STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 08/25/25 through 08/28/25. The credible allegation was validated on 09/02/25, therefore, the exit date was changed to 09/02/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1D44D1-H1.	E0000		09/22/2025
F0000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 08/25/25 through 08/28/25. The corrective action plan was validated on 09/02/25, therefore, the exit date was changed to 09/02/25. The following intakes were investigated: 2600690, 2600672, 256290, 817014,817701, 817687, 817685, 817683, 817681, 817678, 817703, 817674, 817663, 817665, and 817698. 2 of 24 allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.45 at tag F760 at scope and severity of J. Tag F760 constituted substandard quality of care. An extended survey was conducted. IJ began on 01/14/25 and IJ was removed on 01/22/25.	F0000		09/22/2025
F0695 SS = D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is NOT MET as evidenced by:	F0695	F695 During a recent survey, it was observed that the facility failed to prevent resident #20 with oxygen therapy from having petroleum jelly at the bedside. The presence of petroleum-based products in the vicinity of oxygen presents a fire hazard and is not in compliance with oxygen safety standards. Upon identification on August 25, 2025, the petroleum jelly was immediately removed from resident #20's bedside by licensed nurse. Resident #20 and their responsible party were counseled on the risks associated with petroleum-based products while oxygen is in use by Director of Nursing (DON) upon identification on August 25, 2025. An oxygen-safe, non-petroleum moisturizer was provided as an	09/17/2025

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0695 SS = D	Continued from page 1 The facility failed to remove a petroleum-based lotion from a resident's room that received oxygen which posed a significant fire hazard for 1 of 1 resident reviewed for respiratory care (Resident #20). Findings included Resident #20 was admitted to the facility on 8/1/25 with diagnoses that included congestive heart failure and chronic respiratory failure. Resident #20 had a physician's order dated 8/4/25 for oxygen via nasal cannula at 2 liters per minute continuously. Resident #20 was care planned on 8/4/25 for requiring the use of oxygen via a nasal cannula at 2 liters per minute continuously. Interventions include assisting the resident with elevating head of bed to facilitate comfort and breathing, encouraging rest periods throughout the day, and provide oxygen via nasal cannula as ordered. A review of Resident #20's significant change Minimum Data Set (MDS) assessment dated 8/18/25 coded her as cognitively intact and received oxygen during the 7-day look back. On 8/25/25 at 10:35 AM an in-room observation of Resident #20's room found a container of petroleum-based lotion on Resident #20's overbed table. Resident #20 was observed laying in her bed with the head of the bed elevated. The resident was not wearing a nasal cannula; the cannula was hanging from the railing of her bed. Resident #20 stated she had taken off her cannula a few minutes prior and was going to put it back on. The oxygen concentrator was observed to be on and delivering oxygen at 2 liters per minute to the nasal cannula into the environment. The surveyor asked Resident #20 who had given her the petroleum-based lotion, and she stated her husband brought it to her the previous Friday (8/22/25) and she had previously used it on her arms for dry skin and had not used any the current day. Furthermore, Resident #20 stated she had not been told she could not use petroleum-based lotion by the facility, and she had never used it on her lips or around her face. The American Lung Association website Oxygen Safety Guidelines stated, "Avoid flammable creams and lotions such as vapor rubs, petroleum jelly or oil-based hand lotion. Use water-based products instead."	F0695	Continued from page 1 alternative. Resident #20's room was reassessed to ensure no additional hazards were present. Current facility residents with oxygen therapy ordered are at risk of being affected by deficient practice. A facility-wide audit was conducted on August 25, 2025, of all current facility residents receiving oxygen therapy by the DON and designee to ensure that no petroleum-based products were present in their rooms. No further prohibited products identified at bedside. Residents and their families with oxygen orders were educated on the dangers of using petroleum-based products while oxygen is in use. To prevent deficient practice from recurring, the following have been put in place. All current facility and agency licensed nurses and certified nursing assistants were educated on the facility's oxygen safety policies, emphasizing the prohibition of petroleum-based products in rooms where oxygen is being used by the Staff Development Coordinator (SDC) from September 2, 2025, to September 16, 2025. The policy was reviewed and updated to clearly list approved products for skin care in residents on oxygen therapy. The admission and readmission checklist were revised to include verification of oxygen-safe personal care products at the time of admission. Additionally, housekeeping and ancillary staff were educated to report any petroleum-based products they observe in oxygen rooms. Staff unavailable for education by compliance date and newly hired staff will be educated upon hire or prior to working next scheduled shift by the SDC or designee. The DON or designee will conduct audits of 5 residents on oxygen weekly for four weeks, then bi-weekly for four weeks, then monthly for one month to ensure petroleum-based products are not present at the bedside. The results of these audits will be reported to the facility's Quality Assurance Performance Improvement (QAPI) committee by the DON or designee for three months for review and further corrective action if necessary. Date of Compliance: September 17, 2025.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0695 SS = D	Continued from page 2 Resident #20's assigned Nurse #1 was interviewed on 8/25/25 at 10:45 AM. Nurse #1 stated Resident #20 did receive oxygen and should not use petroleum-based lotion while the oxygen concentrator was delivering oxygen through her nasal cannula due to the risk of fire. The nurse removed the petroleum-based lotion from Resident #20's room and stated she was not aware the resident had the lotion. Nurse #1 stated she had been in Resident #20's room earlier that day and had not seen the petroleum-based lotion on the overbed table. The Director of Nursing (DON) stated on 8/28/25 at 10:09 AM Resident #20 should not have had a petroleum-based lotion for use in her room because the resident received oxygen. The DON stated the use of petroleum-based lotion was dangerous to use around her nose when receiving oxygen. The DON went on to say she had checked Resident #20's room earlier in the day and had overlooked the petroleum-based lotion.	F0695		
F0760 SS = SQC-J	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2) The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, and interviews with family, staff, Nurse Practitioner (NP), and Medical Director, the facility failed to prevent significant medication errors when required seizure medication (lacosamide) was not administered during the timeframe of 1/10/25 to 1/14/25 as a result of the medication not being available from the pharmacy. Resident #98 was ordered lacosamide twice daily. The medication supply was depleted and it was not administered as ordered on 1/10/25, 1/11/25, and the morning dose on 1/12/25. On the afternoon of 1/12/25 the lacosamide order was put on hold for two days for the documented reason of "hold until pharmacy arrival". On the morning of 1/14/25 an additional hold order was entered into the medical record for the time period of one day with no documented reason noted on the order. That same morning (1/14/25) Resident #98 experienced a seizure at the facility. She was administered intramuscular (IM) Ativan (medication used to treat seizures) with no effect. The resident continued to seize. Emergency Medical Services (EMS) were contacted for transfer to the hospital. Resident #98 was given 5 milligrams of versed (sedative medication) by EMS	F0760	"Past Noncompliance - no plan of correction required"	01/22/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 3 enroute to the hospital with no change in the resident's condition. At the hospital, Resident #98 was admitted to the intensive care unit (ICU), required intubation (a medical procedure where a tube is inserted into the airway to support breathing), and she remained in the hospital until 2/4/25. This deficient practice affected 1 of 2 residents reviewed for significant medication error. Findings included: Resident #98 was admitted to the facility on 4/18/23. Her diagnoses included epilepsy (seizure disorder) and nontraumatic intracerebral hemorrhage (brain bleed). The quarterly Minimum Data Set (MDS) assessment dated 10/17/24 indicated Resident #98 had severe cognitive impairment. The MDS documented that she had a seizure disorder diagnosis and received anticonvulsant medication. The medical record indicated Resident #98 had a seizure on 11/4/24. Resident #98 was transferred to the hospital and was hospitalized from 11/4/24 until 11/19/24. Resident #98 was readmitted to the facility on 11/19/24 after her hospitalization. On 12/20/24 a progress note by NP #2 indicated Resident #98 was sent to the hospital for an acute change in condition with significant hypoxia and unresponsiveness. A hospital discharge summary dated 1/4/25 indicated Resident #98 was hospitalized from 12/20/24 until 1/4/25 when she was discharged back to the facility. She was hospitalized for acute respiratory failure and presumed aspiration pneumonia. The hospital discharge summary included the following orders for seizure medications: - lacosamide 10 milligrams (mg)/ milliliter (ml), 20 ml twice daily for seizure. The instructions stated, "pick up at [facility pharmacy] pharmacy". The instructions did not indicate a 5-day supply was ordered. - levetiracetam (seizure medication) 100 mg/ml, 15 ml twice daily for seizure -divalproex sodium (seizure medication) 125 mg delayed release capsule, 8 capsules twice daily for seizure A progress note dated 1/4/25 indicated Resident #98 returned to the facility from the hospital.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 4 Resident #98's active care plan as of 1/4/25 included an area initiated on 4/19/23 that indicated she was at risk for seizure activity related to a diagnosis and history of seizure disorder. The care plan goal included to be free from seizure activity. The care plan interventions included administering medications as ordered. Resident #98's physician orders for January 2025 included the following orders related to seizure medications: - On 1/6/25 an order dated 11/19/24 was discontinued and re-entered for lacosamide 10 milligrams (mg)/ milliliter (ml), give 20 ml by mouth two times a day for seizures. There were no changes to the order when it was re-entered. - On 1/6/25 an order dated 11/19/24 was discontinued and re-entered for levetiracetam 100 mg/ml, give 15 ml by mouth two times a day for seizures. There were no changes to the order when it was re-entered. - On 1/6/25 an order dated 11/19/24 was discontinued and re-entered for divalproex sodium delayed release sprinkle 125 mg capsule, give 8 capsules by mouth two times a day for seizures. There were no changes to the order when it was re-entered. A controlled substance medication count page for lacosamide indicated the last dose of lacosamide was signed out on 1/9/25 at 8:18 PM by Nurse #4. Resident #98's January 2025 Medication Administration Record (MAR) indicated levetiracetam and divalproex sodium were administered as ordered. Lacosamide was documented as last administered at 8:00 AM on 1/10/25 by Nurse #1. An interview was conducted with Nurse #1 on 8/26/25 at 2:45 PM. Nurse #1 reported she really could not remember with any certainty, but thought she had given Resident #98 the last dose of her lacosamide on the morning of 1/10/25 since she had documented it on the MAR. The January 2025 MAR indicated lacosamide was documented as not administered on 1/10/25 at 8:00 PM by Nurse #2. The coding for non-administration on the MAR was documented as "other/ see nurse note". A MAR progress note dated 1/11/25 at 3:38 AM by Nurse #2 regarding lacosamide read, "waiting on pharmacy clarification".	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 5 A phone interview was conducted with Nurse #2 on 8/27/25 at 4:19 PM. Nurse #2 said she had worked at the facility for three-four months and had left sometime around the end of January. Nurse #2 stated she did not specifically remember in January 2025 when Resident #98's lacosamide ran out. She said she did not recall the medication or not having the medication but said she remembered there were issues sometimes with receiving medications from pharmacy and it was not uncommon for the facility to not have a medication that was ordered for a resident. She reported if she coded the non-administration reason as "other" for Resident #98's lacosamide it was most likely an issue with not having the medication from pharmacy. Nurse #2 stated all she could say was that if a medication was put on "hold" it was because they did not have the medication. Nurse #2 said she had been told by the facility that if medication was not available then she had to contact the provider to get an order to hold the medication. Nurse #2 explained the standard practice for what she did if a medication was not available. She explained she started by calling the pharmacy first. She said if it was a controlled medication the pharmacy would usually have a certain number of times, they could refill the medication before needing a new prescription. Nurse #2 stated if there were refills left on a prescription the pharmacy would send the medication on the next pharmacy delivery to the facility. She reported if the pharmacy needed a new prescription to refill a medication, then the next step would be to call the provider, and the provider would give an order to hold the medication or go ahead and send a new prescription to the pharmacy for them to send the medication. Nurse #2 said the pharmacy would deliver medications if a medication was not available in the facility's back medication supply system. She indicated it could take a couple of hours to receive the delivery. Nurse #2 stated she could not say she remembered calling anyone about Resident #98's lacosamide in January 2025 because it had been several months ago. The January 2025 MAR indicated lacosamide was documented as not administered on 1/11/25 at 8:00 AM by Medication Aide #1. The coding for non-administration on the MAR was documented as "hold/ see nurse note". There was not a corresponding MAR progress note present in the medical record. A phone interview was conducted with Medication Aide #1 on 8/28/25 at 3:13 PM. Medication Aide #1 said it had been a while since she had worked at the facility but	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 6 reported she remembered Resident #98 and was aware of her seizure history. Medication Aide #1 knew lacosamide was a medication used for seizures. She remembered in January not having Resident #98's lacosamide because she had been waiting for it to be delivered from pharmacy. She did not recall the exact date in January but said she had let a nurse know Resident #98 was out of lacosamide. She stated she thought it was Nurse #3 she had let know. Medication Aide #1 reported the nurse told her Resident #98's lacosamide had been ordered from pharmacy. The January 2025 MAR indicated lacosamide was documented as not administered on 1/11/25 at 8:00 PM by Medication Aide #2. The coding for non-administration on the MAR was documented as "other/ see nurse note" A MAR progress note dated 1/11/25 at 10:54 PM by Medication Aide #2 regarding lacosamide read, "on order." Medication Aide #2 was unavailable for interview. The January 2025 MAR indicated lacosamide was documented as not administered on 1/12/25 at 8:00 AM by Nurse #1. The coding for non-administration on the MAR was documented as "other/ see nurse note" A MAR progress note dated 1/12/25 at 10:47 AM by Nurse #1 regarding lacosamide read, "awaiting pharmacy arrival". On 1/12/25 at 3:24 PM Nurse #1 entered an order from Medical Director #1 to hold Resident #98's lacosamide for 2 days. Under reason for hold the order read, "hold until pharmacy arrival". On 1/14/25 at 10:12 AM Nurse #1 entered an additional order from Medical Director #1 to hold Resident #98's lacosamide for 1 day. There was not a reason listed for the hold. The January 2024 MAR from indicated Resident #98's lacosamide was on hold from 1/12/25 at 8:00 PM through 1/14/25. An interview was conducted on 8/26/25 at 2:45 PM with Nurse #1. She stated she recalled in January 2025 when Resident #98's lacosamide ran out. Nurse #1 said she did not vividly remember speaking to Medical Director #1 about Resident #98's lacosamide or obtaining the order to hold it but said she would not have entered a hold order without talking to a provider. She explained that a nurse had to get an order from a provider to	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 7 hold a medication. Nurse #1 reported she thought she had called the pharmacy about the lacosamide but could not remember exactly. A phone interview was conducted with Nurse #3 on 8/29/25 at 11:00 AM. She recalled Nurse #1 had typically worked on Resident #98's hallway in January. She explained Nurse #1 was the nurse who would have been responsible for notifying the provider that Resident #98 was out of her lacosamide and needed a new prescription sent to pharmacy because she was the assigned nurse for the hall. Nurse #3 thought she recalled Nurse #1 saying she had notified the Nurse Practitioner (NP) about needing a new prescription for lacosamide. Nurse #3 reported there was not a consistent way during that time of how to notify a provider of things and that sometimes text messages were sent to providers instead of calling. Nurse #3 indicated she thought there had been some sort of miscommunication with the provider and the lacosamide did not get ordered. She said, "that tended to happen a lot there [at the facility]". Nurse #3 explained it was not uncommon for a resident to run out of controlled medication because there had not been consistency and follow up during that time with prescriptions and the pharmacy. A progress note dated 1/14/25 at 10:43 AM by Nurse #1 indicated a Nursing Assistant (NA) found Resident #98 in her room convulsing. The resident was assessed and her oxygen level was 83 (normal range is 95-100% on room air) on 2 liters via nasal cannula and her heart rate was 130 (normal range is 60- 100). Medical Director #1 was called to the room. Ativan 2 mg was given IM. After 10 minutes of continuance of convulsions, Medical Director #1 ordered the resident to be sent out for further evaluation. An additional progress note dated 1/14/25 at 10:51 AM by Nurse #1 indicated Emergency Medical Services (EMS) were in facility at that time. An interview was conducted on 8/26/25 at 2:45 PM with Nurse #1. She recalled the morning of 1/14/25 and said Medical Director #1 had been at the facility. Nurse #1 reported she had notified Medical Director #1 on the morning of 1/14/25 that Resident #98 was out of her lacosamide and needed a new prescription sent to the pharmacy to refill the medication. Nurse #1 remembered not long after she asked for the new prescription for lacosamide Resident #98 started having a seizure. She recalled around 10:30 AM on 1/14/25 a staff member came and got her because they were concerned Resident #98 was having a seizure. She could not recall who the	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 8 staff member was. Nurse #1 reported when she went to Resident #98's room, she was still alert but her entire body was shaking. Nurse #1 explained the staff member stayed with Resident #98 and she immediately went and got Medical Director #1 to come to the resident's room. She remembered Medical Director #1 gave orders to try to treat the seizure at the facility, but it was not effective. Nurse #1 stated after about 10 minutes Medical Director #1 ordered Resident #98 to be transferred to the hospital and EMS was called. A progress note dated 1/14/25 at 10:21 AM completed by Medical Director #1 indicated Resident #98 was found to have a seizure that day (1/14/25). It was unknown how long the resident was seizing prior to staff finding her, but staff were aware for about 7 minutes. IM Ativan was given with no effect. Upon searching the building, staff could not locate any more Ativan, and there was no diazepam (seizure medication), phenytoin (seizure medication) or any other seizure medication available that could be given. For this reason, EMS was called. The resident's oxygen saturation remained stable on supplemental oxygen throughout the process. The resident normally took lacosamide and divalproex sodium, however staff reported the lacosamide ran out a few days ago. Under assessment/ plan the note indicated epilepsy, unspecified, intractable, with status epilepticus (a medical emergency characterized by prolonged or recurrent seizures that do not stop on their own). The resident was noted to be treated with Ativan IM without effect, there were no more treatment options available, and the resident was at risk of becoming unstable so she was being transferred to the emergency room (ER). The note said a new prescription for lacosamide was given today to facilitate refill when the resident returned to the facility. An interview was conducted with Family Member #1 on 8/27/25 at 10:00 AM. Family Member #1 remembered when Resident #98 had the seizure in January and went to the hospital. He said he noticed Resident #98 had not been getting her seizure medication at the facility for several days before she had the seizure. Family Member #1 stated he had recognized Resident #98's seizure medication was not in the medication cup when the nurses had brought in her medications. He stated he asked a nurse about her seizure medication and was told it had been ordered. Family Member #1 did not remember the nurse's name. An EMS report dated 1/14/24 indicated a call was received from the facility at 10:37 AM and EMS arrived on scene at 10:47 AM. Under primary impression it stated, "seizures with status epilepticus". The report	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 9 said “facility staff stated the patient has been seizing for 45 min and for 15 minutes prior to calling 911. They administered 2 mg of Ativan with no changes. Staff also stated the patient has not received her lacosamide in several days.” The EMS report said 5 mg of versed was administered with patient response unchanged. The EMS report documented they departed from the facility at 11:00 AM. A hospital intensive care unit (ICU) history and physical note dated 1/14/25 stated Resident #98 was brought to the ER with altered mental status with concerns for ongoing seizure activity. She had persistent tonic (sudden intense muscle stiffening) clonic (rhythmic, convulsive jerking) activity despite 5 mg of IM versed given by EMS. The note stated she had acute on chronic respiratory failure secondary to seizure. An addendum to the note stated indicated the resident had known seizure disorder, chronic obstructive pulmonary disease with chronic respiratory failure (lung disease), prior intracranial hemorrhage presenting with uncontrolled seizures requiring airway protection. It was noted to be unclear if she had been getting all her recommended seizure medications at the facility. A hospital discharge summary dated 2/4/25 listed diagnoses of acute hypoxic respiratory failure (sudden condition when the body cannot get enough oxygen into the blood due to a problem with the lungs), chronic respiratory failure (long term condition were the lungs cannot get enough oxygen into the blood or remove enough carbon dioxide), shock (life threatening medical condition when the body’s organs and tissues do not receive enough blood and oxygen), urinary tract infection (UTI), and seizure disorder. The discharge summary indicated she was admitted to the ICU and required intubation for airway protection in the setting of secretion intolerance/ aspiration (inhalation of foreign material into the lungs). The discharge summary said Resident #98’s home medication regimen included levetiracetam, lacosamide, and valproic acid. It was reported after a pharmacy review that Resident #98 had not been getting the lacosamide at her facility for unclear reasons. The discharge summary stated the UTI may have also triggered breakthrough seizures. The note said she had completed treatment for UTI and possible aspiration. Resident #98 was discharged back to the facility on 2/4/25. On 8/28/25 at 9:02 AM a phone interview was conducted with Medical Director #1. He reported he was the facility’s former Medical Director and had left his position at the facility sometime around the end of	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 10 January 2025. Medical Director #1 stated it was recognized on 1/14/25 when Resident #98 was sent out to the hospital that she had not been receiving her lacosamide and was out of the medication. He reported that the nurse who worked on the medication cart was responsible for notifying the provider when a new prescription was needed (controlled drugs require a new prescription from the provider when refill limits were reached). Medical Director #1 recalled he signed a new prescription for Resident #98's lacosamide the morning of 1/14/25 and then not long after that she had a seizure. He recalled during the morning on 1/14/25 Resident #98 had a seizure and the nurse came and got him. He reported when he went to Resident #98's room that she was having a seizure and was not responsive. He said Resident #98's seizure was treated with 2 mg of IM Ativan and it was not effective. He explained Resident #98 continued to seize and that was why he sent her out to the hospital. Medical Director #1 remembered Resident #98 had been intubated during her hospitalization to protect her airway. He explained intubation was done when someone had altered mental status or decreased alertness and was not able to keep "stuff" out of their airway. Medical Director #1 reported Resident #98 being out of lacosamide was recognized as a problem and brought to his attention the same day she was sent to the hospital. He said he had not been aware before 1/14/25. Medical Director #1 said he did not remember giving the order to "hold" Resident #98's lacosamide. He said it may have been another provider and defaulted to his name on the order because he was the Medical Director. He stated he could not speak to the hold order. Medical Director #1 said it was a tough question for how many doses of seizure medication he would be comfortable with someone with a seizure history like Resident #98 missing. He reported his ultimate preference would be for her not to miss any doses of seizure medication but that he thought missing a couple of doses would not be consequential. He explained a couple of doses would be 1 or 2 doses. He stated Resident #98 had seizures even when she got her seizure medication so he would not like for her to miss any doses. He did not recall exactly when her last seizure was prior to 1/14/25, but said he recalled she had a prior seizure that required hospitalization. Medical Director #1 explained Resident #98 had a higher risk for seizure than the average person. He explained the resident had a lower seizure threshold and required the 3 different seizure medications. Medical Director #1 stated seizure medications raised someone's threshold for seizures (the point when someone is likely to have a seizure). He indicated not getting a seizure medication and/or the presence of an infection could lower someone's seizure threshold and that when	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 11 the seizure threshold was lowered someone was more likely to have a seizure. He stated Resident #98 not receiving her lacosamide was one factor among several that could have contributed to what happened on 1/14/25. Medical Director #1 said, “should she have received them [the medication lacosamide], yes. Did it make things worse that she did not get it? Probably, but I cannot say anything would have been different 100% if she had received the lacosamide.” A phone interview was conducted on 8/26/25 at 2:24 PM with Pharmacist #1. Pharmacist #1 said a prescription was received on 1/4/25 for a 5-day supply of lacosamide for Resident #98. She explained no other prescription was received until 1/14/25 when Medical Director #1 sent a prescription to the pharmacy for the lacosamide. Pharmacist #1 reviewed documentation and said she did not see a request from the facility for the lacosamide to be refilled before 1/14/25. Pharmacist #1 said the facility had to contact the pharmacy when a medication needed to be refilled. She explained a lacosamide prescription could have up to 5 refills per legal requirements and after that, a new prescription was needed from the provider. She said it was the facility’s responsibility to keep up with medications and when they need to be refilled. She reported the facility was supposed to request a refill of a medication when they were down to a 3- or 4-day supply of a resident's medication. Pharmacist #1 explained the half-life (how long it takes for half of the medication to leave the body) of lacosamide was 13 hours. Pharmacist #1 said missing 9 doses of lacosamide would absolutely increase the risk of someone having a seizure. She stated that how much of a risk would depend on the patient’s seizure history. Pharmacist #1 said someone would not have a prescription for lacosamide along with other seizure medications if there was not a concern about seizures. She reviewed Resident #98’s medication record and reported Resident #98 also took divalproex sodium and levetiracetam for seizures. Pharmacist #1 stated she would say lacosamide was “pretty important” for Resident #98 for preventing seizures. Pharmacist #1 explained she would consider Resident #98’s missed doses of lacosamide to be significant since she had a seizure, and it sent her to the hospital. Pharmacist #1 further explained if someone was taking three medications for seizures, they would be at a higher risk and more prone to seizures to need three medications to control them. Pharmacist #1 said if the facility had someone on those seizure medications, they should be aware and be managing those medications and when they need to be refilled or reordered in the case that there are no more refills. She reported that the facility did not have lacosamide	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 12 in their back up medication system. She further reported that the pharmacy was available 24 hours per day. She explained the pharmacy had contracts with local pharmacy's and that if the facility let them know they needed a medication they had carrier delivery available 24 hours a day that would be able to deliver the medication. A phone interview was conducted on 8/29/25 at 2:12 PM with Pharmacist #2. He explained the facility's electronic computer system and pharmacy system were connected. He further explained that the facility could reorder medications through the electronic computer system. Pharmacist #2 said if a controlled medication was reordered and there were no prescription refills left for the medication, the pharmacy would send a fax to the facility. He explained there were two separate faxes the pharmacy sends. One fax stated there were no refills left for the medication prescription and the second fax was a preprinted prescription for the medication for the provider to sign. He stated both faxes were sent to the facility. Pharmacist #2 reviewed documentation and said he did not see any request by the facility for the medication to be refilled before 1/11/25. He stated the facility had requested Resident #98's lacosamide to be refilled through the facility's electronic computer system on 1/11/25. Pharmacist #2 explained there were no refills left on the lacosamide and that the pharmacy had sent a fax to the facility on 1/11/25. He reported there were no other requests through the facility's electronic computer system to refill the medication. A phone interview was conducted with NP #1 on 9/2/25 at 11:39 AM. NP #1 reported she no longer worked at the facility but recalled Resident #98. NP #1 remembered Resident #98 went to the hospital in January and that she was on seizure medications. NP #1 stated the nurses were supposed to let providers know when a prescription was needed for a controlled medication refill. NP #1 said she imagined that the nurses would have let her know a new prescription was needed for Resident #98's lacosamide, but that she did not remember the week of 1/14/25 specifically or what happened. NP #1 reported the nurses were usually pretty good about telling her when there was only a day or two left of a medication and a new prescription was needed. NP #1 reported Resident #98's prescription may have been missed somehow but that she did not remember that specifically as an incident. A phone interview was conducted on 8/27/25 at 1:29 PM with Medical Director #2. He explained he was the interim Medical Director after Medical Director #1 left	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 13 in January. He did not remember the exact date Medical Director #1 had left the facility. Medical Director #2 reported he was familiar with Resident #98 and had reviewed the case involving the incident from January with her missed doses of lacosamide and hospitalization. He reported he was not surprised to be getting a phone call about the case. Medical Director #2 remembered Resident #98 had been out of her lacosamide for a few days and he said that it was a little unusual. He said the pharmacy could take a little time to send medications sometimes, but he recalled her (Resident #98's) lacosamide was held for 4 days and said that was outside of the norm and unusual. Medical Director #2 reported Resident #98 had a "pretty good seizure disorder" and that one or two missed doses of the lacosamide or it being held for one or two doses would be acceptable. He said missing more than one or two doses would not be acceptable because it would increase the risk of Resident #98 having a breakthrough seizure. Medical Director #2 stated holding her seizure medication for that long was longer than he would have held it for and was a little beyond his comfort level. Medical Director #2 stated it was a significant event when Resident #98 seized. He reported there were other things that could cause someone to have a seizure and explained that a UTI could increase the risk but that it was hard to miss the omission of the medication. Medical Director #2 reported he thought the lack of medication likely contributed to Resident #98's seizures. A phone interview was conducted on 8/28/25 at 12:36 PM with Medical Director #3. He explained he was the facility's current Medical Director and started in March. Medical Director #3 reported he was aware of the history that had occurred involving Resident #98 and her lacosamide. He said he thought the missed lacosamide doses were a mistake and that it was an issue. Medical Director #3 explained Resident #98's seizure disorder was complicated, and it would be hard to say a particular number of missed doses exactly that would lead to a seizure because she had seizures even on her medications. He was unable to recall the date of Resident #98's last seizure prior to 1/14/25. Medical Director #3 said Resident #98's infection likely contributed to her having a seizure and that he felt the seizure had been more severe because of the complications the resident had. Medical Director #3 stated he thought the missed doses of lacosamide may have contributed to her possibly having a seizure but that she was on other seizure medications. He agreed Resident #98's nine (9) missed doses of lacosamide would lower her seizure thresh hold making her more likely to have a seizure. He said he did not think	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 14 Resident #98 not getting her lacosamide was alright by any means. An interview was conducted with the Administrator, the Administrator in Training (AIT), and the Director of Nursing (DON) on 08/28/2025 at 4:30 PM. The DON stated she had not been the DON in January. The Administrator primarily spoke during the interview. The Administrator reported Resident #98 had been hospitalized and returned to the facility on 1/4/25. She could not recall the reason for that hospitalization. She explained she believed the hospital had given a prescription for a 3-day supply of lacosamide. The Administrator said the pharmacy did not have a prescription to refill the lacosamide, but the nursing department had thought the pharmacy had the prescription. The Administrator stated the nurse, she said she did not know which one specifically, had called the pharmacy about the medication and had been told the medication would arrive. The Administrator stated when the medication did not arrive the nurse notified the physician and got an order to hold the medication until it came from the pharmacy. She reported during the hold process of the medication; she thought it was Nurse #1 who had called the pharmacy to check on the medication and had been told it was coming. The Administrator explained that on the morning of 1/14/25, Resident #98's lacosamide was not available and Medical Director #1 was in the building so Nurse #1 had gone to him about the lacosamide, and Medical Director #1 sent a prescription to the pharmacy that morning. The Administrator reported then later that same morning Resident #98 had a seizure. She stated Medical Director #1 was in the building at the time and had gone to see Resident #98. She reported that the Medical Director had tried to do things at the facility to stop the seizure, but it was not effective, and Resident #98 was sent out to the hospital by EMS. The Administrator explained the assigned nurse was responsible for contacting the provider for a prescription when needed and that the nurse should have gotten the prescription. She said when the medication did not arrive from pharmacy the nurse should have escalated that by letting the DON or management know the medication had not come. The Administrator reported it should have been identified in the morning clinical meeting by the DON, Unit Manager, or Staff Development Coordinator that typically attended the morning clinical meeting that Resident #98's lacosamide was not available. The Administrator said she thought it had been mentioned in the clinical morning meeting about the lacosamide not being there, but it was assumed that since there was a hold order obtained from the physician the physician was aware, and the medication	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 15 was in the process of being delivered. The Administrator said at the time, nursing was not following processes. The Administrator indicated nurses were to contact the pharmacy before a medication ran out and were to notify the provider a new prescription was needed before a medication ran out. She said there was not good oversight by the former DON and there had not been thorough clinical meetings at the time. She explained that was why changes in management were made and why corporate management had been in the building to make changes. The Administrator said lacosamide was not an available medication in the facility's back up medication system. She stated the nurse should have been persistent in obtaining the controlled prescription for the lacosamide and said it was their duty as a nurse to obtain it. The Administrator said Resident #98's missed doses of lacosamide was a significant medication error. The Administrator was notified of immediate jeopardy on 8/27/25 at 5:40 PM. The facility provided the following Corrective Action Plan with a correction date of 1/22/25: 1. How will corrective action be accomplished for those residents found to have been affected by the deficient practice? · The facility failed to obtain a needed prescription for a controlled antiseizure medication and send to the pharmacy allowing pharmacy to refill the medication, leading to a significant medication error for Resident #98. This resulted in the resident not receiving the medication as ordered, which resulted in nine (9) missed doses of antiseizure medication. Resident #98 began having seizures on 01/14/25 at approximately 10:30 AM. The Medical director was called into the room by the nurse and was at Resident #98's bedside. The medical director gave orders for intramuscular Ativan to be administered immediately. The nurse administered medication as the medical director remained at bedside. When resident #98 did not respond to interventions in the facility, the Medical Director ordered Resident #98 to be sent to the hospital by emergent transport. The medical director and the nurse remained at bedside. Emergency medical services were called and arrived at the facility. Resident #98 was intubated in the emergency department and admitted to the intensive care unit with admitting diagnosis of seizure, respiratory failure, and urinary tract infection. Resident #98 returned to the facility on 02/04/25.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 16 · The nurse obtained a prescription for controlled antiseizure medication from the medical director on 1/14/2025 and sent it to the pharmacy prior to the resident having to be sent to the hospital due to seizure activity and acute change. · Residents spouse and prior medical director were notified of the missed medication by the Nurse on 1/14/2025. · The immediate correction for Resident #98 was securing the prescription from the pharmacy which was delivered on 1/15/2025 at 1:24 AM. On 01/21/25 the Director of Nursing (DON) verified that all of Resident #98's medications were on the medication cart and available for administration upon her return from the hospital. · During corporate review of rehospitalizations on 1/21/2025 a failure in process was identified as resident had missed medications prior to discharge to hospital. The pharmacy and prior medical director were notified on 1/21/2025 and consulted to review issues surrounding missed medication. · A medication error report was completed by Vice President of Clinical Operations on 01/21/2025. · On 01/21/25 the decision was made that upon Resident #98's readmission to the facility the director of nursing (DON) or unit manager will review missed medication report during clinical morning meeting to ensure Resident#98 has not or does not miss any anti-seizure medication. 2. How will the facility identify other residents having the potential to be affected by the same deficient practice? · Current facility residents are at risk of being affected by this deficient practice. · A medication administration record to medication cart audit was completed on 1/21/2025 by the DON and designee to ensure ordered medications are available	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 17 including anti-seizure medications. Medications that were needed were immediately ordered from the pharmacy. All ordered anti-seizure medications were available to be administered to residents with orders. · On 1/21/2025 the interdisciplinary team, including the previous medical director, staff development coordinator, unit manager, administrator in training, wound care nurse, administrator, DON, regional director of clinical services, and the vice president of clinical operations, completed an Ad HOC quality assurance performance improvement (QAPI) meeting to review deficient practice and complete a root cause analysis. It was found with the assistance of the pharmacy that the licensed nurse failed to obtain a new written prescription to send to the pharmacy due to being unaware one was needed. The medication was reordered through the electronic health record (EHR). The previous written prescription did not have any further refills therefore the pharmacy did not send the requested medication leading to a significant medication error. The pharmacy does not call the facility when a new written prescription is needed. The nursing staff contacted the pharmacy on two different occasions inquiring about the medication and was not told a new written prescription was needed, the nursing staff was told it would be sent in the next pharmacy run on both occasions. Nursing staff did not notify the DON of the unavailable medication. Therefore, it was determined the root cause was not lack of ordering but a breakdown in communication and escalation processes between nursing staff, pharmacy, and the DON. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not occur? · To ensure the deficient practice does not recur, the DON and designee educated current facility and agency licensed nurses and medication aides on 1/21/2025 on the following; 1) administering medications as ordered including serious risk of negative outcome if any seizure medication is missed, 2) Medications being unavailable and what to do if the medication is unavailable and how to avoid running out of medications, 3) in the event a medication is not available the licensed nurse should call the pharmacy and check on status of delivery, any barriers to delivery, and if it is a controlled medication ensure to clarify if a new prescription is needed, and how to document in the EHR of efforts and actions taken, 4)	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 18 the medication aide should notify the licensed nurse if medication availability issues are noted, 5) the DON should be notified if a medication is not received from pharmacy when ordered, 6) Tips for reducing risk of medication errors, 7) 7 rights of medication administration, 8) the process the pharmacy takes when a controlled medication is ordered, 9) and how licensed nurses can obtain medications that are on the inventory list located in the medication room from the facility back up medication storage with the credentials given upon hire. All licensed nurses are given credentials upon hire. If the medication needed is a controlled medication the nurse must call the pharmacy and obtain an access code from the pharmacist to be able to access that medication if it is a medication available in the backup system. The pharmacist will ensure an active prescription is on file prior to giving an access code. · On 1/21/2025 at 3:30 PM the Vice President of Clinical Operations met with the pharmacy manager to discuss the online portal and how the facility management staff wound be utilizing the system as a way of monitoring the alerts for prescriptions that required a new prescription before the medication could be refilled. Following the meeting the Vice President of Clinical Operations (VPCO) educated the DON, assistant director of nursing (ADON), and administrator in training (AIT), and Administrator of new process where they will monitor the online portal for the facility pharmacy that will send pharmacy issued alerts daily of residents with controlled medications with zero refills that need a written prescription renewed and sent to the pharmacy as a secondary safeguard to ensure medications are available. The alerts are reviewed during clinical meeting, this is communicated to the nurse assigned, and new prescriptions obtained as needed from the medical providers. The nurse that is assigned to the resident will place orders for medications and request prescriptions as needed. This process was reviewed with the nursing staff by the DON and pharmacy director on 1/21/2025 by the VPCO. · Newly hired facility and agency licensed nurses and medication aides not educated by 1/21/25 will be educated upon hire or prior to working their next scheduled shift staff by the staff development coordinator or designee. Newly hired DON, ADON, Administrator, and AIT will be educated upon hire prior to working their first scheduled shift by the vice president of clinical operations or regional director of clinical services. Education will be tracked using a spreadsheet and the SDC will monitor staff schedules to	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 19 ensure newly scheduled staff receive education prior to working their next scheduled shift. · The corporate team including the Vice President of Operations elected to place her Administrators license on the building as administrator in December 2024. The vice president of operations, the vice president of clinical operations, and the regional director of clinical services have stationed themselves physically daily in the facility since approximately the end of January 2025 due to the facility needing more oversight, support, and guidance to improve clinical outcomes which has proved successful evidenced by reduced resident concerns, clinical issues identified, and improved outcomes for residents. · As of January 2025, the corporate team initiated a Health Information Portability Protection Act (HIPPA) compliant clinical communications thread via a website application that is downloaded to the phones of the Administrator, DON, SDC, Wound Nurse, MDS Nurse, Unit Managers, Supply Clerk, Vice President of Clinical Operations, and Regional Director of Clinical Services to have continuous communication on issues that arise during and after normal business hours so issues and concerns can be addressed in real time. Identified issues are entered into the thread by participants for input from the corporate team and facility to ensure the issues are addressed appropriately. Items regarding resident safety, clinical changes, falls, interventions needed, behaviors, potential risk events that need to be addressed, and other important resident items, this allows issues to be dealt with in real time to minimize further escalation and better resident outcomes. · The corporate team also initiated a thorough review of the 24-hour reports generated by the electronic health record from medication administration notes and progress notes in January 2025. These reviews are completed by the Regional Director of Clinical Services (RDCS) or VPCO 5 days a week, on Monday the report is reviewed for the previous 72 hours. This is completed to identify issues, concerns, or need for action plans that may not have been communicated by the nursing staff. 4. How will the facility monitor its corrective actions to ensure the deficient practice will not recur?	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 20 · On 1/21/2025 the plan was made for the DON or designee to review 5 residents to ensure their ordered medications are available and administered as ordered 3 times a week for 4 weeks, 2 times a week for 4 weeks, and weekly for 1 month. This will be completed by reviewing the electronic medication administration record to ensure scheduled medications were administered and reviewing the missed medication report to ensure ordered medications are available. · On 1/21/2025 the plan was made that the VPCO or RDCS will complete in person monitoring of the following 1) At least 1 clinical meeting weekly to ensure the new process of monitoring the pharmacy clinical dashboard for needed prescriptions to avoid a resident not having needed medications available is being followed by attending the clinical meeting, 2) and audit 2 licensed nurses or medication aides weekly for 12 weeks to ensure the process set forth for medication availability is followed by speaking with and observing staff during medication pass on all shifts to assess knowledge and compliance of the process for medication availability. · The facility will monitor the corrective actions to ensure that the deficient practice is corrected and will not recur by reviewing information collected during audits and reporting to Quality Assurance Performance Improvement committee (QAPI) by the Director of Nursing monthly for three (3) months. At that time the QAPI committee will evaluate the effectiveness of the interventions to determine if continued auditing or adjustments to the plan of correction are necessary. Completion date: 1/22/2025 On 9/2/24, the facility's corrective action plan effective 1/22/25 was validated by the following: In-service education logs were reviewed and indicated the facility had educated licensed nurses and medication aides, including agency staff starting on 1/21/25 on the following ; 1) administering medications as ordered including serious risk of negative outcome if any seizure medication is missed, 2) Medications being unavailable and what to do if the medication is unavailable and how to avoid running out of medications, 3) in the event a medication is not available the licensed nurse should call the pharmacy	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 21 and check on status of delivery, any barriers to delivery, and if it is a controlled medication ensure to clarify if a new prescription is needed, and how to document in the EHR of efforts and actions taken, 4) the medication aide should notify the licensed nurse if medication availability issues are noted, 5) the DON should be notified if a medication is not received from pharmacy when ordered, 6) Tips for reducing risk of medication errors, 7) 7 rights of medication administration, 8) the process the pharmacy takes when a controlled medication is ordered, 9) and how licensed nurses can obtain medications that are on the inventory list located in the medication room from the facility back up medication storage with the credentials given upon hire. Interviews were conducted with licensed nurses and medications aides from different shifts, including agency staff. Staff interviewed verified they had received education from the facility regarding the above topics and were able to verbalize the education they had received. Review of education logs revealed the DON, Assistant Director of Nursing (ADON), AIT, and Administrator were educated by the Vice President of Clinical Operations (VPCO) about using the pharmacy portal for monitoring of prescriptions. Review of the facility education tracking spread sheet for licensed nurse and medication aides, included agency staff and indicated the facility was educating new staff and agency staff. Review of facility auditing tools was completed and revealed the facility had completed audits for review of the 24-hour report, ensuring medication availability and that medications were administered as ordered. Weekly audits were completed of clinical meetings and licensed nurses following the process for medication availability. The weekly audits included the facility conducting medication pass observations with licensed nurses and medication aides. Review of the facility Quality assurance meetings revealed the facility had reviewed the audit during their meetings. Review of facility audits revealed the facility had conducted a MAR to medication cart audit to ensure ordered medications were available including anti-seizure medications. Medication pass observations were conducted during the survey. During the medication pass observations all resident medications were available, including narcotic medications.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0760 SS = SQC-J	Continued from page 22 Resident #98's MARs were reviewed from February 2025-August 2025 and revealed she had received her seizure medications as ordered. MARs were also reviewed for residents currently residing at the facility who received seizure medication. The MARs documented the residents had received their medication as ordered. The facility's compliance date and Immediate Jeopardy Removal Date of 1/22/25 was validated.	F0760		
F0812 SS = E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to date, label and store staff food in a nourishment room refrigerator (100-hall). The facility also failed to date an opened container of applesauce and store in a refrigerator (200-hall). This was for 2 of 2 nourishment rooms observed and had the potential to affect food served to residents in the facility. Findings included	F0812	F812 During the annual recertification survey on August 28,2025, the facility failed to ensure food was labeled in the resident nourishment room, and an open container of applesauce was found in the cabinet without a label or date. The presence of unlabeled and improperly stored food creates a risk of unsafe consumption and does not meet food safety standards. Upon identification on August 28, 2025, the unlabeled food items, including the open container of applesauce, were immediately discarded by the dietary manager. The nourishment room and cabinets were inspected and cleaned on August 28, 2025, to ensure compliance with safe food storage practices by the dietary manager. No residents were served from these items, and there were no adverse outcomes related to this deficiency. Current facility residents are at risk of being affected by the deficient practice. A facility-wide audit was conducted by the dietary manager and designee of facility nourishment rooms, kitchen, and food storage areas to identify any unlabeled or expired food items. The audit was completed on September 1, 2025. Items found were immediately removed and discarded. To prevent the deficient practice from recurring the following have been put into place: all facility and agency licensed nursing staff and certified nursing assistants, dietary staff, and housekeeping staff responsible for handling, storing, or providing nourishment were re-educated on the facility's food safety policies by the staff development coordinator (SDC) or designee. This education included the requirement that all food containers must be labeled with the resident's name, the date opened, and the discard date. Policy and procedures were reviewed to reinforce these requirements, and visible reminders were posted in nourishment rooms. Newly hired facility and agency licensed nursing staff and certified nursing assistants, dietary staff, and housekeeping or staff not educated by September 17, 2025, will be educated upon hire or prior to working their next scheduled	09/17/2025

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345174	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 09/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Elevate Health and Rehabilitation	**91 Victoria Road , Asheville, North Carolina, 28801**

(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
F0812 SS = E	Continued from page 23 On 8/28/25 at 9:45 AM an observation was conducted in the 100-hall nourishment room with the Dietary Manager. The 100-hall nourishment room refrigerator contained 2 personal sized food storage containers located in the door of the refrigerator. The food containers were not labeled or dated with an “use by date”. The Dietary Manager immediately removed the food containers and stated the food containers belonged to staff and should not have been stored in the nourishment room refrigerator, but in the employee breakroom. The Dietary Manager stated she had checked the refrigerator earlier that morning and the containers were not present then. On 8/28/25 at 9:54 AM the 200-hall nourishment room was observed with the Dietary Manager. The snack cupboard was found to contain an open applesauce container with approximately 25% of the contents missing. The Dietary Manager immediately removed and disposed of the opened container. The Dietary Manager stated the applesauce should have been stored in the refrigerator once opened and the applesauce was used by nurses to administer medications to residents. The Dietary Manager stated she had checked the nourishment room earlier that morning and did not see the opened applesauce container. The Administrator stated on 8/28/25 at 4:15 PM the food containers should have been dated and labeled and stored in the staff refrigerator. She stated applesauce should have been dated and refrigerated once opened.	F0812	Continued from page 23 shift by the SDC or designee. The Dietary Manager or designee will conduct twice weekly audits of nourishment rooms, refrigerators, and cabinets for four weeks, then weekly for four weeks, then monthly for one month to ensure all food is properly labeled and stored. Audit results will be reported to the facility’s Quality Assurance Performance Improvement (QAPI) committee for review. Ongoing monitoring will be incorporated into the facility’s routine quality assurance program. Date of compliance: 9/17/2025	