participate in the transfer process should a mechanical lift be used and mechanical lift education/training is based on manufacturer's recommendations in conjunction with applicable state/federal regulations and industry standard.Resident #1 was admitted to the facility on [DATE] with diagnoses that included cerebral infarction (stroke), normal pressure hydrocephalus (excessive accumulation of cerebrospinal fluid in the brain), aphasia (language disorder that affects a person's ability to communicate), hemiplegia and hemiparesis (paralysis and weakness) affecting the left and right side, contracture of the right upper arm, osteoarthritis, osteoporosis, wedge compression fracture of thoracic vertebra 11 to thoracic vertebra 12 and lumbar vertebra, and history of left foot drop. The Significant Change in status Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 was moderately cognitively impaired, had no behavioral symptoms, and had range of motion impairment on both sides of either upper or lower extremities. She was dependent on staff assistance with chair/bed-to-chair transfer. The MDS further indicated that Resident #1 had no falls since prior assessment and received hospice care while a resident at the facility.The Care Area Assessment (CAA) for Falls dated 8/27/25 indicated Resident #1 had a history of stroke and had residual left sided hemiplegia and left foot drop. She was being followed by hospice care starting 8/14/25 due to cerebrovascular accident with left hemiplegia, hydrocephalus, osteoporosis, weakness and hypertension. She had residual left sided facial droop. She was on antiplatelet medications for stroke. She was able to understand and was sometimes able to make herself understood. Speech was clear but slurred at times. She would answer questions with a short delay but most appropriately answered questions. She was able to make needs known. Falls CAA was triggered secondary to antianxiety and