

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Sapphire Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N Country Club Road Brevard, NC 28712	
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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>Based on record review, observations and staff interviews, the facility failed to date open containers of nutritional supplements and failed to remove nutritional supplements stored past the use by date in 2 of 3 nourishment room refrigerators (North and South Units). This practice had the potential to affect residents receiving nutritional supplements. Findings included: Observations of the nourishment room refrigerators on the North and South Units conducted on 05/06/26 at 10:29 AM through 10:41 AM with the Dietary Manager (DM) revealed: a. Stored in the North Unit nourishment room refrigerator was a one-quart sized nutritional shake with no date to indicate when it was opened. The manufacturer's label on the container read, use within 4 days after opening if refrigerated. b. Stored in the South Unit nourishment room refrigerator were two one-quart sized nutritional shakes dated 4/24 and 4/28. The manufacturer's label on the containers read, use within 4 days after opening if refrigerated. Also stored was one opened and undated 8-ounce sized diabetic nutritional shake. The manufacturer's label on the container read if opened use within 48 hours. At the completion of the observation, the DM was interviewed and stated dietary staff did not stock nutritional shakes in the nourishment room refrigerators. The DM stated the nurses were responsible for the nutritional shakes given to residents and for dating those when opened and discarding when past the use by date. The DM revealed dietary staff checked the nourishment room refrigerators twice a day and restocked and checked expiration dates on the snacks and drinks provided by the kitchen. During an interview on 05/06/26 at 1:55 PM, Nurse #1 explained that a physician's order was required for a resident to receive a nutritional shake, and nurses were responsible for administering those. Nurse #1 revealed when a nutritional shake was administered the nurse was responsible for writing the date it was opened and for ensuring nutritional shakes were used and discarded by the use by date on the manufacture's label. An interview was conducted on 05/07/26 at 3:02 PM with the Administrator. The Administrator stated it was the responsibility of the person who opened a nutritional shake to write the date it was opened on the container. She stated historically dietary staff checked the dates on food and drinks stored in the nourishment room refrigerators.</p>		

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Sapphire Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N Country Club Road Brevard, NC 28712	
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)		
<p>F 0645</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>PASARR screening for Mental disorders or Intellectual Disabilities</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) determination for a resident who was admitted to the facility with a serious mental health disorder for 1 of 2 residents reviewed for PASRR (Resident #11). Findings included: A PASRR Determination Notification letter dated 10/27/25 revealed Resident #11 had a Level I PASRR with no expiration date. Resident #11 was admitted to the facility on [DATE] with diagnoses that included bipolar disorder, generalized anxiety disorder, and vascular dementia with severe behavioral disturbance. A psychiatric progress note dated 10/29/25 revealed Resident #11 admitted to the facility from another facility and per the records received from the previous facility, she had a history of bipolar disorder for many years and recent behavioral and psychological symptoms of dementia (BPSD, refers to non-cognitive symptoms and behaviors such as agitation, aggression, anxiety, depression and hallucinations). The psychiatric provider noted Resident 11's had active diagnoses of bipolar disorder, bipolar depression and generalized anxiety disorder that were managed with duloxetine (medication used to treat depression and anxiety) 60 milligrams (mg) once a day, clonazepam (medication used to treat severe anxiety) 0.5 mg twice daily, quetiapine (antipsychotic) 50 mg every morning, quetiapine 150 mg at bedtime, and trazodone (medication used to treat depression) at bedtime. The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #11 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #11's active psychiatric/mood disorder diagnoses included anxiety disorder and bipolar disorder. She received antipsychotic medication on a routine basis only and a gradual dose reduction was documented by the physician as clinically contraindicated on 10/29/25. A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Administrator on 05/05/26 at 2:45 PM revealed Resident #11 had a Level I PASRR effective 04/03/23 with no expiration date. There were no PASRR requests submitted for an evaluation for a [NAME] II PASRR determination prior to 05/05/26. During interviews on 05/05/26 at 3:14 PM and 05/07/26 at 11:55 AM, the Social Worker (SW) revealed when residents admitted to the facility, she checked the NC MUST to see if the resident had a current PASRR but did not check to see if mental health diagnoses were included in the initial screening. The SW explained that previously, a PASRR evaluator had informed her that if a resident had a Level I PASRR then a request for an evaluation for a Level II PASRR determination did not need to be submitted unless the resident had a change in condition. The SW confirmed a request for a Level II PASRR evaluation was not submitted for Resident #11 based on the guidance she was given. During an interview on 03/10/26 at 2:37 PM, the Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations. She explained that based on previous guidance the SW received from the PASRR evaluator, a request for a Level II PASRR evaluation for Resident #11 was not completed. The Administrator stated she would expect for PASRR requests to be submitted per regulatory guidelines.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Sapphire Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N Country Club Road Brevard, NC 28712	
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)		
<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, resident and staff interviews, the facility failed to provide assistance with denture care for 1 of 4 dependent residents reviewed for activities of daily living (Resident #100). Findings included: Resident #100 was admitted to the facility on [DATE] with diagnoses which included stroke, dysphagia (difficulty swallowing), and dementia. The admission Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #100's cognition was severely impaired, setup or clean-up assistance was needed with oral hygiene, had no natural teeth or tooth fragments (edentulous), and had no rejection of care or behaviors during the lookback period. A review of the Nurse Aide (NA) documentation for oral care/denture care revealed from 04/07/26 through 05/05/26 denture care was documented as provided three times for Resident #100 on 04/14/26, 04/25/25, and 04/26/26. The care plan dated 04/19/26 revealed Resident #100 was at risk for oral and dental health problems related to being edentulous and identified a deficit in his ability to perform activities of daily living self-care related to dementia and a stroke. The goals included to maintain the highest practicable level of independence in performing activities of daily living. The interventions included were to provide or assist with oral care at least twice daily using a soft toothbrush or foam swab and to provide cues or minimal assistance to complete activities of daily living as appropriate. Review of the Kardex (a care plan reference guide) utilized by NA staff specified they were to provide or assist Resident #100 with oral care at least twice daily using a soft toothbrush or foam swabs. An observation and interview with Resident #100 were conducted on 05/04/26 at 10:39 AM. Resident #100 stated he wore upper and lower dentures and showed his dentures had brown stains and a buildup of debris around the teeth and gums. Resident #100 stated he could brush his dentures if he had a toothbrush and toothpaste. An interview was conducted on 05/06/26 at 3:37 PM with NA #1. NA #1 revealed she was Resident #100's assigned NA during the day shift on 05/04/26, 05/05/26, and 05/06/26 and she had provided setup assistance with oral care. She explained she gave Resident #100 mouthwash and a basin for him to rinse his mouth because he had difficulty brushing his teeth. NA #1 revealed oral hygiene care was provided at least once during her shift and as needed. NA #1 stated Resident #100, did not have dentures, had his own teeth and confirmed she had not provided denture care. NA #1 revealed denture care meant dentures were soaked overnight, rinsed in morning, and adhesive was applied. A phone interview was conducted on 05/06/26 at 4:37 PM with NA #2. NA #2 confirmed she worked the night shift on 05/05/26 and previously had been Resident #100's assigned NA on multiple occasions. NA #2 stated she was aware Resident #100 wore dentures because she had seen them on the bed or nightstand. NA #2 stated she would do denture care but did not because, most times when she arrived Resident #100 had already eaten, was in bed and was very straight forward he did not want to take out his dentures. NA #2 revealed denture care meant they were soaked overnight. An observation and interviews were conducted on 05/06/26 at 3:24 PM with the Director of Nursing (DON) and Resident #100. Resident #100 stated no one had provided assistance with denture care and agreed to have his dentures cleaned at that time. Resident #100 removed his dentures and gave them to the DON. The DON observed Resident #100's upper and lower dentures had a buildup of debris and brown colored stains around the teeth and gums and took them to be cleaned. A follow-up interview was conducted on 05/06/26 at 3:53 PM with the DON. The DON revealed he reviewed the care plan and Kardex that indicated Resident #100 was supposed to receive oral care at least twice a day. The DON stated dentures should be brushed and soaked overnight and placed in the resident's mouth in morning. During an interview on 05/07/26 at 3:14 PM, the Administrator stated denture care was done daily either by Resident #100 or provided by the NA. The Administrator stated oral hygiene care, ideally should be done twice a day.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/07/2026
NAME OF PROVIDER OR SUPPLIER Sapphire Ridge Health and Rehabilitation		STREET ADDRESS, CITY, STATE, ZIP CODE 115 N Country Club Road Brevard, NC 28712	
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)		
<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on interviews with residents and staff, the facility failed to ensure residents' right to receive mail delivered on Saturdays. This had the potential to affect 107 of 107 residents in the facility. Findings included: A Resident Council group interview was conducted on 05/06/26 at 11:00 AM with Residents #46 (Resident Council President), #33, #35, #42, and #83 in attendance. In addition, the Activity Director was present during the group interview at the residents request. Resident #35 reported if mail was delivered to the facility on Saturday, it was not delivered to the residents until Monday by the Activities Director. Resident #33 and Resident #83 both voiced agreement with Resident #35's statement and when asked, Resident #46 and Resident #42 did not disagree. During interviews on 05/06/26 at 11:00 AM and 11:44 AM, the Activity Director explained she was working as a Certified Occupational Therapist Assistant until 04/24/26 when she took over the position of the Activity Director. She stated she did not currently work weekends and was not sure how the process worked regarding mail being delivered to residents on the weekends. During an interview on 05/06/26 at 3:00 PM, the Receptionist reported she worked Mondays through Fridays during the hours of 8:00 AM to 4:00 PM and there was a weekend receptionist that worked Saturdays and Sundays, usually during the hours of 10:00 AM to 7:00 PM. The Receptionist stated the weekend Receptionist did not have a key to open the outside mailbox to check for any mail delivered on Saturday. The Receptionist explained she retrieved the mail from the outside mailbox on Monday morning and gave the mail to the Business Office Manager and the Activity Director delivered the mail to the residents. During an interview on 05/06/26 at 3:06 PM, the Business Office Manager confirmed that if she was not at work on the weekends, no one currently had access to open the outdoor mailbox to retrieve the mail. The Business Office Manager reported that she worked on Saturdays 90% of the time and she checked the mailbox, sorted the mail and gave the residents mail to activity staff to deliver or on occasion, she delivered the mail to the residents. She explained the previous Activity Director left employment approximately 6 to 7 weeks ago and since then there was no one at the facility to deliver the mail to residents if she was not working. The Business Office Manager stated the new Activity Director transitioned from the therapy department on 04/24/26 but she had not yet been trained on the process of sorting the mail to determine what needed to be delivered to the residents and what needed to be placed in the business office. During an interview on 05/07/26 at 3:45 PM, the Administrator stated the breakdown regarding mail not being delivered to residents on the weekend was due to turnover in the activity department. She explained there were approximately 3 weeks or so when mail wasn't delivered to residents on the weekends because they didn't have an Activity Director and only had an Activity Assistant. The Administrator stated it was important for residents to receive mail and acknowledged they should receive their mail when delivered, including weekends.</p>		