STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Mountain Ridge Health and Rehab	611 Old US Highway 70 East , Black Mountain, North Carolina, 28711

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted on 10/09/25. Additional information was obtained offsite through 10/17/25. The facility was notified of IJ for F689 on 10/14/25 and IJ for F684 on 10/16/25. The survey team went back onsite on 10/21/25 to validate the facility's credible allegations. Therefore, the exit date was changed to 10/21/25. The following intakes were investigated: 2637093, 2638553, 2638774 and 2644425. Intakes 2637093 and 2638774 resulted in immediate jeopardy. 2 of the 4 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity (J) CFR 483.25 at tag F689 at a scope and severity (J) The tags F684 and F689 constituted Substandard Quality of Care. Immediate Jeopardy began on 10/04/25 and was removed on 10/19/25. A partial extended survey was conducted.	F0000		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by: Based on record review, and interviews with staff, Medical Director, Emergency Medical Services (EMS) Supervisor, Physician Assistant and Emergency Room	F0684	POC 684 Resident #1 no longer resides in the facility. Residents sustaining a fall or other injury that results in a head and/or neck trauma have the potential to be affected by this alleged deficient practice. On 10/5/25, the interim Director of Nursing, reviewed risk Management (incident/accident) reports from 7/1/25 to 10/5/25 to validate no residents with complaints of head/neck pain or presenting with a suspected head/neck injury were moved while awaiting emergency service personnel. No concerns were identified. On 10/18/25, the Interim Director of Nursing, reviewed all resident transfers to an acute care hospital from 7/1/25 to 10/17/25, to validate the transfer did not involved a serious injury resulting from a headfirst fall. No concerns were identified.	10/30/2025

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

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F0684 SS = SQC-J	Continued from page 1 Physician, the facility failed to leave Resident #1 in place on the floor after a headfirst fall from a mechanical lift while being transferred by Nurse Aide (NA) #1 and NA #2 on 10/4/25. The resident was prescribed two medications that increased the risk of bleeding. Resident #1 reported head and neck pain to Nurse #1 when she was assessed immediately after the fall. Resident #1 was lying on her back and was turned onto the mechanical lift pad and returned to her bed using the mechanical lift prior to an evaluation by Emergency Medical Services (EMS). Emergency Medical Services (EMS) was called and when they arrived, they were told Resident #1 fell from the mechanical lift, struck her head and complained of neck pain. EMS placed a cervical collar (neck brace used to stabilize the neck/head during emergencies) before sliding her over to the stretcher and transferred Resident #1 to the Emergency Room (ER) where she was diagnosed with a C1 ring fracture (first cervical vertebra, where the skull and neck meet). Resident #1 was evaluated by surgery who determined that she was not a suitable surgical candidate, and she was placed in an Aspen collar (brand name for a rigid cervical collar used to immobilize and support the neck after an injury or surgery). She was discharged to an acute hospice facility on 10/6/25 and expired on 10/15/25. When someone sustains a headfirst injury the head and neck should be protected from moving and they should be left on the floor until EMS completes an assessment. Moving a person with a suspected head and neck injury could cause more damage like shifting of bony fractures, severing of the spinal cord, paralysis, and death. Any movement with a C1 fracture is likely to cause additional harm and moving the person can make the C1 fracture worse, and this can cause irreparable damage to the spinal cord, affect respirations, and/or death. Resident #1's Certificate of Death dated 10/15/25 indicated Resident #1 was pronounced dead on 10/15/25 at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. This deficient practice affected 1 of 3 residents reviewed for quality of care (Resident #1). Immediate jeopardy began on 10/4/25 when Resident #1 who had a witnessed headfirst fall to the floor was transferred back to bed by staff using the mechanical lift before she was assessed by EMS. Immediate jeopardy was removed on 10/19/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective.	F0684	Continued from page 1 The interim Director of Nursing or designee has educated Licensed Nurses on the criteria developed by the Medical Director for assessing a resident, when not to move them and the potential additional injury that could result from moving them after a head or neck injury resulting from a fall on their head. This education was completed on 10/17/25. Any Licensed Nurse not receiving education on this date will receive prior to next scheduled shift. The facility does not utilize agency Licensed Nurses. All newly hired Licensed Nurses will receive this education by the Interim DON or designee during orientation. The nurse managers, consisting of; Staff Development Coordinator, Interim Director of Nursing, Wound Care Nurse or the Minimum Data Set Nurses, educated the Nurse Aides that when a resident is found down on the ground, has a fall or an accident, they are not to move the resident. They are to immediately notify the licensed nurse and wait for instructions on when and if it is safe to move the resident. This education was completed on 10/17/25. Any Nurse Aide not receiving education on this date will receive prior to next scheduled shift. The Interim DON or designee will present this education in new Nurse Aide orientation. The facility does not utilize agency Nurse Aides. All other facility staff were educated by the Administrator or designee that when a resident is found down on the ground, has a fall or an accident, they are not to move the resident. They are to immediately notify the licensed nurse. This education was completed on 10/18/25. Any staff member not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new employee orientation by the interim Director of Nursing or designee. The facility does not utilize agency staff. The Interim Director of Nursing, Administrator, or Minimum Data Set Nurses will monitor incident reports and the 24 hour report 5 days per week for 2 weeks then 3 days per week for 2 months to validate all falls and/or accidents, resulting in headfirst trauma, reflect the provision of care per the Medical Director's criteria and the resident was not moved if emergency services were required. Monitoring began on 10/17/25. All concerns identified will be addressed at time of discovery. The Administrator presented this plan to the Quality Assurance and Performance Improvement Committee, consisting of: the Medical Director, interim Director of Nursing, Staff Development Coordinator, Social Service Director, Business Office Manager, Director of Rehabilitation, the Wound & Infection Prevention Nurse, Maintenance	

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F0684 SS = SQC-J	Continued from page 2 The findings included: Resident #1 was admitted to the facility on 2/15/25 with diagnoses that included cerebral infarction (stroke), normal pressure hydrocephalus (excessive accumulation of cerebrospinal fluid in the brain), aphasia (language disorder that affects a person's ability to communicate), hemiplegia and hemiparesis (paralysis and weakness) affecting the left and right side, contracture of the right upper arm, osteoarthritis, osteoporosis, wedge compression fracture of thoracic vertebra 11 to thoracic vertebra 12 and lumbar vertebra and history of left foot drop. The Significant Change in status Minimum Data Set (MDS) assessment dated 8/15/25 indicated Resident #1 was moderately cognitively impaired, had no behavioral symptoms, and had range of motion impairment on both sides of either upper or lower extremities. She was dependent on staff assistance with chair/bed-to-chair transfer. The MDS further indicated that Resident #1 had no falls since prior assessment and received hospice care while a resident at the facility. Resident #1's care plan last reviewed on 8/22/25 indicated Resident had an activities of daily living self-care performance deficit related to muscle weakness and left and right sided hemiparesis/hemiplegia due to stroke. Interventions included the resident required total assist by two staff to move between surfaces as necessary using a mechanical lift. A review of Resident #1's Medication Administration Record for October 2025 indicated she received Aspirin 81 milligrams one tablet by mouth one time a day (Aspirin's adverse effects include an increased risk of bleeding due to its antiplatelet properties) and Clopidogrel (antiplatelet medication used to prevent clots) one tablet by mouth one time a day. (The most common adverse effects of Clopidogrel are bleeding and bruising more easily). A review of an Incident Report dated 10/4/25 at 11:05 AM by Nurse #1 indicated a witnessed fall involving Resident #1. The nurse aide yelled out in the hall for the nurse to come to (Resident #1's room) quickly. Upon entering the room, (the nurse) found Resident #1 lying supine (lying on back with face upward) in the floor with head nearest the door and legs facing the bed, partially underneath the bed. Bed was in a raised position. Noted mechanical lift beside Resident #1 with lift pad remaining on equipment. The nurse aide stated	F0684	Continued from page 2 Director and Medical Records Director on 10/22/25 for recommendations. The Administrator or designee will present the continued monitoring to the Quality Assurance and Performance Improvement Committee for a period of three months. All concerns identified will be addressed at time of discovery. Completion Date 10/30/25	

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F0684 SS = SQC-J	Continued from page 3 Resident #1 slipped out of the side of the lift and fell on the floor, clarifying that she did hit her head. No bumps or bruises noted on head at this time. Resident #1 was awake and alert and oriented, pupils equal and reactive. Resident #1 complained of left shoulder hurting, also head and neck pain. Resident #1 verified slipping out of mechanical lift pad. Immediate Action Taken: Resident #1 was turned and placed on mechanical lift pad and with 4 assist was transferred into bed using the mechanical lift. Staff education on mechanical lift transfers. Lift and lift pad audit. Injuries Observed at Time of Incident: bruise to left forearm, fracture (per report from hospital, Resident #1 with cervical vertebra 1 fracture), skin tear to left finger. A phone interview with NA #1 on 10/9/25 at 10:36 AM revealed he and NA #2 walked in Resident #1's room to get her ready for the day on 10/4/25 and transfer her from the bed to her wheelchair using a mechanical lift. NA #1 stated that as soon as Resident #1's left foot came off the bed, the lift bar tilted over to the right side, and then Resident #1 slipped out of the sling on the left side. NA #1 stated that Resident #1's upper body came out of the sling, and she hit the floor headfirst. They were both unable to get to Resident #1 in time, and neither of them had their hands on Resident #1. NA #1 further stated that he saw Resident #1's head hit the floor as he heard a noise from her head hitting the floor. NA #1 further stated that he stayed with Resident #1 while NA #2 went to get Nurse #1. Nurse #1 assessed Resident #1 and Resident #1 was crying and complained to Nurse #1 that her neck hurt. After Nurse #1 said it was safe to move Resident #1, they rolled her to her back and used the same sling and mechanical lift to get her back on the bed. A phone interview with NA #2 on 10/9/25 at 4:12 PM revealed she and NA #1 went in to get Resident #1 up and dressed for the day on 10/4/25. NA #2 stated that Resident #1's left foot caught onto the bed in the middle of the bare mattress while NA #2 was moving the mechanical lift away from the bed. NA #2 stated she continued to pull the lift away from the bed with Resident #1's left foot dragging on the bed, and as soon as Resident #1's foot got off the bed, the lift bar turned, and Resident #1 fell out of the sling. Resident #1 was on her back after she fell on the floor and complained that her left arm was hurting in the shoulder area. NA #1 stayed with Resident #1 while NA #2 alerted the nurses. NA #2 further stated that Nurse #1 and Nurse #2 came into the room and checked Resident #1 over. After assessing Resident #1, Nurse #2 said to get her up off the floor, so they got her back up with	F0684		

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F0684 SS = SQC-J	Continued from page 4 the mechanical lift onto her bed. Nurse #2 called EMS while Nurse #1 stayed with Resident #1. A nursing progress note dated 10/4/25 at 11:42 AM by Nurse #1 indicated at 11:05 AM, Nurse #1 was called down to Resident #1's room when the nurse aide yelled for help in this room. Upon entering the room, Resident #1 was found lying supine on the floor with her head nearest her door and her legs facing and partially underneath the bed. Resident #1 was conscious and answered appropriately. Nurse #1 noted the mechanical lift by resident and the lift pad still remained on the lift about 4 feet up in the air. Resident #1's skin warm and dry and a small amount of bleeding coming from her left middle finger was noted. Resident #1 was turned and placed on mechanical lift with 4 assist into bed. Resident #1 was crying and stated that her head and neck hurt. Large bruised and bulging area to lateral left forearm measuring 9 centimeters (cm) by 4.5 cm. The on-call primary care provider and family were called and an order to transfer resident out to hospital was received. Resident #1 was transferred to the hospital via stretcher with EMS. An interview with Nurse #1 on 10/9/25 at 11:23 AM revealed when she came into Resident #1's room, her head was facing the door, and her legs were facing the bed which was raised. Nurse #1 stated that Resident #1 was responsive and that she knew where she was. Resident # 1 was paralyzed on her legs and her right arm, and she could move a little bit of her left arm but not very much. Nurse #1 stated that Resident #1 said her head and her neck hurt so Nurse #1 immediately suspected there might be a subdural hematoma or a neck fracture. Nurse Aide (NA) #1, NA #2 and Nurse #2 were also in the room with her. After checking Resident #1's neurological status, they log-rolled her to get her on the mechanical lift pad. While lifting Resident #1 using the mechanical lift and sling, Nurse #1 kept Resident #1's head stabilized by holding her head and keeping it straight. They got her in the bed and kept her flat on the bed. Resident #1 did not seem confused, but she complained of her head and neck increasingly hurting. Nurse #1 stated that she stayed with Resident #1 and told EMS when they came in that she needed a cervical collar. EMS put a cervical collar on Resident #1 before they transferred her to the stretcher. A follow-up interview with Nurse #1 on 10/9/25 at 2:28 PM revealed in retrospect, it probably would have been a good idea to leave Resident #1 on the floor or use a slide board. Nurse #1 stated she took responsibility for the situation because she was in charge of Resident #1, and she should have stepped up and said that they	F0684		

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F0684 SS = SQC-J	Continued from page 5 were going to use a slide board or not move Resident #1 and wait for EMS to get her. Nurse #1 stated she had second thoughts about the situation afterwards, and she just went by what Nurse #2 had decided after she assessed Resident #1. A second follow-up interview with Nurse #1 on 10/9/25 at 3:22 PM revealed she couldn’t recall if Resident #1 complained of neck pain or was saying “up, up” while she was on the floor. Nurse #1 stated that when Resident #1 was on the floor, Nurse #2 asked her to turn her head and Resident #1 did, but she couldn’t remember if Resident #1 complained of pain in her neck then. Nurse #1 further stated that when Resident #1 got back into the bed, she was complaining more of her neck hurting. Nurse #1 also stated that she was aware of inconsistencies in her statements from the incident report and progress note, and that this was due to everything happening so fast. Nurse #1 stated that she knew she documented Resident #1 complaining of neck pain, but she could not remember if it was before or after they had moved her off the floor. She stated that they did not have a cervical collar available at the facility. An interview with Nurse #2 on 10/9/25 at 11:41 AM revealed she was working on the other hall on 10/4/25 when NA #2 poked her head out of Resident #1’s room and asked for help. Nurse #2 stated that she saw Nurse #1 go into the room. Nurse #2 went into Resident #1’s room and as she walked in, she saw Nurse #1 assessing Resident #1. Nurse #2 stated she saw blood on the floor and Resident #1 was on her left side with her left elbow underneath her. Resident #1 was complaining of her head hurting, so they checked her for injury. They rolled Resident #1 to her back, and Resident #1 complained of her head and her left arm hurting. Resident #1 had a big bruise on her left elbow, and she kept on saying the words “hurt” and “up.” Resident #1 told her she hit her head, so they checked her pupils which were normal. Nurse #2 indicated she decided to get Resident #1 back into the bed because she was alert and talking, so they got the sling underneath her, immobilized her head by Nurse #1 holding it straight, and lifted her using the mechanical lift back into bed. Nurse #2 called the on-call doctor and Resident #1’s family member who agreed to send Resident #1 to the hospital for evaluation. Nurse #2 called EMS and requested an emergent transfer. A follow-up interview with Nurse #2 on 10/9/25 at 3:16 PM revealed Resident #1 complained of her head and her left arm hurting when she was on the floor, and she never complained of neck pain to her. Nurse #2 stated	F0684		

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F0684 SS = SQC-J	Continued from page 6 that she assessed Resident #1 by talking to her and asking her to turn her head. Nurse #2 stated that Resident #1 was shaking and nodding her head, but she did not complain of neck pain to her. Nurse #2 indicated Resident #1 complained of pain all over, that the floor was cold, and she kept on saying “up, up” which meant she wanted up off the floor. A review of the local county EMS record dated 10/4/25 for Resident #1 indicated EMS arrived on scene at the facility where Resident #1 presented lying supine in bed, alert, skin pink/warm/dry. Staff advised that at approximately 11:00 AM, Resident #1 was being lifted in a mechanical lift and slid out onto her left side. The resident endorsed a head strike, but no loss of consciousness. They were able to get assistance to get her back into bed. Resident #1 complained of neck pain, but no injuries to head were noted, no bleeding, no hematoma. A cervical collar was placed, and Resident #1 was slid over to stretcher and loaded into ambulance without issue. A phone interview with the EMS Supervisor on 10/16/25 at 12:12 PM revealed that for a patient who fell headfirst to the floor, it would be up to the discretion of the medic who arrived on scene on what to do, but the usual procedure would be to put a cervical collar and immobilize the spine especially if the patient was on a blood thinner. The EMS Supervisor stated they didn’t always put a cervical collar on a patient with a suspected head and neck injury before moving them and each situation was different, but it would be better to leave them on the floor. The EMS Supervisor stated that it would have been better if the facility staff left Resident #1 on the floor and kept her comfortable until EMS came to get her. He further stated that if the patient was uncomfortable on the floor, it was fine to move them, but if they were complaining of neck and back pain, then they would suspect spinal injuries, and they would need to take the necessary precautions like putting a neck brace, and providing spinal immobilization prior to moving them. The EMS Supervisor stated that moving a patient with suspected head and neck injury would cause more pain, and if the neck injury was severe, it could cause paralysis. A review of Resident #1’s hospital discharge summary dated 10/6/25 indicated Resident #1 presented to the emergency room on 10/4/25 after falling from a (mechanical) lift while being moved at her nursing facility. She was unsure how this occurred, but she did report falling to her left side, striking her head but not losing consciousness. She was returned to her bed	F0684		

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F0684 SS = SQC-J	Continued from page 7 by the facility staff and EMS was contacted. Resident #1 was transported to the hospital where she was found to be neurologically intact to her normal level but with imaging demonstrating a cervical vertebra 1 fracture involving the right anterior and posterior arches. Imaging of the brain was unremarkable. An MRI (magnetic resonance imaging) of the cervical spine without contrast dated 10/5/25 for Resident #1 indicated right C1 ring (first cervical vertebra of the spine, located at the base of the skull where the skull and neck meet) fractures with moderate displacement (movement of a tissue from its usual or proper location) of the anterior ring (front part of the ring-shaped C1 vertebra) and associated disruption (rupture or tearing of tissue) of the right transverse ligament with small avulsion fragment (avulsion happens when a small piece of bone attached to a ligament or tendon breaks away from the rest of the bone) to the posterior lateral of the dens (bony projection that extends superiorly from the body of the second cervical vertebra). She was referred to the Hospital Medicine service and admitted for further evaluation. It was noted Resident #1 was on Hospice at her facility and had recently transitioned to this due to a history of multiple strokes. She was evaluated by surgery who determined that she was not a suitable surgical candidate. Given this, it was felt that she would need to transition to General Inpatient Hospice. She was placed in an Aspen collar (brand name for a rigid cervical collar used to immobilize and support the neck after an injury or surgery) at admission and will require a Philadelphia collar (rigid cervical orthosis used to immobilize the neck and spine after an injury or surgery) for bathing. (Philadelphia collar is made of rigid plastic and foam, while the Aspen collar refers to a specific brand of more modern, adjustable collar that uses breathable, moisture-wicking pads.) Resident #1 was considered to be stable for discharge to hospice on 10/6/25. A review of Resident #1's Certificate of Death dated 10/15/25 indicated Resident #1 was pronounced dead on 10/15/25 at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. An interview with the Interim Director of Nursing (DON) on 10/21/25 at 1:43 PM revealed the nurse should assess the resident and determine from the assessment what actions should be taken next. If the resident had a change of condition after the fall such as excessive bleeding, altered level of consciousness, expression of pain that was not at baseline or unusual or if the resident had a fall with head injury or strike, the	F0684		

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F0684 SS = SQC-J	Continued from page 8 nurse should contact the on-call provider with what they found during their assessment of the resident. Whether a resident should be moved off the floor after a headfirst fall would be on a case-by-case basis. The DON stated that for Resident #1's case, there was some blood involved, and the nurse needed to move the resident to determine the source of bleeding. The DON stated that she was told there was blood on the floor and they did not know where it was coming from. She also stated that the nurses should follow the facility policy for potential for head injury after a fall which included performing an assessment and notifying the physician of any signs of injuries. The DON indicated she could not say if they should have moved the resident because she was not there when Resident #1 fell. A phone interview with the Medical Director on 10/9/25 at 1:20 PM revealed they did not like any fall to happen, but he had reviewed Resident #1's fall incident with facility staff, and it sounded like the staff followed the process. He stated that there were two people doing the transfer and they used the correct sling. The Medical Director also stated that he was aware Resident #1 obtained a cervical vertebra 1 fracture which was most likely from the fall. He added that he couldn't think of anything else that might have caused this fracture. A follow-up interview with the Medical Director on 10/9/25 at 2:34 PM revealed from what the nurse told him, Resident #1 was moving her head, and she complained more about her neck hurting after they had moved her off the floor. The Medical Director stated after the nurse's assessment, they had stabilized Resident #1's neck, and she was moving her neck before they transferred her from the floor to her bed. He further stated that if Resident #1 had complained of neck pain while she was on the floor, they should have just stabilized her on the floor and let EMS move her. He also shared that the possible harm of moving Resident #1 from the floor to the bed after a headfirst fall was the possibility of a fracture which she had and neurological compromise which he did not see in her hospital records. A phone interview with the Emergency Room Physician Assistant (PA) on 10/17/25 at 11:54 AM revealed she examined Resident #1 in the ER on 10/4/25. The PA stated that Resident #1 was sent to the ER for a work-up after she slipped or fell out of a mechanical lift at the nursing facility. The PA stated Resident #1 was diagnosed with C1 fracture and a left arm hematoma and was admitted to the hospitalist's care. The PA	F0684		

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F0684 SS = SQC-J	Continued from page 9 further stated that they talked to the neurosurgical team to get their input, and they determined that Resident #1 wasn't a surgical candidate, so she was admitted to the inpatient hospice. The PA stated that she couldn't say whether the facility should have left Resident #1 on the floor instead of moving her to the bed without using a cervical collar, and that it was hard to say what possible outcomes Resident #1 would have experienced from this. The PA also stated that she couldn't talk about Resident #1's prognosis after the injuries she obtained from the fall. A phone interview with the Emergency Room (ER) Physician on 10/17/25 at 1:28 PM revealed he did not examine Resident #1 while she was in the ER on 10/4/25. The ER Physician stated he just signed off on the PA's assessment, and he agreed with everything she did. The ER Physician stated that if an elderly person falls headfirst and it was witnessed just like Resident #1's fall, and if this happened in the ER, they would do cervical spine immobilization first by using a cervical collar or a neck brace before moving the patient off the floor. The ER Physician stated cervical spine immobilization would be important in this case to prevent further spinal cord injury. He also stated that he couldn't say for sure if the displacement on the MRI result was from the fall itself or from being moved off the floor without proper immobilization. The Administrator was notified of immediate jeopardy on 10/16/25 at 1:00 PM. The facility provided the following credible allegation of immediate jeopardy removal: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. · On 10/4/25, Resident #1 fell head first to the floor during a mechanical lift transfer. As a result of the fall, Resident #1 suffered a head/neck injury. The staff on scene, which included the Staff Development Coordinator, RN floor nurse, Nurse Aide #1 and Nurse Aide #2, moved Resident #1 back to bed using the mechanical lift. Resident #1 should not have been moved. Resident #1 was transferred to the Emergency Department and diagnosed with a C1 neck fracture. · Other residents that are likely to suffer a serious adverse outcome as a result of this noncompliance are any residents sustaining a fall or other injury that results in a head and/or neck trauma.	F0684		

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F0684 SS = SQC-J	Continued from page 10 · Risk Management (incident/accident) reports from 7/1/25 to 10/5/25 were reviewed to identify any other incidents involving a mechanical lift transfer or falls with major injury, with a focus on any incidents that involved head or neck injury that were moved and should not have been. There were no falls or accidents found that involved head and neck injury, or serious injury of any type, resulting from a resident falling on their head, that were moved that should not have been. This review was completed on 10/5/25 by the Interim Director of Nursing. · On 10/18/25 the Interim Director of Nursing reviewed all resident transfers to an acute care hospital from 7/1/25 to 10/17/25. The Interim Director of Nursing reviewed the reason for transfer to identify if the transfer to the hospital involved a serious injury resulting from a fall on their head. None were transferred for head or neck injury. · On 10/6/25 the Administrator reviewed all Facility Reported Incidents from (7/1/25 to 10/5/25) reported to the North Carolina Department of Health and Human Services to identify any potential reported incidents that involved serious injury resulting from a fall on their head or neck. None were identified. On 10/18/25 the Administrator confirmed that no additional reports had been sent to the North Carolina Department of Health & Human Services for any reason since 10/5/25. · On 10/6/25 the Administrator reviewed the grievance log from 7/1/25 to 10/5/25 to identify any complaints of serious injury resulting from a fall on their head or neck. None were identified. On 10/18/25 the Administrator confirmed that there have been no grievances made that involved physical injury of any kind since 10/5/25. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete. · On 10/16/25 the Administrator collaborated with the Medical Director to develop the content of education to be provided to Licensed Nurses on appropriate post fall response actions, including recognizing the severity of the fall and potential injury. This education was developed from the facility policy Potential Head Injury, and direction from the Medical Director. · The Medical Director indicated signs and/or symptoms of unconsciousness, complaints of head or neck pain, tenderness of head or neck on physical examination and	F0684		

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F0684 SS = SQC-J	Continued from page 11 obvious deformities should be addressed by maintaining the resident's physical alignment and spine, while not moving the resident when awaiting emergency service personnel arrival. The education included possible additional serious injury (that include paralysis and/or death) that could result from the act of moving a resident after a serious accident (fall on their head) resulting in head or neck injury. · On 10/17/25 all Licensed Nurses that were working were educated by the Interim DON on the training developed by the Medical Director for assessing a resident, when not to move them and the potential additional injury that could result from moving them after a head or neck injury resulting from a fall on their head. The facility does not utilize agency staff. All newly hired staff will receive this education by the Interim DON or designee during orientation. · Starting on 10/17/25 all nurses not previously educated will be called by the Interim DON prior to their next shift, starting with the night shift for 10/17/25. The Interim Director of Nurses will review the education developed by the Medical Director for assessing a resident, when not to move them and the potential additional injury that could result from moving them after a fall on their head resulting in a head or neck. The Interim Director of Nursing will also inform the Licensed Nurses that this same information has been provided in writing and at each nurses' station. The Interim Director of Nurses will confirm the nurses understanding of the education and inform them to call with any questions. This will continue until all Licensed Nurses have been educated by phone. The Interim DON or designee is maintaining the list of staff to confirm education. The facility does not utilize agency staff. · Starting on 10/18/25 the Staff Development Coordinator, or Interim Director of Nursing, or the Wound Care Nurse or the Minimum Data Set Nurses will again educate all nurses in person, on assessing a resident, when not to move them and the potential additional injury that could result from moving them resulting from falling on their head and acknowledge that they understand the information provided. This in person education will be completed on or before their next shift. The Interim DON or designee is maintaining the list of staff to confirm education. The facility does not utilize agency staff. · On 10/17/25 all Nurse Aides that were working were educated by the Interim DON that when a resident is found down on the ground or has a fall or accident they	F0684		

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F0684 SS = SQC-J	Continued from page 12 are not to move the resident. They are to immediately notify the licensed nurse and wait for instructions on when and if it is safe to move the resident. · Starting 10/17/25 all Nurse Aides not previously educated were called by the Interim DON, Wound Care Nurse, and the MDS Nurse and educated that when a resident is found down on the ground or has a fall or accident, they are not to move the resident. They are to immediately notify the licensed nurse and wait for instructions on when and if it is safe to move the resident. All newly hired Nurse Aides will be educated by the Interim DON or designee during orientation. The facility does not utilize agency staff. The Interim DON or designee is maintaining the list of staff to confirm education. · Starting on 10/18/25 the Licensed Nurses will review with each Nurse Aide on their unit that they cannot move a resident that has fallen or found down until the Licensed Nurse assess the resident. This will be done at the beginning of each shift for the next 2 weeks by the licensed nurse to the nurse aides during shift change. · Starting on 10/17/25 the Administrative staff, Activities staff, Therapy, Housekeeping, Laundry, Maintenance and Dietary Departments will be educated by the Administrator, the Director of Maintenance or the Certified Dietary Manager that no resident can be moved if they are found on the ground or have a fall or accident. They are to immediately notify the licensed nurse. All staff will be educated on or before their next shift by the Administrator or designee. Newly hired staff will be educated by the Interim DON during orientation. · Starting on 10/17/25 the Interim DON, Administrator, Minimum Data Set Nurses will review 5 days a week, the incident/accident reports, 24-hour report, the order listing report for medication changes, the Discharge report, and grievance log to ensure that all falls and injuries, resulting from a fall on their head, have been handled according to this plan. Completion Date: 10/19/25 On 10/21/25 the facility's credible allegation of immediate jeopardy removal was validated by the following: Review of facility audits revealed the facility completed audits of all incidents, hospital transfers, grievance logs, and facility reportable incidents from	F0684		

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F0684 SS = SQC-J	Continued from page 13 7/1/25 to 10/5/25. Incident reports were audited by the facility for falls with injury, head/ neck injury, and reviewed for if residents with injury was moved inappropriately. The facility did not identify any issues from the incident report audit. The facility completed an audit of resident hospital transfers to identify any hospital transfers related to a fall with injury or head/ neck injury; there were no issues identified. Facility reportable incidents were reviewed and did not contain any reportable incidents related to falls with injury. Grievance log audits were completed to identify any grievance related to physical injury; there were no issues identified. Grievance logs, facility reportable incident logs, incident logs, and hospital transfer logs were reviewed. There were no issues related to falls with injury, head/ neck injury, or residents being moved in appropriately. All facility audits were reviewed and verified as completed. Review of education revealed specific post fall education was developed by the Medical Director and included assessment steps to take after a resident has a fall, when to not move a resident, and when to call emergency medical services (EMS). The education included additional injury and/or adverse outcomes if a resident was moved after a head or neck injury. Review of in-service education logs revealed the education material developed by the Medical Director was used to educate licensed nurses on assessing a resident after a fall, when not to move a resident after a fall, and additional injury that could incur if a resident was moved. It was verified the Staff Development Nurse and involved floor nurse received the education. In-service logs revealed all staff were educated to notify the nurse and to not move a resident after a fall. Additional in-service logs revealed licensed nurses were providing education to NAs each shift regarding not moving a resident after a fall and to notify the nurse if a resident falls. Interviews were conducted with licensed nurses. The nurses confirmed they had received education on the facility's post fall assessment steps and when not to move a resident. The licensed nurses were able to accurately verbalize the education they received. Interviews were conducted with NAs, dietary staff,	F0684		

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F0684 SS = SQC-J	Continued from page 14 housekeeping, maintenance, office, administration/management staff. Interviews were conducted with staff from different shifts. The staff interviews revealed they had received education on notifying a nurse if a resident falls or is found on the floor and to not moving the resident. Staff were able to accurately verbalize the education they had received. Immediate Jeopardy Removal Date of 10/19/25 was validated.	F0684		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on record review, observation, and interviews with staff and the Medical Director, the facility failed to provide a safe transfer of Resident #1 using a mechanical lift. Resident #1 had left foot drop, hemiplegia (paralysis) and hemiparesis (weakness) on both sides and was prescribed an anti-platelet medication. Resident #1 was transferred with a mechanical lift by Nurse Aide (NA) #1 and NA #2 on 10/4/25 and they failed to ensure that Resident #1's feet (with shoes on) cleared the bed while in the mechanical lift. Resident #1's feet got caught on the mattress and as the lift was moved, the force of Resident #1's feet coming loose caused Resident #1 to swing and fall headfirst out of the sling that was approximately 4 feet in the air. Resident #1 landed on the floor and complained of pain in her head/neck area and was transferred to the Emergency Department (ED) for evaluation. Resident #1 was diagnosed with a C1 ring fracture (first cervical vertebra, where the skull and neck meet), and was placed in a cervical collar. She was determined to be not a suitable surgical candidate and transitioned to an acute hospice facility on 10/6/25. Resident #1's Certificate of Death dated 10/15/25 indicated Resident #1 was pronounced dead on	F0689	POC 689 Resident #1 no longer resides in the facility. Residents requiring transfer via mechanical lift have the potential to be affected by this alleged deficient practice. On 10/4/25, the Staff Development Coordinator completed a review of current residents in conjunction with interviews of Licensed Nurses and Nurse Aides that identified sixteen (16) residents out of ninety two (92) require transfer via mechanical lift. On 10/5/25, the interim Director of Nursing reviewed risk management reports from 7/1/25 to 10/5/25 to confirm no other incidents involving a mechanical lift transfer occurred. No concerns, unknown to facility management were identified. The Staff Development Coordinator has educated all Nurse Aides on the safe process based on manufacture instructions and facility guidelines for transferring a resident via mechanical lift, to include; always having a partner is required and they must be actively assisting, appropriate lift sling selection (when the resident is placed in the center of the sling, it should extend 3 to 6 inches past their body on each side), correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure before moving lift. This education was confirmed to be accepted and understood via successful completion of the lift competency. This education was initiated on 10/4/25 and completed by 10/7/25. Any Nurse Aide not receiving this education then successfully completing an in-person lift competency by this date will complete prior to next scheduled shift. This information will be presented in new Nurse Aide orientation by the Staff Development Orientation and will include successful completion of an in-person lift competency prior to first day of floor orientation. The facility does not utilize agency Nurse Aides. The Staff Development	10/30/2025

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F0689 SS = SQC-J	Continued from page 15 10/15/25 at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. This deficient practice affected 1 of 3 residents reviewed for accidents (Resident #1). Immediate jeopardy began on 10/4/25 when Resident #1 was unsafely transferred using a mechanical lift and fell out of the sling to the floor headfirst. Immediate jeopardy was removed on 10/18/25 when the facility implemented a credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower scope and severity level of D (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure education and monitoring systems put into place are effective. The findings included: A review of the manufacturer's instruction manual for the mechanical lift used by the facility read in part: Special care MUST be taken with people with disabilities who cannot cooperate while being lifted. The patient should be elevated high enough to clear the bed and their weight supported by the lift. When the patient is lifted from the bed (with the patient's head supported), he/she will be raised to a sitting position. When patient is clear of the bed surface, swing their feet off the bed by either aiding or guiding the patient. Illustrations were included of a second person supporting the legs of the patient while being aided or guided to swing their feet off the bed. When moving the patient lift away from the bed, turn patient so that he/she faces assistant operating the patient lift. Open control valve lowering patient so that his feet rest on or over the base of the lift, straddling the mast. Close control valve. NOTE: The lower center of gravity provides stability making the patient feel more secure and the lift easier to pull or push. Pull the patient lift away from the bed and push from behind with both hands. Illustrations were included detailing a second person supporting the patient from behind while the lift was being pulled away from the bed. A review of the facility's undated "Safe Resident Handling/Transfers" policy indicated two facility staff members will participate in the transfer process should a mechanical lift be used and mechanical lift education/training is based on manufacturer's recommendations in conjunction with applicable state/federal regulations and industry standard. Resident #1 was admitted to the facility on 2/15/25 with diagnoses that included cerebral infarction	F0689	Continued from page 15 Coordinator educated Licensed Nurses on the proper process (based on manufacture instructions and facility guidelines) for transferring a resident via mechanical lift and that their observations conducted of Nurse Aides transfers requiring a mechanical lift should include validation of; two qualified staff members' active participation, appropriate lift sling selection, correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure. This education was initiated on 10/4/25 and completed by 10/16/25. Any Licensed Nurse not receiving this education by this date will receive prior to next scheduled shift. This information will be presented in new Licensed Nurse orientation by the Staff Development Coordinator. The facility does not utilize agency Licensed Nurses. The Staff Development Coordinator has performed mechanical lift competencies with Licensed Nurses to confirm their knowledge of the safe transferring of a resident via mechanical lift. These competencies were initiated on 10/17/25 and completed by 10/20/25. Any Licensed Nurse not successfully completing this competency by this date will do so prior to next scheduled shift. Successful completion of this competency will be completed by the Staff Development Coordinator in new Licensed Nurse orientation. The facility does not utilize agency Licensed Nurses. The nurse managers, consisting of; Staff Development Coordinator, Interim Director of Nursing, Wound Care Nurse or the Minimum Data Set Nurses, will monitor resident transfers via mechanical lift by performing random, unscheduled observations of lift transfers to validate ongoing adherence of the education provided to the Nurse Aides. Beginning on 10/6/25, these observations will be done 5 days per week for 2 weeks then 3 days per week for 2 months. All concerns identified will be addressed at time of discovery. The Administrator presented this plan to the Quality Assurance and Performance Improvement Committee, consisting of: the Medical Director, interim Director of Nursing, Staff Development Coordinator, Social Service Director, Business Office Manager, Director of Rehabilitation, the Wound & Infection Prevention Nurse, Maintenance Director and Medical Records Director on 10/22/25 for recommendations. The Administrator or designee will present the continued monitoring to the Quality Assurance and Performance Improvement Committee for a period of three months. All concerns identified will be addressed at time of discovery.	

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F0689 SS = SQC-J	Continued from page 16 (stroke), normal pressure hydrocephalus (excessive accumulation of cerebrospinal fluid in the brain), aphasia (language disorder that affects a person's ability to communicate), hemiplegia and hemiparesis (paralysis and weakness) affecting the left and right side, contracture of the right upper arm, osteoarthritis, osteoporosis, wedge compression fracture of thoracic vertebra 11 to thoracic vertebra 12 and lumbar vertebra, and history of left foot drop. The Significant Change in status Minimum Data Set (MDS) assessment dated 8/15/25 indicated Resident #1 was moderately cognitively impaired, had no behavioral symptoms, and had range of motion impairment on both sides of either upper or lower extremities. She was dependent on staff assistance with chair/bed-to-chair transfer. The MDS further indicated that Resident #1 had no falls since prior assessment and received hospice care while a resident at the facility. The Care Area Assessment (CAA) for Falls dated 8/27/25 indicated Resident #1 had a history of stroke and had residual left sided hemiplegia and left foot drop. She was being followed by hospice care starting 8/14/25 due to cerebrovascular accident with left hemiplegia, hydrocephalus, osteoporosis, weakness and hypertension. She had residual left sided facial droop. She was on antiplatelet medications for stroke. She was able to understand and was sometimes able to make herself understood. Speech was clear but slurred at times. She would answer questions with a short delay but most appropriately answered questions. She was able to make needs known. Falls CAA was triggered secondary to antianxiety and antidepressant medication use. Contributing factors included physical performance limitations affecting balance, gait, strength, and muscle endurance. Risk factors included falls and other major and minor injuries related to falls. Resident #1's care plan last reviewed on 8/22/25 indicated Resident #1 had an activities of daily living self-care performance deficit related to muscle weakness and left and right sided hemiparesis/hemiplegia due to stroke. Interventions included the resident required total assist by two staff to move between surfaces as necessary using a mechanical lift. Resident #1 was also at risk for falls related to gait and balance problems. The following interventions were listed: anticipate and meet the resident's needs, be sure the resident's call light was within reach and encourage the resident to use it for assistance as needed, attempt to put call bell on the right side, and educate the resident/family/caregivers about safety reminders and what to do if a fall occurs.	F0689	Continued from page 16 Completion Date: 10/30/25	

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F0689 SS = SQC-J	Continued from page 17 A review of Resident #1's Medication Administration Record for October 2025 indicated she received Aspirin 81 milligrams one tablet by mouth one time a day (Aspirin's adverse effects include an increased risk of bleeding due to its antiplatelet properties.) and Clopidogrel (antiplatelet medication used to prevent clots) one tablet by mouth one time a day. (The most common adverse effects of Clopidogrel are bleeding and bruising more easily than usual.) An undated handwritten and signed statement by Nurse Aide (NA) #1 indicated: "Me (NA #1) and (NA #2) walked into the room to prepare (Resident #1) for the day by getting her dressed and then prepared to get her out of bed. We grabbed a lift and lift pad. We placed the lift pad under her making sure that it was in the proper position. We then attached the lift pad to the hooks on the lift and began lifting her off the bed. Once she reached a proper height to move her from the bed we began to do so. Her feet rubbed against the bed, so we moved slowly. Just as her feet left the bed, the bar on the lift tilted and she slid out of the lift pad and landed on the floor. We were unable to reach in time to catch her before she landed on the ground. After this happened, I went to check on her as I asked (NA #2) to get the nurse working with us that day. (Nurse #1) and (Nurse #2) came to check on her and her condition. We then got her off the floor once they had determined it was safe to do so. We got her back on the bed. Then (Nurse #2) began to notify people of what happened and (Nurse #1) continued to watch over her as we returned to taking care of the other residents." A phone interview with NA #1 on 10/9/25 at 10:36 AM revealed he and NA #2 walked in Resident #1's room to get her ready for the day on 10/4/25. They changed her brief and put a shirt and pants on her. They put on her socks and shoes and placed the lift pad underneath her. They attached the sling on the lift with NA #1 on the left side and NA #2 on the right side of Resident #1's bed. Then NA #2 proceeded to lift her up off the bed. NA #1 stated that while NA #2 was pulling the lift away from the bed, he didn't notice at first that Resident #1 had not cleared the bed and that her left foot was still touching the bed. NA #1 stated that this was because NA #1 turned away from Resident #1 to get her wheelchair ready and he was not within reach of Resident #1. NA #1 stated that as soon as Resident #1's left foot came off the bed, the lift bar tilted over to the right side, and then Resident #1 slipped out of the sling on the left side. NA #1 stated that Resident #1's	F0689		

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F0689 SS = SQC-J	Continued from page 18 upper body came out of the sling, and she hit the floor headfirst. They were both unable to get to Resident #1 in time, and neither of them had their hands on Resident #1. NA #1 further stated that he saw Resident #1's head hit the floor as he heard a noise from her head hitting the floor. NA #1 further stated that he stayed with Resident #1 while NA #2 went to get Nurse #1. Nurse #1 assessed Resident #1. Resident #1 was crying and complained to Nurse #1 that her neck hurt. After Nurse #1 said it was safe to move Resident #1, they rolled her to her back and used the same sling and mechanical lift to get her back on the bed. An undated handwritten and signed statement by Nurse Aide (NA) #2 indicated: "(NA #1) and I (NA #2) were getting (Resident #1) out of bed for the day. We got her dressed first. We put on her brief first, then moved to putting her pants on, socks next and shoes last. We moved to getting the sling under her first, rolling her my way, put the sling under her, then moving her (NA #1)'s way getting the rest of the sling under her. I moved the lift towards (Resident #1) and hooked her into the lift. (NA #1) was getting the wheelchair ready as I was moving (Resident #1). Her foot caught onto the bed as I was moving her, which in turn made the lift bar extremely tilt, which caused her to fall out and land on the ground. (NA #1) stayed with (Resident #1) while I ran to get the nurses on the floor. The nurses came and assessed her to see what condition she was in. Once it was deemed safe we moved her from the floor to the bed. (Nurse #2) contacted people to inform them of the situation while (Nurse #1) continued to look after (Resident #1). We returned to taking care of the other residents." A phone interview with NA #2 on 10/9/25 at 4:12 PM revealed she and NA #1 went in to get Resident #1 up and dressed for the day on 10/4/25. They got her dressed and changed. They put the sling under Resident #1 and then NA #2 proceeded to lift her up off the bed while NA #1 got the wheelchair ready. NA #2 stated that she raised the lift just high enough to clear Resident #1's bottom off the bed, but it wasn't raised at the maximum height. NA #2 stated that Resident #1's left foot caught onto the bed in the middle of the bare mattress while NA #2 was moving the mechanical lift away from the bed. NA #2 stated she did not think about stopping or asking NA #1 to support Resident #1's legs once she saw Resident #1's left foot got caught on the bed. NA #2 stated she continued to pull the lift away from the bed with Resident #1's left foot dragging on the bed, and as soon as Resident #1's foot got off the	F0689		

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F0689 SS = SQC-J	Continued from page 19 bed, the lift bar turned, and Resident #1 fell out of the sling. Resident #1 was on her back after she fell on the floor and complained that her left arm was hurting in the shoulder area. NA #1 stayed with Resident #1 while NA #2 alerted the nurses. NA #2 further stated that Nurse #1 and Nurse #2 came into the room and checked Resident #1 over. After assessing Resident #1, Nurse #2 said to get her up off the floor, so they got her back up with the mechanical lift onto her bed. Nurse #2 called EMS while Nurse #1 stayed with Resident #1. A review of an Incident Report dated 10/4/25 at 11:05 AM by Nurse #1 indicated a witnessed fall involving Resident #1. The nurse aide yelled out in the hall for the nurse to come to (Resident #1's room) quickly. Upon entering the room, (the nurse) found Resident #1 lying supine (lying on back with face upward) in the floor with head nearest the door and legs facing the bed, partially underneath the bed. Bed was in a raised position. Noted mechanical lift beside Resident #1 with lift pad remaining on equipment. The nurse aide stated Resident #1 slipped out of the side of the lift and fell on the floor, clarifying that she did hit her head. No bumps or bruises noted on head at this time. Resident #1 was awake and alert and oriented, pupils equal and reactive. Resident #1 complained of left shoulder hurting, also head and neck pain. Resident #1 verified slipping out of mechanical lift pad. Immediate Action Taken: Resident #1 was turned and placed on mechanical lift pad and with 4 assist was transferred into bed using the mechanical lift. Staff education on mechanical lift transfers. Lift and lift pad audit. Injuries Observed at Time of Incident: bruise to left forearm, fracture (per report from hospital, Resident #1 with cervical vertebra 1 fracture), skin tear to left finger. A nursing progress note dated 10/4/25 at 11:42 AM by Nurse #1 indicated at 11:05 AM, Nurse #1 was called down to Resident #1's room when the nurse aide yelled for help in this room. Upon entering the room, Resident #1 was found lying supine on the floor with her head nearest her door and her legs facing and partially underneath the bed. Resident #1 was conscious and answered appropriately. Nurse #1 noted the mechanical lift by resident and the lift pad still remained on the lift about 4 feet up in the air. Resident #1's skin warm and dry and a small amount of bleeding coming from her left middle finger was noted. Resident #1 was turned and placed on mechanical lift with 4 assist into bed. Resident #1 was crying and stated that her head and neck hurt. Large bruised and bulging area to lateral left forearm measuring 9 centimeters (cm) by	F0689		

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F0689 SS = SQC-J	Continued from page 20 4.5 cm. The on-call primary care provider and family were called and an order to transfer resident out to hospital was received. Resident #1 was transferred to the hospital via stretcher with EMS. An interview with Nurse #1 on 10/9/25 at 11:23 AM revealed when she came into Resident #1's room, her head was facing the door, and her legs were facing the bed which was raised. Nurse #1 stated that Resident #1 was responsive and that she knew where she was. Resident # 1 was paralyzed in her legs and her right arm, and she could move a little bit of her left arm but not very much. Nurse #1 stated that Resident #1 said her head and her neck hurt so Nurse #1 immediately suspected there might be a subdural hematoma or a neck fracture. Nurse Aide (NA) #1, NA #2 and Nurse #2 were also in the room with her. After checking Resident #1's neurological status, they log-rolled her to get her on the mechanical lift pad. While lifting Resident #1 using the mechanical lift and sling, Nurse #1 kept Resident #1's head stabilized by holding her head and keeping it straight. They got her in the bed and kept her flat on the bed. Resident #1 did not seem confused, but she complained of her head and neck increasingly hurting. Nurse #1 further stated that from what was reported to her by the nurse aides, while they were lifting Resident #1 with the mechanical lift, her weight went to one side and the mechanical lift bar tilted (The lift bar is the swivel bar pad that has hooks on both ends to attach the sling that supports the patient during lift.) and then Resident #1 slipped out of the sling. Nurse #1 stated that Resident #1 fell from about 4 feet off the floor and the sling was still up when she came into the room. Nurse #1 reported that Resident #1 was not able to hold the bar at all with her left hand and that she couldn't see her grasping anything at that point. Nurse #1 stated that she stayed with Resident #1 and told EMS when they came in that she needed a cervical collar. EMS put a cervical collar on Resident #1 before they transferred her to the stretcher. An interview with Nurse #2 on 10/9/25 at 11:41 AM revealed she was working on the other hall on 10/4/25 when NA #2 poked her head out of Resident #1's room and asked for help. Nurse #2 stated that she saw Nurse #1 go into the room. Nurse #2 went into Resident #1's room and as she walked in, she saw Nurse #1 assessing Resident #1. Nurse #2 stated she saw blood on the floor and Resident #1 was on her left side with her left elbow underneath her. Resident #1 was complaining of her head hurting, so they checked her for injury. They rolled Resident #1 to her back, and Resident #1 complained of her head and her left arm hurting.	F0689		

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F0689 SS = SQC-J	Continued from page 21 Resident #1 had a big bruise on her left elbow, and she kept on saying the words “hurt” and “up.” Resident #1 told her she hit her head, so they checked her pupils which were normal. Nurse #2 decided to get Resident #1 back into the bed because she was alert and talking, so they got the sling underneath her, immobilized her head by Nurse #1 holding it straight, and lifted her using the mechanical lift back into bed. Nurse #2 called the on-call doctor and Resident #1’s family member who agreed to send Resident #1 to the hospital for evaluation. Nurse #2 called EMS and requested an emergent transfer. The interview further revealed that Nurse #2 asked both NA #1 and NA #2 what happened afterwards, and they told her that while they were doing a lift transfer on Resident #1, her shoe had caught in the middle of the bed, and then she slipped out the left side of the sling. Nurse #2 stated that with Resident #1’s feet coming off the bed, the lift bar swung and caused her upper body to tilt and slide off the sling. Nurse #2 stated that on the lift training, the nurse aides were instructed that the residents had to clear the bed before pulling out the lift, but she didn’t know if Resident #1’s shoe was still touching the bed when NA #2 started pulling out the lift away from her bed. Nurse #2 added that the nurse aides also needed to have a hand on the resident at all times while lifting them up, but in Resident #1’s case, neither of the nurse aides had their hands on Resident #1 while they lifted her up. A review of Resident #1’s hospital discharge summary dated 10/6/25 indicated: (Resident #1) presented to the emergency room on 10/4/25 after falling from a (mechanical) lift while being moved at her nursing facility. She was unsure how this occurred, but she did report falling to her left side, striking her head but not losing consciousness. She was returned to her bed by the facility staff and EMS was contacted. She was transported to the hospital where she was found to be neurologically intact to her normal level but with imaging demonstrating a cervical vertebra 1 fracture involving the right anterior and posterior arches. Imaging of the brain was unremarkable. She was referred to the Hospital Medicine service and admitted for further evaluation. Of note, she was on Hospice at her facility, recently transitioned to this due to a history of multiple strokes. She was evaluated by surgery who determined that she was not a suitable surgical candidate. Given this, it was felt that she would need to transition to General Inpatient Hospice. She was placed in an Aspen collar (brand name for a rigid cervical collar used to immobilize and support the neck after an injury or surgery) at admission and will require a Philadelphia collar (rigid cervical	F0689		

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F0689 SS = SQC-J	Continued from page 22 orthosis used to immobilize the neck and spine after an injury or surgery) for bathing. (Philadelphia collar is made of rigid plastic and foam, while the Aspen collar refers to a specific brand of more modern, adjustable collar that uses breathable, moisture-wicking pads.) She was considered to be stable for discharge to hospice on 10/6/25. A review of Resident #1's Certificate of Death dated 10/15/25 indicated Resident #1 was pronounced dead on 10/15/25 at a hospice facility. The immediate cause of death listed was complications of blunt force trauma to neck. A phone interview with the Medical Director on 10/9/25 at 1:20 PM revealed they did not like any fall to happen, but he had reviewed Resident #1's fall incident with facility staff, and it sounded like the staff followed the process. He stated that there were two people doing the transfer and they used the correct sling. The Medical Director stated that it seemed like they did not do anything wrong except that Resident #1's foot got caught on the bed. He further stated that if Resident #1's foot didn't get caught on the bed, she might not have fallen. The Medical Director also stated that he was aware Resident #1 obtained a cervical vertebra 1 fracture which was most likely from the fall. He added that he couldn't think of anything else that might have caused this fracture. A phone interview with the Interim Director of Nursing (DON) on 10/14/25 at 12:00 PM revealed she was made aware of Resident #1's fall after she received a text message on 10/4/25 at 11:27 AM. The Interim DON stated that the way Resident #1's fall was explained to her, Resident #1 was in the sling and as they were pulling the sling away from the bed, the sole of her shoe got caught on the mattress and caused the sling to tip and Resident #1 slid out of the side of the sling. The Interim DON shared that they had both nurse aides show them what happened, and at one point, NA #1 turned away to get Resident #1's wheelchair. The Interim DON stated that the only thing she could think of that the nurse aides could have done to prevent Resident #1's fall was that both nurse aides could have kept both of their hands completely on Resident #1 while they lifted her. NA #2 should have stopped moving the lift when she saw Resident #1's shoe get caught on the mattress or have NA #1 guide the Resident #1's leg while she was being lifted. An interview and observation of re-enactment with the Administrator on 10/9/25 at 11:02 AM revealed both nurse aides cleaned Resident #1 up and they had to	F0689		

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F0689 SS = SQC-J	Continued from page 23 strip her bed because it got soiled. NA #2 controlled the lift while NA #1 was on the other side of the bed. The Administrator stated that as Resident #1's bottom cleared the bed, NA #2 pulled out the lift with the sling hooked up to the mechanical lift. Resident #1's foot got stuck on the bed and when the foot got unstuck as NA #2 was pulling the lift out, the lift bar tilted to the right side and caused her to swing out of the sling on the left side with her upper body first. The Administrator was notified of immediate jeopardy on 10/14/25 at 12:13 PM. The facility provided the following immediate jeopardy removal plan: 1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance. · On 10/4/25, at approximately 11:05 am, Resident #1 sustained a fall during a mechanical lift transfer. An immediate assessment of Resident #1's post fall condition, conducted by the Staff Development Coordinator and the assigned, direct care Registered Nurse revealed the need to initiate a transfer to the local emergency department for evaluation and treatment. Resident #1 was complaining of pain in her head/neck area. She had a raised area to her forearm and a skin tear to her finger. The Staff Development Coordinator called the on-call doctor and received the order to transfer. The Staff Development Coordinator called Resident #1's family to inform them of the accident and to let them know that Resident #1 would be transferred to the hospital. Resident #1 exited the facility via emergency services personnel. At exit, Resident #1 was verbally responding to questions that confirmed her continued orientation to person, place and time. The only physical variations from her baseline being a discolored, raised area on her left forearm and a small skin tear on her left middle finger. Resident #1's care plan was updated to reflect the 10/4/25 fall intervention of staff education, the presence of left arm bruising, left middle finger skin tear and the C1 fracture. This was completed by the Minimum Data Set Coordinator on 10/6/25. · On 10/4/25 the Staff Development Coordinator called the Interim Director of Nursing (DON) to notify her of Resident #1's incident. On 10/4/25 the Interim Director of Nursing initiated the notification tree which included the Administrator, the Corporate Director of Clinical Services and the Corporate Director of Operations.	F0689		

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F0689 SS = SQC-J	Continued from page 24 · On 10/4/25 The Staff Development Coordinator, in conjunction with the assigned, direct care Registered Nurse, for Resident #1, completed a visual observation of the scene, resident room 501. This observation did not readily identify the root cause of the incident. · In response to the incident, an immediate investigation was initiated by the Staff Development Coordinator, that included the suspension of both Nurse Aides (NA) performing Resident #1's lift transfer. The suspensions were carried out on 10/4/25. · On 10/6/25, Nurse Aide#1 and Nurse Aide#2 were required to return to the facility to participate in a reenactment of the 10/4/25 incident as a component of the investigation. The Administrator, interim Director of Nursing and Staff Development Coordinator conducted and observed a demonstration of the lift transfer process, using the exact mechanical lift and lift sling used during the incident. These reenactments were conducted with both Nurse Aide#1 and Nurse Aide#2 independent of one another with the Administrator and Staff Development Coordinator acting as the second staff member. The Nurse Aides were asked to perform the reenactment independently to establish consistency in the description of the events. It was determined that the Nurse Aides failed to ensure Resident #1's feet (with shoes on) would remain free of the bare mattress while in the sling once her lower extremities were relaxed. This occurred when Nurse Aide #1 turned to get the wheelchair Resident #1 was transferring to, at which time, neither Nurse Aide #1 nor Nurse Aide #2 were touching Resident #1. · On 10/04/2025 the Staff Development Coordinator removed both the lift and lift sling used during the incident, pending a review by the Maintenance Director, assessing both the function and quality of the equipment. · The Maintenance Director completed a thorough examination of all facility lifts for function per the manufacturer guidelines. This was completed on 10/4/25. The Maintenance Director completed a visual observation of all facility lift slings with no evidence of adverse findings per the manufacturer guidelines. This was completed on 10/4/25. · A review of current residents in conjunction with interviews of Licensed Nurses and Nurse Aides during incident education was completed to identify residents requiring the use of a lift for transfers. This was completed on 10/4/25 by the Staff Development	F0689		

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F0689 SS = SQC-J	Continued from page 25 Coordinator. Sixteen (16) residents out of ninety two (92) were noted to be transferred via lift. The Care Plans were checked by the MDS Coordinator on 10/9/25. Updates were made as needed. However, the intent of this plan is to ensure all residents that have a lift transfer are safe. We understand that other residents with acute issues may require a lift transfer from time to time. · Risk Management reports from 7/1/25 to 10/5/25 were reviewed to confirm no other incidents involving a mechanical lift transfer occurred. This was completed by the interim Director of Nursing on 10/5/25. No concerns, unknown to facility management were identified. · A component of the ongoing investigation of Resident #1's fall also included the review of the personnel files of both Nurse Aides performing Resident #1's lift transfer to identify any prior disciplinary action regarding lift transfers or resident care. This was completed by the Interim Director of Nursing on 10/5/25 and yielded no concerns. · The review of all incidents reported by the facility to the North Carolina Department of Health and Human Services, for the entire employment period of both Nurse Aides, to confirm no historical events of a similar nature occurred was completed by the Administrator on 10/6/25 with no concerns identified. Nurse Aide #1 was hired on 2/6/24 and Nurse Aide #2 was hired on 7/16/24. · A review of facility grievance logs for the entire employment period of both Nurse Aides was also completed by the Administrator on 10/6/25 to confirm no historical events of a similar nature occurred. Nurse Aide #1 was hired on 2/6/24 and Nurse Aide #2 was hired on 7/16/24. 2. Specify the action the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or recurring, and when the action will be complete: · The Staff Development Coordinator has educated all Nurse Aides on the safe process based on manufacturer instructions and facility guidelines for transferring a resident via lift, to include; always having a partner is required and they must be actively assisting, appropriate lift sling selection (when the resident is placed in the center of the sling, it should extend 3 to 6 inches past their body on each side), correct positioning in sling, secure placement of sling to	F0689		

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F0689 SS = SQC-J	Continued from page 26 attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure before moving lift. This education was confirmed to be accepted and understood via successful completion of the lift competency. This education and competency was started on 10/4/25 and completed on 10/7/25. Any Nurse Aide not receiving this information and successfully completing an in-person lift competency by this date will complete before their next scheduled shift. This information will be presented in new Nurse Aide orientation by the Staff Development Orientation and will include successful completion of an in-person lift competency prior to first day of floor orientation. The facility does not utilize agency staff. · Subsequently, the Staff Development Coordinator educated Licensed Nurses on the proper process (based on manufacturer instructions and facility guidelines) for transferring a resident via mechanical lift and that their observations conducted of Nurse Aides transfers requiring a mechanical lift should include validation of; two qualified staff members' active participation, appropriate lift sling selection, correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure. This education was initiated on 10/4/25 and completed by 10/7/25. On 10/14/25 The Staff Development Coordinator started a second round of training for the Licensed Nurses. This training will be completed by 10/16/25. Any Licensed Nurse not receiving this education by this date will receive education via phone call by the Staff Development Coordinator prior to their next scheduled shift. This information will be presented in new Licensed Nurse orientation by the Staff Development Coordinator. The facility does not utilize agency staff. · All Licensed Nurses will receive lift competency training, which is, the safe process based on manufacturer instructions and facility guidelines for transferring a resident via lift, to include; always having a partner is required and they must be actively assisting, appropriate lift sling selection (when the resident is placed in the center of the sling, it should extend 3 to 6 inches past their body on each side), correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure before moving lift demonstrating they are qualified to perform lift transfers. This was done by	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345048	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 10/21/2025

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F0689 SS = SQC-J	Continued from page 27 the Staff Development Coordinator. The competency training includes the use of a lift, 2 nurse aides and/or the Staff Development Coordinator as the second person (if needed), sling, and Manikin brand medical model. This was initiated on 10/17/25 and all Licensed Nurses will complete the training on or before their next scheduled shift. · All Nurse Aides have been trained and successfully completed a lift competency which is, the safe process based on manufacturer instructions and facility guidelines for transferring a resident via lift, to include; always having a partner is required and they must be actively assisting, appropriate lift sling selection (when the resident is placed in the center of the sling, it should extend 3 to 6 inches past their body on each side), correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure before moving lift. demonstrating they are qualified to perform lift transfers. On-duty Licensed Nurses were informed of the Nurse Aide(s) successful completion of the lift competency prior to initiating resident care on their first scheduled shift beginning on 10/4/25. This was done by the Staff Development Coordinator. The competency training includes the use of a lift, 2 nurse aides and/or the Staff Development Coordinator as the second person (if needed), sling, and Manikin brand medical model. This was initiated on 10/4/25 and completed on 10/7/25. · On 10/4/25, in response to the lift incident, the interim Director of Nursing, in conjunction with the corporate Director of Clinical Services, initiated the process of requiring all resident lift transfers, on every shift, 7 days per week be observed by a Licensed Nurse to ensure current residents identified to potentially be affected by any possible deficient practice, were free of any risk to their personal safety. This is to ensure validation of two qualified staff members' active participation, appropriate lift sling selection, correct positioning in sling, secure placement of sling to attachment points, confirmation lift base legs spread, resident is raised above bed, chair or applicable surface and again, confirm sling straps are secure. · This will continue for 4 weeks starting on 10/4/25 to confirm ongoing adherence to the education provided to Nurse Aides. The nurse aides will inform the floor nurse when they are preparing to transfer a resident with a lift. They will then go perform any incontinence	F0689		

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F0689 SS = SQC-J	Continued from page 28 care needed, get the resident dressed and then return to get the nurse. If for some reason the Nurse cannot observe immediately, the Nurse Aide will continue with another resident and check back with the Nurse. This has not been a problem since the plan was initiated on 10/4/25. These observations are logged daily by the nurse assigned to each unit. The Administrative nurses will gather the logs each day for review. This response action would include not only facility residents requiring the use of a lift for transfers, per their care plan, at the time of incident occurrence, but also ensure the safety of any resident experiencing a change of condition or acute event that results in the need to use a lift for transfer. Alleged date of IJ removal:10/18/25 On 10/21/25 the facility's credible allegation of immediate jeopardy removal was validated by the following: Review of facility audits revealed the facility completed audits of all incidents and grievance logs from 2/6/25 to 10/5/25. Incident reports were audited by the facility for falls involving a lift, falls with injury, and falls with head/ neck injury. The facility did not identify any issues from the incident report audit. Grievance log audits were completed to identify any grievance related to physical injury or involving NA #1 or NA #2; there were no issues identified. The DON completed an audit on 10/5/25 of NA #1 and NA #2 employee file for any prior disciplinary action related to falls or the mechanical lift. There were no issues identified. The facility completed an audit to identify any resident who used a lift for transfers. There were 16 residents identified as using a lift. Care plans were reviewed for all residents identified as using a mechanical lift for transfers. All the residents were care planned to use a mechanical lift for transfers. All facility audits were reviewed and verified as completed. The facility had a total of 6 mechanical lifts. 4 total mechanical lifts and 2 sit to stand lifts. The facility completed an inspection of all lifts and lifts slings on 10/4/25. The inspection was completed by the Director of Maintenance. There were no issues identified during the inspection. An observation was completed of nursing staff	F0689		

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F0689 SS = SQC-J	Continued from page 29 transferring a dependent resident using the total mechanical lift. The lift transfer was completed by 2 NA's and a Nurse. The staff actively participated in the transfer, monitored for safety, and performed the transfer as outlined in the education provided by the facility on performing lift transfers. There were no issues identified during the lift transfer observation. It was verified all lift transfers are being observed and supervised by a licensed nurse 7 days a week. Daily lift transfer observation logs were completed by the Licensed Nurse on each shift and turned into the DON. Lift transfer competency validation check offs were completed for Licensed Nurses and NAs (including NA #1 and NA #2). Interviews with Licensed Nurses and NAs revealed competency validation was completed using return demonstration. Review of in-service logs revealed all Licensed Nurses and NAs received education on how to perform a lift transfer, lift manufacturer instructions, and lift transfer safety. Interviews were conducted with Licensed Nurses and NAs from different shifts. The Licensed Nurses and NAs confirmed they had received education on performing lift transfers. The Licensed Nurses and NAs were able to accurately verbalize the education they received. Immediate Jeopardy Removal Date of 10/18/25 was validated.	F0689		