STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345010	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bear Mountain Health and Rehabilitation	**500 Beaverdam Road , Asheville, North Carolina, 28804**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/29/25 through 12/30/25. Event ID# 1DF6C8-H1. The following intakes were investigated: 2696576 1 of the 1 complaint allegations resulted in deficiency.	F0000		01/20/2026
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff, Pharmacist, and Medical Director interview, the facility failed to transcribe and implement orders for diabetes care according to the hospital discharge summary for a resident with diabetes. The hospital discharge summary ordered sitagliptin/metformin (Janumet extended release). The facility instead entered and administered metformin, omitting the sitagliptin component and the extended-release formulation. This deficient practice occurred for 1 of 3 residents reviewed for providing care according to professional standards (Resident #1). Findings included: A hospital discharge summary dated 8/28/25 included the following medication order: metformin-sitagliptin (Janumet extended release (XR) 100 milligram (mg)-1000 mg oral tablet, 1 tablet by mouth daily for diabetes. According to manufacturer's information, metformin-sitagliptin is a combination of two medications and is marketed under the brand name of Janumet extended release XR. Resident #1 was admitted to the facility on 8/28/25. Her diagnoses included Type-2 diabetes mellitus.	F0658	Based on record review, staff, Pharmacist, and Medical Director interview, the facility failed to transcribe and implement orders for diabetes care according to the hospital discharge summary for a resident with diabetes. The hospital discharge summary ordered sitagliptin/metformin (Janumet extended release). The facility instead entered and administered metformin, omitting the sitagliptin component and the extended-release formulation. This deficient practice occurred for 1 of 3 residents reviewed for providing care according to professional standards (Resident #1). The affected resident is no longer a resident at the facility. Newly admitted residents with orders for antidiabetic medications are at risk of being affected by the deficient practice. Residents admitted to the facility over the past 30 days (12/1/2025-12/31/2025) were audited by the Director of Nursing (DON) and the Unit Manager (UM) to ensure no transcription errors occurred during medication order entry into the electronic health record. This audit was completed on 12/31/2025. No additional issues were noted during the audit. To ensure the deficient practice does not recur the following has been put in place: current facility and agency licensed nurses were educated on 1/14/2026 on medication order entry, medication errors, significance of entering the wrong medication, and providing care that meets professional standards. They were also educated on the practice of having a second person review medications entered to the discharge orders to ensure accuracy. A third check is then completed during the clinical morning meeting with nurse management. The education was completed by the UM and DON. Newly hired facility and agency licensed nurses not educated by 1/19/2026 will be educated upon hire or prior to working their next scheduled shift by the UM or DON.	01/20/2026

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 reverse for further 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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F0658 SS = D	Continued from page 1 A physician order dated 8/28/25 entered by Nurse #1 read, metformin 1000 mg tablet give one tablet by mouth once a day. Resident #1's August 2025 and September 2025 medication administration record (MAR) included an order that read, metformin oral tablet 1000 mg give one tablet by mouth one time a day for diabetes mellitus. The start date of the medication on the MAR was 8/29/25. The MAR documented she received the medication on 8/30/25, 8/31/25, 9/1/25, 9/2/25, 9/3/25, 9/4/25, 9/5/25, 9/6/25, and 9/7/25. The MAR documented the medication was discontinued on 9/8/25. Nurse #1 was unavailable for interview. An admission Minimum Data Set (MDS) assessment dated 9/2/25 indicated Resident #1 had severe cognitive impairment. The MDS documented that she received hypoglycemic medication. An interview was conducted with Pharmacist #1 on 12/29/25 at 4:12 PM. Pharmacist #1 stated an order was received from the facility on 8/28/25 for metformin 1000 mg. daily. The Pharmacist said there was not an order for Janumet for Resident #1 from the facility. The Pharmacist reported metformin and Janumet were not the same medication. She explained Janumet XR was a combination medication containing sitagliptin and metformin and was an extended-release medication. She said extended-release medication lasted longer because it was released slowly over a 24-hour period. She stated the order the pharmacy had received from the facility was for metformin immediate release. The Pharmacist explained extended-release medication was absorbed over time so it lasted longer and said immediate release medication should be given every 12 hours. Pharmacist #1 said Resident #1 would not get as much glycemic control (management of blood glucose levels) over time if she was only taking immediate release metformin one time a day. The pharmacist felt it was a significant medication error because Resident #1 was only getting the metformin which was only half of the combination medication (Janumet) she was supposed to be getting. An interview was conducted with the Medical Director on 12/29/25 at 4:43 PM. The Medical Director said if Resident #1 had poor oral intake, then she did not need the Janumet and said metformin would be a better choice for her. She said it was a medication error but that she did not think it had negative effect or hurt Resident #1.	F0658	Continued from page 1 The DON or UM will audit all new facility admissions for 12 weeks to ensure no medication transcription errors occur during order entry upon admission. Any errors noted will be immediately reported to the medical provider and rectified. Audit results will be brought by the DON and reviewed in the Quality Assurance Performance Improvement Committee meeting monthly for 3 months and ongoing as indicated to ensure regulatory compliance and quality care. Compliance Date: 1/20/2026	

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F0658 SS = D	Continued from page 2 An interview was conducted with the Director of Nursing (DON) on 12/30/25 at 12:17 PM the DON stated Janumet XR was ordered for Resident #1 on her hospital discharge summary. She said Nurse #1 entered the wrong medication for Resident #1 in the electronic computer system. She reported one nurse was supposed to enter the admission orders into the electronic computer system and then a second nurse was supposed to review and confirm the orders to make the orders active. The DON explained Nurse #1 had entered and confirmed the admission orders for Resident #1 and the orders had not been checked by a second nurse. The DON stated she thought the error would have been caught if the orders had been checked by a second nurse. An interview was conducted with the Administrator on 12/30/25 at 4:19 PM. The Administrator said orders should be put in according to the hospital discharge summary and entered accurately into the electronic computer system. She stated from her knowledge there was a two-step process for putting in and checking admission orders. The Administrator explained Nurse #1 was a new nurse and thought she may not have known the facility process.	F0658		
F0773 SS = D	Lab Srvcs Physician Order/Notify of Results CFR(s): 483.50(a)(2)(i)(ii) §483.50(a)(2) The facility must- (i) Provide or obtain laboratory services only when ordered by a physician; physician assistant; nurse practitioner or clinical nurse specialist in accordance with State law, including scope of practice laws. (ii) Promptly notify the ordering physician, physician assistant, nurse practitioner, or clinical nurse specialist of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician's orders. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and staff, Clinical Practice Manager, and Physician Assistant (PA) interviews, the facility failed to notify the medical provider of abnormal laboratory results for 1 of 1 resident reviewed for notification of laboratory results (Resident #1). Findings included:	F0773	Based on record review, and staff, Clinical Practice Manager, and Physician Assistant (PA) interviews, the facility failed to notify the medical provider of abnormal laboratory results for 1 of 1 resident reviewed for notification of laboratory results. The affected resident is no longer a resident at the facility. Current facility residents with abnormal lab results are at risk of being affected by this deficient practice. To ensure no other residents were affected the Director of Nursing (DON) and the Unit Manager (UM) completed an audit of labs ordered and completed during the last 30 days (12/1/2025-12/31/2025) to ensure all lab results had been reported or reviewed by the medical provider and with notation of notification. No further issues were noted during the audit. This audit was completed on 1/2/2026. To ensure the deficient practice does not recur the following has been put into place: current facility and agency licensed nurses were educated by the DON and UM on 1/14/2026 on the process of receiving laboratory results and if they have abnormal findings reporting those to the medical provider, documenting the notification of results, and the significance of failing to report abnormal results to the medical provider. The process for receiving lab results is as	01/20/2026

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F0773 SS = D	Continued from page 3 Resident #1 was admitted to the facility on 8/28/25. Her diagnoses included Type-2 diabetes mellitus, hypertension (high blood pressure), long-term use of anticoagulants (blood thinning medication), metabolic encephalopathy (confusion caused by chemical imbalances in the body), malignant neoplasm of the pancreas (pancreatic cancer), hypo-osmolality (excess water relative to solutes such as electrolytes) and hyponatremia (low sodium level), anemia (low red blood cells), hypothyroidism (thyroid disorder), and a disorder of urea cycle metabolism (body cannot properly remove ammonia from the body). An admission Minimum Data Set (MDS) assessment dated 9/2/25 indicated Resident #1 had severe cognitive impairment. A physician order dated 9/4/25 entered by the PA read, comprehensive metabolic panel (CMP) (lab that checks electrolytes, blood sugar, protein levels, kidney, and liver function) with estimated glomerular filtration rate (GFR) (checks kidney function), complete blood count (CBC) with differential (lab that counts different blood cells in the body to help diagnose infections, anemia, and other conditions). The order specified the labs were scheduled for 9/5/25. Resident #1's electronic medical record contained laboratory results for a CMP with GFR and a CBC with differential. The lab report showed that the samples were collected on 9/5/25 at 1:06 PM and received at the lab on 9/5/25 at 10:24 PM. The report indicated the lab reported date (date the laboratory results were sent to the facility) was 9/6/25 at 1:00 AM. The record documented that the PA reviewed the results on 9/9/25 at 10:43 AM. -The CMP lab results dated 9/5/25 showed that Resident #1's sodium level was 150 (135-145 normal range, high sodium blood levels indicate dehydration). Her chloride level was 117 (95-107 normal range, high chloride level in the blood indicates dehydration, kidney disease, or acid-base imbalances). Her non-fasting glucose level was 190 (normal range 70-139). Her alkaline phosphatase level (liver function lab) was 679 (normal range 40-142) and her Aspartate Aminotransferase AST level (liver function lab) was 61 (normal range 9-40) -The CBC lab results dated 9/5/25 showed Resident #1 had a high white blood cell count of 13 (normal range 4-11, a high white blood cell count is an indicator of possible infection). Her hemoglobin (red blood cells that carry oxygen) was 9.8 (12-16 normal range) and her	F0773	Continued from page 3 follows: 1) when a lab has resulted the result is then faxed to the facility and available on the lab's online portal 2) the nurse who is caring for that resident at the time the lab results are available will be responsible for calling and notifying the medical provider of lab results 3) if abnormalities are not present, the nurse can place the results into the medical providers rounding book to be reviewed at the next facility visit, 4) in the event of a critical lab value the laboratory will call the facility and speak with the nurse caring for the resident, at which time the nurse will notify the medical provider of the critical results, 5) As a secondary check the results will be reviewed by nursing management (DON and UM) each morning to ensure all results have been received and reported to the medical provider by pulling all labs completed in the last 24 hours from the laboratory portal. Newly hired facility and agency licensed nurses not educated by 1/19/2026 will be educated upon hire or prior to working their next scheduled shift by the UM or DON. The DON or UM will audit lab results 3 times a week for 12 weeks to ensure medical providers have been notified of abnormal results and the notification has been documented. Any abnormal labs without notification will be immediately reported to the medical provider and documented. Audit results will be brought by the DON and reviewed in the Quality Assurance Performance Improvement Committee meeting monthly for 3 months and ongoing as indicated to ensure regulatory compliance and quality care. Compliance Date: 1/20/2026	

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F0773 SS = D	Continued from page 4 hematocrit (percentage of your total blood volume that is made up of red blood cells) was 28.5 (normal range 36-48). There was no documentation in Resident #1's electronic medical record from 9/5/25 through 9/8/25 indicating that staff had notified the medical provider of the lab results. An interview was conducted with Nurse #2 on 12/30/25 at 2:09 PM. Nurse #2 worked the night shift (7:00 PM-7:00 AM) on 9/5/25 and 9/6/25. She could not recall if in September 2025 labs were uploaded electronically into the resident's electronic medical record or if lab results were faxed to the facility. She explained that the process of receiving lab results had changed at some point and that the results were now faxed to the facility, but she could not remember when it changed. Nurse #2 stated that when the lab results were automatically uploaded electronically into the resident record it was passed on in the shift change report that the oncoming nurse needed to look for lab results on that shift. She did not recall receiving lab results for Resident #1 or notifying a provider about any results on 9/5/25 or 9/6/25. She stated that if she had received the labs during her shift, she would have documented that she received them and identified the provider she notified. Nurse #2 stated when lab results came back, they were supposed to be called to the provider immediately if there were abnormal or critical results. Nurse #2 stated if there was nothing documented in Resident #1's electronic medical record by her then she did not receive the lab results or contact a medical provider. An interview was conducted with Nurse #3 on 12/30/25 at 3:10 PM. Nurse #3 worked the day shift (7:00 AM-7:00 PM) on 9/6/25. He did not recall any lab work for Resident #1 or calling the provider to report any abnormal labs for Resident #1 on 9/6/25. He stated that if he had called the provider or received orders, he would have made a note about it in Resident #1's electronic medical record. Nurse #3 explained it was standard practice to call lab results to the provider if there were abnormal results. He stated it was typically passed on in the shift change report if they were waiting on lab results for a resident or the Director of Nursing (DON) would tell him to look out for labs if they were waiting on lab results. Nurse #3 said otherwise he would not know who had lab results pending unless he went into each resident's individual electronic medical record and opened the results tab to look for results. Nurse #3 stated unless he opened every resident's individual lab result tab in the	F0773		

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F0773 SS = D	Continued from page 5 electronic medical record every shift he would not know if there were lab results back. Nurse #3 reported there was not a way for the electronic computer system to highlight lab results returning to his knowledge. He did not recall anything specific or standing out about Resident #1 on 9/6/25 but stated he would have documented it in the medical record if he had called lab results to a medical provider so everyone would be aware. An interview was conducted with the PA on 12/30/25 at 11:29 AM. The PA reviewed the labs for Resident #1 and stated the lab results were received on 9/6/25 at 1:00 AM and that they should have been reported to the on-call provider. The PA explained that when she was in the building lab reports that had not been reviewed by a provider would populate in the electronic computer system under lab results for the entire building and she reviewed them. The PA stated Resident #1's labs should have been called to the on-call provider on 9/6/25 due to her high sodium level, elevated liver enzymes, and high white blood cell count. The PA stated Resident #1's hemoglobin and hematocrit levels might possibly raise concern, but that she would be more concerned about the other abnormalities. The PA explained she would be more concerned about correcting Resident #1's sodium level and why her white blood cell count was elevated. The PA stated if the lab results had been called to her, she would have ordered additional fluid resuscitation, and she would have done an immediate (STAT) repeat of her labs to determine if her white blood cell count had gone down any. A telephone interview was conducted on 12/30/25 at 2:39 PM with the Clinical Practice Manager for the facility provider group. She stated there were no phone calls placed from the facility on 9/6/25 to the on-call service. An interview was conducted with the DON on 12/30/25 at 12:17 PM. The DON stated lab results were automatically sent from the lab and electronically uploaded to the resident's electronic medical record. She reported that unless the nurse opened the individual residents electronic medical record and checked the lab results tab they would not see the lab results nor would the staff know that pending lab results were back. The DON explained it should be passed on in the nurse shift change report if lab results were pending so the nurse would know to check the residents electronic record for the lab results. The DON stated if it was not passed on in shift change report then the nurse could check the lab log to see what labs had been drawn for that day. The DON explained nurses were supposed to call and	F0773		

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F0773 SS = D	Continued from page 6 notify the provider of lab results if there were any "lows" or "highs" next to the values on the report, critical results, or for anything that was out of normal range. She stated if lab results were called to an on-call provider the nurse would make a progress note about it and carry out any new orders that were received. The DON explained the "reported date" on the lab result was the date the facility received the lab results. The DON confirmed that Resident #1's lab results were received by the facility on 9/6/25 at 1:00 AM. The DON stated she did not see a progress note by a nurse to indicate the labs had been reported to the provider and could not say for sure if the provider was notified of Resident #1's lab results. The DON reviewed Resident #1's labs that were drawn on 9/5/25 and confirmed they were not reviewed by the PA until 9/9/25. After reviewing the lab report results, the DON said Resident #1's sodium was high, chloride was high, glucose was high, and white blood cells were high. The DON stated "yes" the labs should have been called to the provider. The DON explained she normally checked all the labs but had been on vacation that week. She said the Unit Managers were supposed to cover for her and make sure everything was done while she was on vacation but there had only been one Unit Manager at the time. An interview was conducted with the Administrator on 12/30/25 at 4:19 PM. The Administrator stated that abnormal lab results should be called immediately to the provider when they were received from the lab. She stated she was not sure where the breakdown in communication was or what happened with Resident #1's labs that were reported to the facility on 9/6/25. The Administrator explained there were different nurses working in the building that week who were not the facility's typical staff and who had not worked in the building for a while. She explained she thought the facility had more agency nurses working in the building that week who were not the facility's routine agency nurses. She stated the DON had been on vacation that week and when the DON was not there, the oversight of the labs and ensuring the provider was contacted was different. The Administrator stated the unit managers were supposed to follow up on things like labs when the DON was gone but said there was a transition in unit managers during that time and there had been only one unit manager.	F0773		