STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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MOUNTAIN RIDGE HEALTH AND REHAB	**611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711**

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/29/24 through 05/02/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# I06811.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/29/24 through 05/02/24. The following intakes were investigated: NC00206502, NC 00213518, and NC00213615. Nine (9) of the 9 complaint allegations did not result in deficiency. Event ID# I06811.	F 000		
F 690 SS=E	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition	F 690		5/23/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE:
(X6) DATE: 05/21/2024

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 690	Continued From page 1 demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on record review, observations and interviews with resident representative, staff, Nurse Practitioner, and Urology Physician Assistant (PA), the facility failed to prevent urinary catheter bags from touching the floor to reduce the risk of infection for 2 of 3 residents (Resident #69 and Resident #51) reviewed for urinary catheters. In addition, the facility failed to obtain physician orders to flush a suprapubic catheter as recommended by the Urology PA for Resident #51. The findings included: 1. Resident #69 was re-admitted to the facility on 4/1/24 with diagnoses that included urinary retention, obstructive uropathy (disorder of the urinary tract that occurs due to obstructed urinary flow), and benign prostatic hyperplasia (BPH - age-associated prostate gland enlargement that can cause urination difficulty). The admission Minimum Data Set assessment	F 690	1. Resident□s #69 is having their urinary catheter bag maintained off the floor. Resident #51 does not currently reside in the facility and urinary catheter related orders will be reviewed upon return. 2. Residents with urinary catheters have the potential to be affected by this alleged deficient practice. The Nurse Managers have reviewed current residents with urinary catheters to validate catheter bag placement and to validate any necessary urinary catheter flush orders are present and being carried out. No other concerns were identified. 3. The Director of Nursing or Assistant Director of Nursing has educated Certified Nursing Assistants, Licensed Nurses and Rehabilitation Department employees on appropriate urinary catheter placement off the floor, Licensed Nurses on initiating orders to flush urinary catheters if ordered by the provider and the facility Nurse Practitioner on following	

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Continued From page 2

dated 4/5/24 indicated Resident #69 was moderately cognitively impaired, had no rejection of care behaviors, and had an indwelling catheter.

Resident #69's care plan last revised on 4/11/24 indicated Resident #69 had an indwelling urinary catheter related to urinary retention, obstructive uropathy, and BPH. Interventions included to position the catheter bag and tubing below the level of the bladder.

An observation was made of Resident #69 on 4/29/24 at 8:36 AM while he was lying in bed in his room. Resident #69 had an indwelling catheter connected to a catheter bag with the bottom of the catheter bag touching the floor while it was hooked to his bed.

Another observation of Resident #69 on 4/30/24 at 2:55 PM revealed him coming out of his room while propelling his wheelchair into the hallway. Resident #69's catheter bag was touching the floor. During the observation, the Assistant Director of Nursing (ADON) was alerted on 2:57 PM about Resident #69's catheter bag touching the floor. The ADON stopped Resident #69 and requested to take him back into his room to check on how to reposition his catheter bag. The ADON repositioned the catheter bag in the front bar of Resident #69's wheelchair but she was unable to keep his tubing off the floor. The ADON stated that Resident #69's wheelchair was too low, and it was hard to find a spot to clip his catheter bag to and prevent it from touching the floor. By this time, Resident #69 requested to go back to bed, so he was assisted by staff to bed.

An interview with Nurse Aide (NA) #1 on 4/30/24 at 3:12 PM revealed she had trouble with

F 690

recommendations to flush urinary catheters when recommended by Urology or document disagreement with recommendation. This education will be completed by 5/23/2024. Any Certified Nursing Assistant, Licensed Nurse or Rehabilitation department employee not receiving this education by 5/23/2024 will receive prior to next scheduled shift. Any new hires will be educated during the orientation process. The facility does not utilize agency staff.

4. The Infection Preventionist or Unit Managers will conduct visual observations of residents with urinary catheters to confirm catheter bag is maintained off floor and review the medical record to validate flushes are occurring if ordered. This will be completed 3 times per week for 4 weeks then weekly for 2 months. Results of monitoring will be presented by the Director of Nursing to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Certified Dietary Manager, Social Service Director, Minimum Data Set Coordinator and Maintenance Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.

5. Completion date is 5/23/2024

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positioning Resident #69's catheter bag in his wheelchair and she usually clipped it on the crossbar under his seat, but the clip won't stay on or sometimes won't clip on.

An interview with Nurse #2 on 4/30/24 at 3:17 PM revealed she had assisted NA #2 in getting Resident #69 up from bed and into his wheelchair, but she did not notice his catheter bag touching the floor. Nurse #2 stated that Resident #69's catheter bag should have been positioned to where it was not touching the floor.

An interview with NA #2 on 4/30/24 at 3:19 PM revealed she clipped Resident #69's catheter bag onto the crossbar under the seat but she did not notice that his catheter bag was touching the floor.

A follow-up interview with the ADON on 5/1/24 at 3:05 PM revealed she had figured out that Resident #69's catheter bag should be positioned at the bar on the back of his wheelchair and not the crossbar because it was low. She stated this position would keep the catheter bag and the catheter tubing off the floor.

An interview with the Director of Nursing (DON) on 5/2/24 at 12:28 PM revealed that catheter bags should not be touching the floor. The DON stated she had only seen Resident #69's clamp at the bottom of the catheter bag touching the floor but the staff should try to find a place to put his bag to where it would not touch the floor.

2. Resident #51 was admitted to the facility on 9/6/22 with diagnoses that included neuromuscular dysfunction of bladder and benign

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prostatic hyperplasia (BPH).

Resident #51's care plan revised on 4/16/24 indicated Resident #51 had a suprapubic catheter related to neurogenic bladder and BPH. Interventions included to position the catheter bag and tubing below the level of the bladder.

The quarterly Minimum Data Set assessment dated 4/17/24 indicated Resident #51 was severely cognitively impaired, did not exhibit rejection of care behaviors and had an indwelling catheter.

a. An observation was made on 4/29/24 at 10:00 AM of Resident #51 while he was sitting in his wheelchair in his room. Resident #51 had a urinary catheter with the urinary catheter bag lying flat on the floor beside his wheelchair foot rests.

Another observation of Resident #51 on 4/30/24 at 8:35 AM revealed his urinary catheter bag touching the floor while he was sitting in his wheelchair in the dining room during breakfast. The bottom part of the catheter bag was touching the floor. At 8:39 AM, Resident #51 was observed being pushed out of the dining room, out in the hallway and towards his room by Nurse #1. Resident #51's catheter bag was noted to be touching the floor during this observation.

An interview with Nurse #1 on 4/30/24 at 8:43 AM revealed that she noticed Resident #51's catheter bag touching the floor, but she couldn't do anything about it while he was in the dining room. Nurse #1 stated she wanted to place Resident #51 back into his room and check how she could reposition Resident #51's catheter bag. While in Resident #51's room, Nurse #1 was observed

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positioning Resident #51's catheter bag on the upper bar of his wheelchair in the front. Nurse #1 explained that it was previously positioned on the lower bar which was too low to keep it from touching the floor. Nurse #1 stated she did not know who had taken Resident #51 into the dining room that morning.

An interview with Nurse Aide (NA) #1 on 4/30/24 at 9:02 AM revealed that she had gotten up Resident #51 into his wheelchair and had placed him in the dining room for breakfast. NA #1 stated that she did not notice that Resident #51's catheter bag was touching the floor when she pushed him into the dining room. NA #1 also shared that she had been having issues with Resident #51's catheter because he had a really long tubing, and it was hard to find a good position to clip his catheter bag to in his wheelchair. NA #1 stated that the top bar was wider, so she didn't place it on the top bar, and she clipped the catheter bag onto the bottom bar on Resident #51's wheelchair.

An interview with the Assistant Director of Nursing (ADON) on 5/1/24 at 3:05 PM revealed that she had checked Resident #51's wheelchair and she figured out that the best position to place it to keep the catheter bag off the floor was the bar behind the wheelchair and not the bars in the front.

An interview with the Director of Nursing (DON) on 5/2/24 at 12:28 PM revealed that catheter bags should not be touching the floor. The DON stated that Resident #51 moved around a lot in his wheelchair, but staff should figure out how to properly position his catheter bag during the day to keep it from touching the floor.

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b. A phone interview with Resident #51's Responsible Party (RP) on 4/29/24 at 11:04 AM revealed she was concerned about Resident #51's urinary catheter having to be changed more often than once a month because it was leaking. The RP stated that the Urologist had told the staff that Resident #51's catheter needed to be flushed daily to prevent it from clogging up.

A review of Resident #51's physician orders for April 2024 indicated no orders to flush Resident #51's suprapubic catheter.

Further review of Resident #51's medical record indicated an e-mail note from the Urology Physician Assistant (PA) addressed to Resident #51's RP and dated 4/1/24. The note included the following information: For leakage around the suprapubic tube or through the urethra, I would suggest irrigating and aspirating his suprapubic tube with 60 cubic centimeters (cc) of sterile fluid and a catheter tip syringe to see if there was any sediment or blockages that could be cleared which might be the reason why he was leaking around the catheter. The note further indicated: I attempted to reach the facility on 3/27/24 to relay this message. I left a message on the 100 hall nurses' voicemail with no return call back. I just wanted to forward this message to you. The note was initialed by the Nurse Practitioner (NP) on 4/29/24.

An Emergency Room (ER) Report dated 4/20/24 indicated Resident #51 was sent to the ER due to difficulty removing his suprapubic catheter. The note indicated: Multiple attempts were made by staff to remove suprapubic catheter; port was already cut but still unable to remove it.

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F 690	Continued From page 7 Discussed with Urology and felt slightly uncomfortable pulling any harder than they were already pulling. Recommended CT (computed tomography) to make sure there was no stone or mechanical obstruction. Urology assistance with replacement appreciated. Due to resident's urinalysis (UA) and urology recommendations, will give dose of antibiotics, culture, and send home with antibiotics due to sediment and UA results. The UA results indicated the urine was cloudy, urine pH of 9 (normal value between 4.5 and 8), urine protein greater than 500 (normal value less than 150), urine nitrite negative, urine leukocyte esterase moderate, urine white blood cells 44/hpf (high power field) (normal value 10/hpf or less), bacteria rare, triple phosphate crystal moderate, and budding yeast rare. The CT of pelvis without contrast result indicated: Suprapubic catheter in place. There was granulation tissue along the tract in the soft tissues which was likely within normal limits. The catheter was otherwise normal in appearance. Bladder wall thickening with perivesicular (outermost layer consisting of fat, fibrous tissue and blood vessels) no soft tissue stranding. Findings would be suspicious for underlying cystitis (inflammation of the bladder). Recommend clinical correlation with recent urinalysis. A progress note by the NP dated 4/22/24 indicated Resident #51 was transferred to the emergency department (ED) for an acute visit status post suprapubic catheter obstruction. Here at the facility, the nurses were unable to take out the suprapubic catheter for replacement. The note further indicated that the NP spoke with Resident #51's RP on 4/22/24. The RP was present throughout Resident #51's admission in	F 690		

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the ED. He was evaluated by Urology according to the RP and was diagnosed with a urinary tract infection and was started on (antibiotics). Recommendations were to flush the catheter at least once a day to avoid any obstructions or complications.

A phone interview with the NP on 5/2/24 at 9:00 AM revealed that it had been an ongoing process with Resident #51's suprapubic catheter leaking, and the staff had been having to replace it often. The NP stated that she knew Resident #51 was being seen by Urology and that he was also seen by a Urologist in the ER. The NP stated that she wanted for the staff to flush Resident #51's catheter because this was the recommendation from the Urology PA from the e-mail note dated 4/1/24. The NP confirmed that she saw this note on 4/29/24 when she initialed it but Resident #51 was also seen in the ER on 4/20/24 by a Urologist. The NP stated that the best source of information regarding Resident #51 was his RP because she was on top of everything that happened with him. The NP stated that Resident #51's RP told her that the Urologist in the ER recommended for them to continue to flush his catheter, but the NP stated she was not sure if she gave an order for this. The NP stated she had concerns about flushing the catheter all the time, but his catheter had a lot of sediments that could cause obstruction so unfortunately, Resident #51's catheter had to be flushed to prevent it from being obstructed. The NP further stated that flushing would increase the risk of infection, but he was colonized so his UA would always show infection. The NP added that she knew that they placed Resident #51 on antibiotics at the ER because they had done a lot of manipulation with his catheter. The NP also

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F 690	Continued From page 9 shared that flushing Resident #51's catheter would help avoid having obstruction and they should follow the recommendations from the Urologist. She said that she didn't remember if she gave an order to flush the catheter, and she was not sure if she talked to any of the nurses about it. A phone interview with the Urology PA on 5/2/24 at 10:59 AM revealed he received a message on 3/27/24 via patient portal (healthcare-related online application that allows patients to interact and communicate with their healthcare providers) from Resident #51's RP requesting for assistance because Resident #51 had been having difficulty with his catheter leaking all the time. The Urology PA stated he relayed his recommendations which included to try irrigating Resident #51's catheter through his medical assistant who tried to call the facility on 3/27/24. When his medical assistant could not get anyone from the facility to respond, she e-mailed the recommendation to Resident #51's RP via patient portal on 4/1/24. He also stated that he saw the ER notes from Resident #51's visit on 4/20/24 due to leaking/clogged suprapubic catheter but there was no indication that he had significant pain that would suggest true obstruction, and they were able to change the catheter in the ER with no problems. The Urology PA explained that if there was obstruction, Resident #51 would have presented with severe lower abdominal pain and the notes did not indicate that a bladder scan was done to see how much urine was retained in the bladder. The Urology PA further stated that it was difficult to say whether the ER visit could have been avoided if the staff had been flushing his catheter because the catheter could still get blocked because of the sediments even though it was	F 690		

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F 690	Continued From page 10 being flushed. A follow-up interview with Resident #51's RP on 5/2/24 at 10:43 AM revealed she had called Urology a few times for issues regarding Resident #51's catheter and they had been responsive to her, but she didn't realize that they had responded through the patient portal. The RP stated that as soon as she saw it, she gave the e-mail note to Nurse #3, but she couldn't remember the date she gave it to her. When the Urologist saw Resident #51 in the ER, they did a CT scan but did not find an obstruction and the Urologist recommended that it should be flushed everyday with sterile water. The RP shared that the Urologist said flushing the catheter would keep the sediment down which could prevent the urine from flowing properly. A phone interview with Nurse #3 on 5/2/24 at 12:17 PM revealed she received an e-mail note from Resident #51's RP but she couldn't remember the date she received it. Nurse #3 stated the note indicated the need to flush Resident #51's catheter and she placed the note in the Medical Records box to be scanned into Resident #51's electronic medical record. Nurse #3 stated she didn't notify the NP about the note and did not know if she let the Director of Nursing, or the Supervisor know about it. She stated that because it did not look like an order, she thought that they were already aware of it and that it was just proof of the RP talking to the Urologist about his recommendations. An interview with the Director of Nursing (DON) on 5/2/24 at 12:28 PM revealed she had not seen the e-mail note from the Urology PA before, but she said that she would think that the NP would	F 690		

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F 690	Continued From page 11 reach out to Urology to discuss their recommendations and follow up with them before she initiated any orders. The DON stated that if this was something that Resident #51's RP wanted, the NP probably had already talked to her about the risks and complications of flushing Resident #51's catheter, and that there would be no problem with getting an order for flushing his catheter.	F 690		
F 812 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 remove expired produce from the walk-in refrigerator. The facility also failed to store boxes of food in the walk-in freezer off the floor. This practice had the potential to affect	F 812	1.On 4/29/2024 the vegetables and fruit identified by the surveyor were immediately removed and discarded. The boxes in the freezer were properly stored. 2. Residents in the facility have the	5/23/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345048	A. BUILDING ______ B. WING ______	C 05/02/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN RIDGE HEALTH AND REHAB	**611 OLD US HIGHWAY 70 EAST BLACK MOUNTAIN, NC 28711**

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F 812	Continued From page 12 food served to residents. Findings included: a. On 4/29/24 at 8:43 AM an observation with the Dietary Manager (DM) in the walk-in refrigerator found 2 plastic bags of bell peppers that contained individual peppers with splotchy brown/black spots and were fuzzy in appearance. Other expired produce included a bag of whole lettuce that was brown in appearance and contained off colored liquid in the bottom of the bag. The lettuce had a use by date of 3/25/24 labeled on the bag. Additionally, the walk-in refrigerator contained 2 boxes of grapes located on the second shelf that were brown in appearance and mushy when touched. The DM immediately removed the expired produce. The DM stated during the observation that the expired produced should have been removed prior. She said the dietary staff who put up stock and the cooks checked the refrigerator for expired food, and the produce was overlooked. b. On 4/29/24 at 8:49 AM an observation of the walk-in freezer with the DM found 2 boxes of frozen food stored on the floor of walk-in freezer. The DM immediately placed the boxes on a shelf. The DM stated during the observation that the food boxes of food were overlooked when the stock was being stored on the last delivery day (Friday). The Administrator was interviewed on 5/2/34 at 1:27 PM. He stated the produce in the walk-in refrigerator should have been identified as not good quality for production and disposed of. The Administrator said the boxes of food stored on the floor of the walk-in freezer should have not	F 812	potential to be affected by this alleged deficient practice. On 4/29/2024 the Certified Dietary Manager (CDM) and/or designee went through the walk-in cooler and freezer. Any items that were out of date and/or not suitable for use were removed. The CDM ensured that all items were stored properly and that no items were on the floor of the cooler or freezer. 3. A. The Registered Dietitian (RD) or Certified Dietary Manager has in-serviced dietary staff on the proper storage of food. This was initiated on 4/29/2024 and completed by 5/23/2024. Any dietary employee not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new hire orientation. B. A tool for Sanitation Inspection was implemented by the CDM. The CDM will make random inspections of the kitchen, to include the cooler and freezer, for proper food storage and cleanliness of the kitchen. This will be done 3 times a week for 4 weeks, then weekly for 2 months and ongoing. 4. Results of inspections will be presented by the Administrator to the Quality Assurance and Performance Improvement Committee that includes the Medical Director, Administrator, Director of Nursing, Assistant Director of Nursing, Infection Preventionist, Activity Director, Environmental Services Director, Certified Dietary Manager, Social Service Director, Minimum Data Set Coordinator and Maintenance Director for a period of 3 months. Any concerns identified will be addressed at time of discovery.	

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MOUNTAIN RIDGE HEALTH AND REHAB	**611 OLD US HIGHWAY 70 EAST** **BLACK MOUNTAIN, NC 28711**

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F 812	Continued From page 13 been left on the floor and stored on a shelf.	F 812	5. Completion date is 5/23/2024	