STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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 05/04/26 through 05/07/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID 230779-H1	E0000		06/02/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/04/26 through 05/07/26. Event ID: 230779-H1. The following intakes were investigated: 829851, 2564531, 2262181, 2698595, 2979789, and 2979871 2 of the 15 complaint allegations resulted in deficiency.	F0000		06/02/2026
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.	F0812	The facility failed to date open containers of nutritional supplements and failed to remove nutritional supplements stored past the use by date on 2 of 3 nourishment room refrigerators (North and South Units). On 5-6-26, the Dietary Manager (DM) immediately removed and discarded the undated and expired nutritional supplements from the North and South Unit nourishment room refrigerators. The West unit nourishment room refrigerator was checked on 5-6-26 and no expired or undated nutritional supplements were identified. The citation identified a potential to affect residents receiving nutritional supplements, no specific resident was identified int he 2567 as having consumed an expired or undated supplement. All residents receiving nutritional supplements had the potential to be affected. On 5-6-26, the DM/designee completed a review of all facility nourishment room refrigerators for opened, undated, or past-use-by date nutritional supplements. Any opened supplement without an open date/discard date or any supplement beyond the manufacturer's use-by instruction was discarded immediately by the DM.	06/02/2026

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

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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 1 This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations and staff interviews, the facility failed to date open containers of nutritional supplements and failed to remove nutritional supplements stored past the use by date in 2 of 3 nourishment room refrigerators (North and South Units). This practice had the potential to affect residents receiving nutritional supplements. Findings included: Observations of the nourishment room refrigerators on the North and South Units conducted on 05/06/26 at 10:29 AM through 10:41 AM with the Dietary Manager (DM) revealed: a. Stored in the North Unit nourishment room refrigerator was a one-quart sized nutritional shake with no date to indicate when it was opened. The manufacturer’s label on the container read, use within 4 days after opening if refrigerated. b. Stored in the South Unit nourishment room refrigerator were two one-quart sized nutritional shakes dated 4/24 and 4/28. The manufacturer’s label on the containers read, use within 4 days after opening if refrigerated. Also stored was one opened and undated 8-ounce sized diabetic nutritional shake. The manufacturer’s label on the container read if opened use within 48 hours. At the completion of the observation, the DM was interviewed and stated dietary staff did not stock nutritional shakes in the nourishment room refrigerators. The DM stated the nurses were responsible for the nutritional shakes given to residents and for dating those when opened and discarding when past the use by date. The DM revealed dietary staff checked the nourishment room refrigerators twice a day and restocked and checked expirations dates on the snacks and drinks provided by the kitchen. During an interview on 05/06/26 at 1:55 PM, Nurse #1 explained that a physician’s order was required for a resident to receive a nutritional shake, and nurses were responsible for administering those. Nurse #1 revealed when a nutritional shake was administered the nurse was responsible for writing the date it was opened and for ensuring nutritional shakes were used and discarded by the use by date on the manufacture’s label. An interview was conducted on 05/07/26 at 3:02 PM	F0812	Continued from page 1 By 5-20-26, the Director of Nursing (DON)/designee educated the licensed nurses, unit managers (UM), dietary leadership, Central Supply Clerk (CSC), and Administrator In Training (AIT) on the nutritional supplement storage process. Education included; nutritional supplements must be dated and initialed when opened, the discard date must be written based on the manufacturer's instructions, any undated, or past use-by date supplement must be discarded immediately, and nourishment room refrigerators must be checked each shift by nursing staff responsible for the unit. Newly hired licenses nurses, UM, dietary leadership, CSC or AIT will receive this education from the DON before working independently. The UM/designee will audit all nourishment room refrigerators for opened, undated, or expired nutritional supplements 3 times per week for 4 weeks, then 2 times a week for 4 weeks and then weekly for 4 weeks. Any concern identified will be corrected immediately, the non-compliant item (s) will be discarded, and the responsible staff member will be re-educated by the DON/designee. Audit results will be reviewed by the DON add presented to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months or longer if compliance is not sustained. The QAPI committee may revise the plan based on audit trends. Compliance Date: 6-2-26	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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 2 with the Administrator. The Administrator stated it was the responsibility of the person who opened a nutritional shake to write the date it was opened on the container. She stated historically dietary staff checked the dates on food and drinks stored in the nourishment room refrigerators.	F0812		06/02/2026
F0645 SS = D	PASARR Screening for MD & ID CFR(s): 483.20(k)(1)-(3) §483.20(k) Preadmission Screening for individuals with a mental disorder and individuals with intellectual disability. §483.20(k)(1) A nursing facility must not admit, on or after January 1, 1989, any new residents with: (i) Mental disorder as defined in paragraph (k)(3)(i) of this section, unless the State mental health authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State mental health authority, prior to admission, (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services; or (ii) Intellectual disability, as defined in paragraph (k)(3)(ii) of this section, unless the State intellectual disability or developmental disability authority has determined prior to admission- (A) That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility; and (B) If the individual requires such level of services, whether the individual requires specialized services for intellectual disability. §483.20(k)(2) Exceptions. For purposes of this section- (i)The preadmission screening program under paragraph(k)(1) of this section need not provide for determinations in the case of the readmission to a	F0645	The Facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) determination for a resident who was admitted to the facility with a serious mental health disorder for 1 of 2 residents reviewed for PASRR (Resident #11) On 5-7-26, the Social Worker (SW) submitted a PASRR request for Resident #11 for Level II PASRR review/evaluation. The SW/designee will track the PASRR request until determination is received and will update the resident's record and care plan as indicated by the determination. All current residents with a mental health disorder, intellectual disability, related condition, qualifying behavioral health diagnosis, or psychotropic medication use had the potential to be affected. By 5-21-26, the Medical Records Clerk (MRC)/designee completed a facility-wide audit of current residents to compare PASRR status against admission documentation, diagnoses, behavioral health history, psychotropic medication use, and North Carolina Medical Uniform Screening Tool (NC MUST) information to identify any additional residents who may require a PASRR request. No additional residents were identified as requiring corrective action at the time of the audit. Any resident later identified as requiring PASRR follow-up will have a request submitted by the SW/designee. The administrator educated the SW/designee these expectations on 5-20-26. By 5-20-26 , the administrator/designee educated the SW, MRC, Minimum Data Set (MDS) staff and Interdisciplinary Team (IDT) on PASRR requirements. Education included that a Level II PASRR with no expiration does not automatically eliminate the need to review for Level II referral triggers; mental health disorders, intellectual disability/related condition indicators, behavioral symptoms, psychotropic medication use, and hospital/admission documentation must be reviewed at admission and with significant changes. The SW/designee will complete a PASRR review checklist for new admissions and readmissions and will review	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0645 SS = D	Continued from page 3 nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital. (ii) The State may choose not to apply the preadmission screening program under paragraph (k)(1) of this section to the admission to a nursing facility of an individual- (A) Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital, (B) Who requires nursing facility services for the condition for which the individual received care in the hospital, and (C) Whose attending physician has certified, before admission to the facility that the individual is likely to require less than 30 days of nursing facility services. §483.20(k)(3) Definition. For purposes of this section- (i) An individual is considered to have a mental disorder if the individual has a serious mental disorder defined in 483.102(b)(1). (ii) An individual is considered to have an intellectual disability if the individual has an intellectual disability as defined in §483.102(b)(3) or is a person with a related condition as described in 435.1010 of this chapter. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to submit a request for an evaluation for a Level II Preadmission Screening and Resident Review (PASRR) determination for a resident who was admitted to the facility with a serious mental health disorder for 1 of 2 residents reviewed for PASRR (Resident #11). Findings included: A PASRR Determination Notification letter dated 10/27/25 revealed Resident #11 had a Level I PASRR with no expiration date. Resident #11 was admitted to the facility on 10/28/25 with diagnoses that included bipolar disorder, generalized anxiety disorder, and vascular dementia with severe behavioral disturbance.	F0645	Continued from page 3 residents during weekly care plan/IDT meetings for new diagnoses, new psychotropic medications, behavioral changes, or other indicators that may require a PASRR request. The education regarding this newly implemented checklist for the SW/designee was presented on 5-20-26 by the administrator. Newly hired staff in the roles of SW, MRC, IDT staff and MDS staff will receive education during orientation and before independently completing PASRR-related duties by the administrator/designee. The MRC/designee will audit 5 residents 3 times per week for 4 weeks, then 5 residents 2 times per week for 4 weeks, and then 5 residents weekly for 4 weeks to verify the PASRR level is present, current, reviewed against diagnoses/medications, and that a Level II request was submitted when indicated. Audit findings will be provided to the Administrator and SW for immediate correction. Audit results will be presented to the Quality Assurance and Process Improvement (QAPI) committee by the SW monthly for 3 months or longer if compliance is not sustained. The QAPI committee may revise the plan based on audit trends. Compliance Date: 6-2-26	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0645 SS = D	Continued from page 4 A psychiatric progress note dated 10/29/25 revealed Resident #11 admitted to the facility from another facility and per the records received from the previous facility, she had a history of bipolar disorder for many years and recent behavioral and psychological symptoms of dementia (BPSD, refers to non-cognitive symptoms and behaviors such as agitation, aggression, anxiety, depression and hallucinations). The psychiatric provider noted Resident 11's had active diagnoses of bipolar disorder, bipolar depression and generalized anxiety disorder that were managed with duloxetine (medication used to treat depression and anxiety) 60 milligrams (mg) once a day, clonazepam (medication used to treat severe anxiety) 0.5 mg twice daily, quetiapine (antipsychotic) 50 mg every morning, quetiapine 150 mg at bedtime, and trazodone (medication used to treat depression) at bedtime. The admission Minimum Data Set (MDS) assessment dated 11/03/25 revealed Resident #11 was not currently considered by the state Level II PASRR process to have a serious mental illness or intellectual disability. Resident #11's active psychiatric/mood disorder diagnoses included anxiety disorder and bipolar disorder. She received antipsychotic mediation on a routine basis only and a gradual dose reduction was documented by the physician as clinically contraindicated on 10/29/25. A North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry provided by the Administrator on 05/05/26 at 2:45 PM revealed Resident #11 had a Level I PASRR effective 04/03/23 with no expiration date. There were no PASRR requests submitted for an evaluation for a Levell II PASRR determination prior to 05/05/26. During interviews on 05/05/26 at 3:14 PM and 05/07/26 at 11:55 AM, the Social Worker (SW) revealed when residents admitted to the facility, she checked the NC MUST to see if the resident had a current PASRR but did not check to see if mental health diagnoses were included in the initial screening. The SW explained that previously, a PASRR evaluator had informed her that if a resident had a Level I PASRR then a request for an evaluation for a Level II PASRR determination did not need to be submitted unless the resident had a change in condition. The SW confirmed a request for a Level II PASRR evaluation was not submitted for Resident #11 based on the guidance she was given. During an interview on 03/10/26 at 2:37 PM, the	F0645		06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0645 SS = D	Continued from page 5 Administrator stated the SW was responsible for submitting requests for Level II PASRR evaluations. She explained that based on previous guidance the SW received from the PASRR evaluator, a request for a Level II PASRR evaluation for Resident #11 was not completed. The Administrator stated she would expect for PASRR requests to be submitted per regulatory guidelines.	F0645		06/02/2026
F0677 SS = D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is NOT MET as evidenced by: Based on record review, observations, resident and staff interviews, the facility failed to provide assistance with denture care for 1 of 4 dependent residents reviewed for activities of daily living (Resident #100). Findings included: Resident #100 was admitted to the facility on 03/27/26 with diagnoses which included stroke, dysphagia (difficulty swallowing), and dementia. The admission Minimum Data Set (MDS) assessment dated 04/06/26 assessed Resident #100's cognition was severely impaired, setup or clean-up assistance was needed with oral hygiene, had no natural teeth or tooth fragments (edentulous), and had no rejection of care or behaviors during the lookback period. A review of the Nurse Aide (NA) documentation for oral care/denture care revealed from 04/07/26 through 05/05/26 denture care was documented as provided three times for Resident #100 on 04/14/26, 04/25/25, and 04/26/26. The care plan dated 04/19/26 revealed Resident #100 was at risk for oral and dental health problems related to being edentulous and identified a deficit in his ability to perform activities of daily living self-care related to dementia and a stroke. The goals included to maintain the highest practicable level of independence in performing activities of daily living. The interventions included were to provide or assist with oral care at least twice daily using a soft toothbrush or foam swab and to provide cues or	F0677	The facility failed to provide assistance with denture care for 1 of 4 dependent residents reviewed for activities of daily living (Resident #100). On 5-6-26, the Director of Nursing (DON) assisted Resident #100 with denture care by cleaning the resident's dentures. Resident #100's oral/denture care needs, supplies, care plan and Kardex were reviewed to ensure staff direction reflected assistance with oral care at least twice daily and denture care according to the resident's needs and preferences. Any refusal of oral or denture care will be documented and reported to the nurse for follow-up. All residents requiring staff assistance with oral hygiene and/or denture care had the potential to be affected. On 5-7-26, Unit Managers (UM)/designees completed visual oral hygiene/denture checks and reviewed care plan/Kardex instructions for current residents requiring staff assistance with oral hygiene and/or denture care. Any resident identified as needing oral care, denture care, supplies, or care plan/Kardex clarification received immediate follow-up. By 5-31-26, the DON/designee educated licenses nurses, UM, and certified nursing assistants (CNA) on oral hygiene and denture care expectations. Education included: follow the resident-specific care plan and Kardex; provide or assist with oral care at least twice daily when care planned; denture care includes brushing/rinsing dentures, soaking dentures overnight when accepted by the resident, and placing dentures for the resident as appropriate; mouthwash alone is not denture care when dentures require cleaning; document care provided or refused; and report refusal, missing supplies, build up/debris, mouth pain or other oral concerns to the nurse. If a resident prefers to sleep with dentures in, then denture care is still to be provided at least twice daily or at the resident's preference, encouraging the resident to allow the dentures to soak for at least one hour to help	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0677 SS = D	Continued from page 6 minimal assistance to complete activities of daily living as appropriate. Review of the Kardex (a care plan reference guide) utilized by NA staff specified they were to provide or assist Resident #100 with oral care at least twice daily using a soft toothbrush or foam swabs. An observation and interview with Resident #100 were conducted on 05/04/26 at 10:39 AM. Resident #100 stated he wore upper and lower dentures and showed his dentures had brown stains and a buildup of debris around the teeth and gums. Resident #100 stated he could brush his dentures if he had a toothbrush and toothpaste. An interview was conducted on 05/06/26 at 3:37 PM with NA #1. NA #1 revealed she was Resident #100's assigned NA during the day shift on 05/04/26, 05/05/26, and 05/06/26 and she had provided setup assistance with oral care. She explained she gave Resident #100 mouthwash and a basin for him to rinse his mouth because he had difficulty brushing his teeth. NA #1 revealed oral hygiene care was provided at least once during her shift and as needed. NA #1 stated Resident #100, "did not have dentures, had his own teeth" and confirmed she had not provided denture care. NA #1 revealed denture care meant dentures were soaked overnight, rinsed in morning, and adhesive was applied. A phone interview was conducted on 05/06/26 at 4:37 PM with NA #2. NA #2 confirmed she worked the night shift on 05/05/26 and previously had been Resident #100's assigned NA on multiple occasions. NA #2 stated she was aware Resident #100 wore dentures because she had seen them on the bed or nightstand. NA #2 stated she would do denture care but did not because, "most times when she arrived Resident #100 had already eaten, was in bed and was very straight forward he did not want to take out his dentures." NA #2 revealed denture care meant they were soaked overnight. An observation and interviews were conducted on 05/06/26 at 3:24 PM with the Director of Nursing (DON) and Resident #100. Resident #100 stated no one had provided assistance with denture care and agreed to have his dentures cleaned at that time. Resident #100 removed his dentures and gave them to the DON. The DON observed Resident #100's upper and lower dentures had a buildup of debris and brown colored stains around the teeth and gums and took them to be cleaned.	F0677	Continued from page 6 prevent discoloration of the denture(s). The resident has the right to sleep with dentures in if that is their preference. Newly hired licensed nurses and CNAs will receive this education before their first independent shift from the DON or UM. The UM/designee will audit 5 residents requiring oral hygiene/denture assistance 3 times per week for 4 weeks, then 5 residents 2 times per week for 4 weeks, then 5 residents weekly for 4 weeks, Audits will include visual review of oral/denture condition as appropriate, availability of supplies, care plan/Kardex accuracy, and documentation of care of refusal. Any concerns will be corrected immediately, and involved staff will be re-educated. Audit results will be reviewed by the DON and presented to the Quality Assurance and Process Improvement (QAPI) committee monthly by the DON for 3 months or longer if compliance is not sustained. The QAPI committee may revise the plan based on audit trends. Compliance Date: 6-2-26	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0677 SS = D	Continued from page 7 A follow-up interview was conducted on 05/06/26 at 3:53 PM with the DON. The DON revealed he reviewed the care plan and Kardex that indicated Resident #100 was supposed to receive oral care at least twice a day. The DON stated dentures should be brushed and soaked overnight and placed in the resident's mouth in morning. During an interview on 05/07/26 at 3:14 PM, the Administrator stated denture care was done daily either by Resident #100 or provided by the NA. The Administrator stated oral hygiene care, "ideally" should be done twice a day.	F0677		06/02/2026
F0576 SS = C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video	F0576	On Saturday, 5-9-2026, the Assistant Business Office Manager (ABOM) came to the facility, retrieved mail from the locked facility mailbox, and resident mail was distributed to residents. The Administrator/designee verified resident mail on hand was delivered and that the facility had a process for Saturday mail retrieval and delivery. All residents residing in the facility had the potential to be affected. The Administrator/designee reviewed the current mail process on 5-9-2026 and confirmed that resident mail on hand had been distributed. Any resident concern or grievance regarding mail delivery will be addressed immediately through the facility grievance process. On 5-20-26, the Administrator/designee educated the Interdisciplinary Team (IDT), Activity Staff, Business Office Manager (BOM), ABOM, receptionists, and weekend receptionists on residents' rights related to timely mail delivery, including Saturday mail. An additional mailbox key was obtained by the maintenance director on 5-7-26. Beginning 5-9-26, the Administrator/designee will confirm each Friday who is responsible for Saturday mail retrieval and delivery. The assigned weekend staff member will check the mailbox on Saturday, sort resident mail from business office mail, and deliver resident mail to residents the same day it is retrieved while maintaining privacy of communication. Newly hired staff in applicable roles will receive education during orientation by the Administrator/designee. The Administrator/Administrator In Training/designee will audit the Saturday mail process weekly for 12 weeks to verify the mailbox was checked, resident mail was delivered, the staff member responsible was identified, and the delivery	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0576 SS = C	Continued from page 8 communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on interviews with residents and staff, the facility failed to ensure residents' right to receive mail delivered on Saturdays. This had the potential to affect 107 of 107 residents in the facility. Findings included: A Resident Council group interview was conducted on 05/06/26 at 11:00 AM with Residents #46 (Resident Council President), #33, #35, #42, and #83 in attendance. In addition, the Activity Director was present during the group interview at the residents request. Resident #35 reported if mail was delivered to the facility on Saturday, it was not delivered to the residents until Monday by the Activities Director. Resident #33 and Resident #83 both voiced agreement with Resident #35's statement and when asked, Resident #46 and Resident #42 did not disagree. During interviews on 05/06/26 at 11:00 AM and 11:44 AM, the Activity Director explained she was working as a Certified Occupational Therapist Assistant until 04/24/26 when she took over the position of the Activity Director. She stated she did not currently work weekends and was not sure how the process worked regarding mail being delivered to residents on the weekends. During an interview on 05/06/26 at 3:00 PM, the Receptionist reported she worked Mondays through Fridays during the hours of 8:00 AM to 4:00 PM and there was a weekend receptionist that worked Saturdays and Sundays, usually during the hours of 10:00 AM to 7:00 PM. The Receptionist stated the weekend Receptionist did not have a key to open the outside mailbox to check for any mail delivered on Saturday. The Receptionist explained she retrieved the mail from the outside mailbox on Monday morning and gave the mail to the Business Office Manager and the Activity Director delivered the mail to the residents.	F0576	Continued from page 8 log was completed. Any concern will be corrected immediately and the responsible staff member will be re-educated by the Administrator/designee. Audit results will be presented to the Quality Assurance and Process Improvement (QAPI) committee monthly for 3 months or longer if compliance is not sustained. The QAPI committee may revise the plan based on audit trends. Compliance Date: 6-2-26	06/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345208	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Sapphire Ridge Health and Rehabilitation	**115 N Country Club Road , Brevard, North Carolina, 28712**

(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
F0576 SS = C	Continued from page 9 During an interview on 05/06/26 at 3:06 PM, the Business Office Manager confirmed that if she was not at work on the weekends, no one currently had access to open the outdoor mailbox to retrieve the mail. The Business Office Manager reported that she worked on Saturdays “90% of the time” and she checked the mailbox, sorted the mail and gave the residents mail to activity staff to deliver or on occasion, she delivered the mail to the residents. She explained the previous Activity Director left employment approximately 6 to 7 weeks ago and since then there was no one at the facility to deliver the mail to residents if she was not working. The Business Office Manager stated the new Activity Director transitioned from the therapy department on 04/24/26 but she had not yet been trained on the process of sorting the mail to determine what needed to be delivered to the residents and what needed to be placed in the business office. During an interview on 05/07/26 at 3:45 PM, the Administrator stated the breakdown regarding mail not being delivered to residents on the weekend was due to turnover in the activity department. She explained there were approximately 3 weeks or so when mail wasn’t delivered to residents on the weekends because they didn’t have an Activity Director and only had an Activity Assistant. The Administrator stated it was important for residents to receive mail and acknowledged they should receive their mail when delivered, including weekends.	F0576		06/02/2026