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	05/30/2025

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

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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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37014 Based on record reviews and staff interviews, the facility failed to ensure an as needed (PRN) psychotropic medication, Lorazepam (medication used to relieve anxiety), had a stop date of 14 days for 1 or 5 residents (Resident #7) reviewed for unnecessary medications. The findings included: Resident #7 was readmitted to the facility on [DATE] with diagnoses that included anxiety and depression. A physician's order entered by Nurse #1 on 05/04/25 at 4:11 PM for Resident #7 read, Lorazepam 0.5 milligrams (mg) every 12 hours as needed (PRN) for anxiety. There was no stop date. Resident #7's quarterly Minimum Data Set, dated dated dated [DATE] revealed she was cognitively intact, displayed no behaviors or rejection of care and did not receive antianxiety medication. Review of Resident #7's May 2025 medication administration record (MAR) revealed the Lorazepam 0.5 mg every 12 hours PRN for anxiety remained an active order. There were no doses administered. During an interview on 05/29/25 at 2:34 PM, the Director of Nursing (DON) revealed recently, most of their providers had started entering their own orders and weren't always good about putting stop dates for medications when indicated but they did have standing orders that a medication could be discontinued after 60 days if not used. The DON explained Resident #7's order for PRN Lorazepam was verified with the on-call provider upon her return from the hospital on 05/04/25 and the order should have indicated a stop date of 14-days. The DON stated she was confident that the Consulting Pharmacist would have caught that Resident #7's physician order for PRN Lorazepam did not have a stop date when he conducted his monthly medication review for May 2025. A phone attempt for an interview with Nurse #1 on 05/30/25 at 9:10 AM was unsuccessful. During an interview on 5/30/25 at 12:03 PM, the Administrator stated Resident #7's physician order for PRN Lorazepam should have had a stop date of 14 days. He stated it would have been an opportunity for the admitting nurse to have questioned the provider when orders were being verified.

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 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** 41069 Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessments in the areas of hospice care, and PASRR for 3 of 4 residents (Resident #25, Resident #31, and Resident #36) whose MDS were reviewed. The findings included: 1. Resident #25 was admitted to the facility on [DATE] with diabetes mellitus. A Hospice Initial Certification dated 2/3/25 indicated Resident #25 was certified as eligible for hospice care based on her diagnosis and current condition, and that she was expected to have a limited life expectancy of 6 months of less if the terminal illness ran its course. The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #25 did not receive hospice care while a resident at the facility. An interview with the MDS Coordinator on 5/29/25 at 8:38 AM revealed Resident #25 was on hospice care, and that she completed Resident #25's quarterly MDS dated [DATE]. The MDS Coordinator stated she was not sure how she missed hospice care on Resident #25's MDS. She stated that it was an oversight and that Resident #25's quarterly MDS should have reflected that she received hospice care. An interview with the Administrator on 5/30/25 at 12:03 PM revealed the MDS should have been coded correctly. 37014 2. Resident #31 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder-depressive type, bipolar disorder and Post-Traumatic Stress Disorder (PTSD). A PASRR Level II determination notification letter dated 01/02/25 revealed Resident #31 had a Level II PASRR with no expiration date. The significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #31 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 05/29/25 at 8:38 AM, the MDS Coordinator confirmed Resident #31 had a Level II PASRR and the MDS assessment dated [DATE] was completed by another MDS Coordinator who was no longer employed. The MDS coordinator stated was not sure how it was missed and the MDS assessment should have reflected Resident #31 had a Level II PASRR. An interview with the Administrator on 05/30/25 at 12:03 PM revealed he expected MDS assessments to be coded correctly. (continued on next page)

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	3. Resident #36 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, delusional disorder, anxiety disorder, and major depressive disorder. A PASRR Level II determination notification letter dated 07/25/24 revealed Resident #36 had a Level II PASRR with no expiration date. The annual Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #36 was not currently considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or a related condition. During an interview on 05/29/25 at 8:38 AM, the MDS Coordinator confirmed Resident #36 had a Level II PASRR and the MDS assessment dated [DATE] was completed by another MDS Coordinator who was no longer employed. The MDS coordinator stated was not sure how it was missed and the MDS assessment should have reflected Resident #36 had a Level II PASRR. An interview with the Administrator on 05/30/25 at 12:03 PM revealed he expected MDS assessments to be coded correctly.

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069 Based on record review, observations, resident and staff interviews, the facility failed to post cautionary and safety signage outside residents' rooms that indicated the use of oxygen for 5 of 5 residents reviewed for respiratory care (Resident #14, Resident #74, Resident #28, Resident #7 and Resident #51). The findings included: 1. Resident #14 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, and acute respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues). A review of Resident #14's physician orders indicated an order dated 4/25/25 for oxygen to be administered continuously via nasal cannula at 3 liters per minute every shift. The quarterly Minimum Data Set assessment dated [DATE] Resident #14 was cognitively intact and received oxygen therapy while a resident at the facility. An observation on 5/27/25 at 10:17 AM revealed Resident #14 sitting in her wheelchair by her bed with oxygen being administered by an oxygen concentrator. There was no signage posted outside Resident #14's room indicating supplemental oxygen was in use. An observation of Resident #14 on 5/28/25 at 12:13 PM revealed her sitting up in her recliner while eating her lunch meal. Resident #14 received oxygen via nasal cannula which was connected to an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use. An interview with Nurse #2 on 5/29/25 at 10:52 AM revealed Resident #14 had always used oxygen, but she was not aware of any oxygen use signage that the facility used for residents receiving supplemental oxygen. An interview with the Director of Nursing (DON) on 5/29/25 at 11:18 AM revealed the facility didn't put oxygen signage by the door of each resident receiving oxygen, and they hadn't done this in years. The DON stated that she would have to look for the reason why they had not been using them, and that she would need to pull the facility's policy on oxygen use. A follow-up interview with the DON on 5/29/25 at 12:00 PM revealed she reviewed the facility's policy which stated that because the facility was located on a smoke-free campus, they only needed to place signage at major entry points of the facility, and that this was what they had been doing. An interview with the Administrator on 5/29/25 at 1:21 PM revealed that they had received conflicting information regarding putting up oxygen signage and whether it was required only at entry points or on each resident room door. The Administrator stated that they would change the facility's policy and put the oxygen signs up in each resident room after he reviewed the current federal guidelines. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	2. Resident #74 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease. She was readmitted to the facility on [DATE] for acute respiratory failure with hypoxia (a condition in which there is an inadequate supply of oxygen to the body's tissues), and pulmonary embolism (a condition in which one or more arteries in the lungs become blocked by a blood clot). The admission Minimum Data Set assessment dated [DATE] indicated Resident #74 was cognitively intact, but she did not receive oxygen therapy while a resident at the facility. A review of Resident #74's physician orders indicated an order dated 5/28/25 for oxygen to be administered at 2 liters per minute as needed via nasal cannula to maintain oxygen saturation above 90%. An observation and interview with Resident #74 on 5/27/25 at 11:02 AM revealed she only started receiving oxygen when she was at the hospital where she had a blood clot in her lungs. Resident #74 was observed receiving oxygen via nasal cannula which was connected to an oxygen concentrator and was running at 2 liters per minute. There was no oxygen in use signage visible outside her room by the door. An observation of Resident #74 on 5/28/25 at 12:11 PM revealed her sitting up in her wheelchair while being assisted by a staff member with her lunch tray set-up. Resident #74 received oxygen via nasal cannula which was connected to an oxygen tank at the back of her wheelchair. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use. An interview with Nurse #2 on 5/29/25 at 10:52 AM revealed Resident #74 only started using oxygen after she got back from the hospital wherein she had blood clots in her lungs. Nurse #2 stated that she was not aware of any oxygen use signage that the facility used for residents receiving supplemental oxygen. An interview with the Director of Nursing (DON) on 5/29/25 at 11:18 AM revealed the facility didn't put oxygen signage by the door of each resident receiving oxygen, and they hadn't done this in years. The DON stated that she would have to look for the reason why they had not been using them, and that she would need to pull the facility's policy on oxygen use. A follow-up interview with the DON on 5/29/25 at 12:00 PM revealed she reviewed the facility's policy which stated that because the facility was located on a smoke-free campus, they only needed to place signage at major entry points of the facility, and that this was what they had been doing. An interview with the Administrator on 5/29/25 at 1:21 PM revealed that they had received conflicting information regarding putting up oxygen signage and whether it was required only at entry points or on each resident room door. The Administrator stated that they would change the facility's policy and put the oxygen signs up in each resident room after he reviewed the current federal guidelines. 51464 3. Resident #28 was admitted to the facility on [DATE] with diagnoses that included pneumonia, heart failure and acute kidney failure. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A review of Resident #28's physician orders revealed an order dated 5/15/25 for oxygen to be administered continuously every day and night shift via nasal cannula at 2-3 liters per minute to keep oxygen saturation greater than 90%. A review of the Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #28 was severely cognitively impaired and was coded for oxygen use. An observation on 5/27/25 at 10:19 AM revealed Resident #28 sitting in her wheelchair by her bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use. An observation on 5/28/25 at 8:34 AM revealed Resident #28 sitting in her wheelchair by her bed with oxygen being administered via nasal cannula by an oxygen concentrator. There was no cautionary or safety signage posted outside her room indicating supplemental oxygen was in use. During an interview with Nurse #3 on 5/29/25 at 2:12 PM it was revealed nursing staff were responsible for placing oxygen signage on the resident's door upon admission or if oxygen was a new order. She did not know why Resident #28 did not have signage on her door. An interview on 5/29/25 at 11:18 AM with the Director of Nursing (DON) revealed the facility did not put signage on the individual doors of residents receiving oxygen. She indicated she would look up the facility policy on oxygen signage use. During a follow-up interview with the DON on 5/29/25 at 12:00 PM she revealed the facility's policy stated that because the facility was a smoke-free campus oxygen signage only needed to be placed at the major entry points of the facility. An interview with the Administrator on 5/29/25 at 1:21 PM revealed he had received conflicting information regarding oxygen signage and whether it was required only at entry points or on the door of each resident receiving oxygen. The Administrator indicated they would amend their policy and place oxygen signage on the door of each resident receiving oxygen and educate staff on the amended policy. 37014 4. Resident #7 was readmitted to the facility on [DATE] with diagnoses that included respiratory failure and chronic obstructive pulmonary disease (COPD, difficulty breathing). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #7 had intact cognition and received oxygen therapy while a resident at the facility. A physician's order dated 05/12/25 for Resident #7 revealed she was to receive continuous oxygen administered via nasal canula at 2 liters per minute (LPM) every shift. An observation on 05/27/25 at 2:08 PM revealed Resident #7 lying in bed receiving supplemental oxygen via nasal cannula with the flow rate on the oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door, doorframe or in Resident #7's room to indicate oxygen was in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A subsequent observation conducted on 05/28/25 at 3:43 PM revealed Resident #7 lying in bed receiving supplemental oxygen via nasal cannula with the oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door or doorframe of Resident #7's room to indicate oxygen was in use. During an interview on 05/29/25 at 10:11 AM, Nurse #4 confirmed Resident #7 received continuous oxygen. Nurse #4 stated the facility did not use oxygen cautionary signage for residents receiving supplemental oxygen. During an interview on 05/29/25 at 11:18 AM, the Director of Nursing (DON) revealed the facility didn't put oxygen cautionary signage on or by the room doors of residents receiving supplemental oxygen and hadn't done so in years. The DON stated she wasn't sure why the facility did not use oxygen cautionary signage and would check the facility's policy for oxygen use. During a follow-up interview on 05/29/25 at 12:00 PM, the DON stated the facility's policy for oxygen use stated that because the facility was a smoke-free campus, they only needed to place cautionary signage at the major entry points of the facility which was what they had been doing. During an interview on 05/29/25 at 1:21 PM, the Administrator stated they had received conflicting information regarding oxygen cautionary signage and whether it was required only at entry points to the facility or on the room doors of the residents receiving supplemental oxygen. The Administrator state they would change the facility's policy to reflect placing oxygen signage on the room doors of residents receiving supplemental oxygen and would educate staff on the policy change. 5. Resident #51 was admitted to the facility on [DATE] with diagnoses that included chronic respiratory failure, emphysema (lung condition that causes shortness of breath) and chronic obstructive pulmonary disease (COPD, difficulty breathing). The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #51 had intact cognition and received oxygen therapy while a resident at the facility. A physician's order dated 03/12/25 for Resident #51 revealed he was to receive continuous oxygen administered via nasal canula at 2 liters per minute (LPM) every shift. During an observation and interview on 05/27/25 at 10:26 AM, Resident #51 was sitting up in bed receiving supplemental oxygen via nasal cannula connected to an oxygen concentrator set at 2 LPM. Resident #51 revealed he had received supplemental oxygen at 2 LPM for quite some time, which helped him with his breathing. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use. An observation conducted on 05/28/25 at 3:52 revealed Resident #51 sitting in his wheelchair receiving supplemental oxygen via nasal cannula that was connected to a portable, oxygen cylinder fastened to the back of his wheelchair. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use. An observation conducted on 05/29/25 at 10:58 AM revealed Resident #51 lying in bed with the head of the bed slightly elevated and sleeping soundly. He was receiving supplemental oxygen via nasal cannula connected to an oxygen concentrator set at 2 LPM. There was no cautionary signage posted on the door or doorframe of Resident #51's room to indicate oxygen was in use. (continued on next page)

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 05/29/25 at 11:18 AM, the Director of Nursing (DON) revealed the facility didn't put oxygen cautionary signage on or by the room doors of residents receiving supplemental oxygen and hadn't done so in years. The DON stated she wasn't sure why the facility did not use oxygen cautionary signage and would check the facility's policy for oxygen use. During a follow-up interview on 05/29/25 at 12:00 PM, the DON stated the facility's policy for oxygen use stated that because the facility was a smoke-free campus, they only needed to place cautionary signage at the major entry points of the facility which was what they had been doing. During an interview on 05/29/25 at 1:21 PM, the Administrator stated they had received conflicting information regarding oxygen cautionary signage and whether it was required only at entry points to the facility or on the room doors of the residents receiving supplemental oxygen. The Administrator state they would change the facility's policy to reflect placing oxygen signage on the room doors of residents receiving supplemental oxygen and would educate staff on the policy change.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. 51464 Based on observation and staff interviews the facility failed to discard food with signs of spoilage in 1 of 1 walk-in cooler and date open food items and food ready for use in 1 of 1 walk-in cooler. This practice had the potential to affect food served to residents. The findings included: An observation of the walk-in cooler with the Dietary Manager on 5/27/25 at 9:12 AM revealed the following: a. An opened 32-ounce container of sour cream with no open date. b. An undated egg flat containing 17 eggs. Two of the eggs were cracked on top with shiny clear material noted around the cracks. An interview on 5/29/25 at 1:48 PM with the Dietary Manager revealed the facility's policy stated to put a date on any food item when it was opened, and that any spoiled food should be discarded immediately. She indicated she and the cook were responsible for checking dates on items in the coolers and freezer daily. The Dietary Manager revealed the sour cream container and egg flat should have had an open date, and the broken eggs should have been thrown out. An interview on 5/30/25 at 12:05 PM with the Administrator revealed the Dietary Manager and cook were responsible for labeling and dating items in the kitchen. He expected all food items to be labeled, dated and for the dietary staff to check the coolers and discard any food items that were undated or had visible signs of spoilage.