

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345522	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/12/2025
NAME OF PROVIDER OR SUPPLIER Fletcher Rehabilitation and Healthcare Center			STREET ADDRESS, CITY, STATE, ZIP CODE 86 Old Airport Road , Fletcher, North Carolina, 28732	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS A complaint investigation survey was conducted from 12/11/25 through 12/12/25. Event ID #1DDF00-H1. The following intakes were investigated: 2687367, 2676727, 2658151, 2644906, 2638561, 2628282, 2617445, and 2602373. 3 of the 25 complaint allegations resulted in deficiency.	F0000		
F0689 SS = G	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 observation, record review, and staff interviews, the facility failed to safely transfer a dependent resident from the bed to the reclining wheelchair using a mechanical lift which resulted in an avoidable injury for 1 of 3 residents reviewed for accidents (Resident #1). On 11/18/25 around 6:30 AM, Nurse Aide #1 independently transferred Resident #1 to the reclining wheelchair and was unhooking the sling straps when the mechanical lift tilted and the sling bar of the mechanical lift hit Resident #1 above the left eyebrow causing a laceration. Resident #1 was sent to the Emergency Department for evaluation, a Computed Tomography (CT, detailed x-ray imaging of the inside of the head) revealed no negative findings, the laceration was repaired with sutures and Resident #1 returned to the facility the same day (11/18/25). Findings included:	F0689	"Past Noncompliance - no plan of correction required"	

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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F0689 SS = G	<p>Continued from page 1</p> <p>Resident #1 was admitted to the facility on 06/05/23 with diagnoses that included traumatic brain injury (TBI, injury to the brain caused by an external force), abnormal posture, and contracture of muscles-multiple sites.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated 09/06/25 assessed Resident #1 with severely impaired cognitive skills for daily decision making. He had impairment on both sides of the upper and lower extremities and was totally dependent on staff for self-care, transfers and ambulation.</p> <p>An Activity of Daily Living (ADL) care plan, last revised 09/12/25, revealed Resident #1 had an ADL self-care performance deficit related to TBI and contractures. Included was an intervention that noted Resident #1 required a mechanical lift and 2-person assistance for all transfers.</p> <p>Review of Resident #1's electronic health record revealed Resident #1 was not prescribed an anticoagulant.</p> <p>A nurse progress note dated 11/18/25 at 6:33 AM written by Nurse #1 revealed Resident #1 sustained a laceration above the left eye after bumping it on the mechanical lift during a transfer.</p> <p>A second nurse progress note dated 11/18/25 at 7:40 AM written by Nurse #1 revealed Resident #1 was sent to the Emergency Department (ED) via Emergency Medical Services (EMS) transport.</p> <p>During a phone interview on 12/12/25 at 11:12 AM, Nurse Aide (NA) #1 revealed she was no longer employed at the facility and confirmed she was assigned to provide Resident #1's care on 11/17/25 to 11/18/25 during the hours of 7:00 PM to 7:00 AM. NA #1 confirmed she had transferred Resident #1 from his bed to the wheelchair using a mechanical lift without additional staff assistance on 11/18/25. NA #1 explained as she was getting Resident #1 ready for the day toward the end of her shift, she independently used the mechanical lift to transfer Resident #1 from the bed and lowered him down inside the reclining wheelchair. NA #1 recalled as she was unhooking the sling straps, the mechanical lift tilted and the sling bar of the mechanical lift hit Resident #1 in the face. NA #1 stated at first, she thought Resident #1 was ok, she finished unhooking the straps and then noticed that he was bleeding. NA #1 stated she then went and informed Agency Nurse #2 what had happened. NA #1 stated they had been instructed to</p>	F0689		

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F0689 SS = G	<p>Continued from page 2 always have 2-person assistance when using a mechanical lift and prior to transferring Resident #1, she had reached out to other staff to see if anyone was available to help but no one was. NA #1 stated she knew she shouldn't have transferred Resident #1 on her own but at the time thought that she could do it without additional staff assistance.</p> <p>During a phone interview on 12/12/25 at 11:28 AM, Agency Nurse #2 revealed she had worked during the hours of 7:00 PM to 7:00 AM on 11/17/25 to 11/18/25 but was not assigned to provide care to Resident #1. Agency Nurse #2 recalled it was a hectic morning on 11/18/25 when NA #1 came to inform her that Resident #1 had gotten hit with the sling bar of the mechanical lift during a transfer. Agency Nurse #2 stated she could not recall all the details that NA #1 had told her about what happened but did remember NA #1 stating she had transferred Resident #1 on her own using a mechanical lift without additional staff assistance. Agency Nurse #2 recalled when she and Agency Nurse #1 assessed Resident #1's injury, the laceration above the left eyebrow was open and they both felt he would need stitches to repair. Agency Nurse #2 stated upon assessment Resident #1 seemed to be at his normal baseline, smiling and not displaying any indicators of pain.</p> <p>During a phone interview on 12/11/25 at 2:50 PM, Agency Nurse #1 confirmed she was Resident #1's assigned nurse from 11/17/25 to 11/18/25 during the hours of 7:00 PM to 7:00 AM but did not witness the incident. Agency Nurse #1 stated from what she could recall, she was told by NA #1 that sometime between 6:30 AM and 7:00 AM, as NA #1 was transferring Resident #1 from the bed to the reclining wheelchair, the sling bar of the mechanical lift hit Resident #1 in the face. Agency Nurse #1 stated when she got to the room to assess Resident #1, he had a laceration above his left eyebrow. She stated the bleeding was mostly controlled at that point and she applied first aid. Agency Nurse #1 stated the laceration was open and she immediately knew that Resident #1 would need to go the hospital for stitches to repair the laceration. Agency Nurse #1 stated when she assessed Resident #1, he was smiling, appeared at his normal baseline and did not display any indicators of pain. Agency Nurse #1 explained both she and NA #1 knew that transfers using a mechanical lift required 2-person assistance and when she asked NA #1 why she did not ask her or another staff member to assist with the transfer, NA #1 never gave her a reason. Agency Nurse #1 stated Resident #1 was sent out to the hospital for treatment, and the laceration was repaired with stitches but could not recall how many.</p>	F0689		

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F0689 SS = G	<p>Continued from page 3 She stated when Resident #1 returned back to the facility later that same day (11/18/25) he was still at his normal baseline.</p> <p>A Hospital ED After Visit Summary note dated 11/18/25 for Resident #1 revealed Resident #1 was seen for evaluation and treatment of a facial laceration. The note indicated a head CT was obtained and "looked good" (no negative findings). The laceration was repaired with sutures and Resident #1 was sent back to the facility with orders for an antibiotic ointment to be applied twice a day for seven (7) days and to keep the laceration covered, clean and dry.</p> <p>Review of Resident #1's November 2025 treatment administration record revealed a physician order dated 11/18/25 to apply bacitracin ointment (topical antibiotic used to prevent infection in minor skin injuries) 500 unit/grams to the left upper eyebrow every shift for 7 days. The treatment was started on 11/18/25 during the evening shift (7:00 PM to 7:00 AM) and completed on 11/25/25 during the day shift (7:00 AM to 7:00 PM). Treatments were initialed each shift as completed per the physician order except for 11/19/25 during the day shift and 11/20/25 during the evening shift.</p> <p>During an observation on 12/11/25 at 9:21 AM, Resident #1 was lying in bed in fetal position with noticeable bilateral hand contractures. Resident #1 was alert and smiled when greeted but provided no response other than repetitive verbalizations. He had a thin, red healing scar above the left eyebrow that was approximately 2 to 2.5 inches in length with no signs of infection or bruising noted. Resident #1 displayed no signs of discomfort or pain.</p> <p>During an interview on 12/12/25 at 3:05 PM, the Director of Nursing (DON) stated she was informed by a nurse working the morning of 11/18/25 that Resident #1 was being sent out to the ED due to a facial laceration, but the nurse had not witnessed what had happened. The DON stated the laceration above Resident #1's left eyebrow was repaired while at the ED with approximately 4 or 5 stitches and he returned to the facility that afternoon (11/18/25). The DON stated when she and the Administrator spoke with NA #1 about what happened, NA #1 admitted to transferring Resident #1 independently using a mechanical lift and NA #1 explained during the transfer, the mechanical lift tilted causing the sling bar to hit Resident #1 in the face. The DON stated NA #1 was immediately suspended and subsequently terminated due to not following the facility's policy which required 2-person assistance</p>	F0689		

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F0689 SS = G	<p>Continued from page 4 with mechanical lift transfers. The DON stated it was an unfortunate but avoidable accident as NA #1 had received previous training on mechanical lifts but just made the bad decision not to follow the facility policy. The DON stated an Ad Hoc QAPI (Quality Assurance and Performance Improvement) meeting was held to discuss the incident, and a decision was made to develop and implement a corrective action plan on 11/18/25.</p> <p>During interviews on 12/12/25 at 1:02 PM and 3:30 PM, the Administrator confirmed she was notified via the facility group nurse chat (messaging system) of the transfer incident on 11/18/25 involving Resident #1. The Administrator stated when interviewed, NA #1 admitted she had transferred Resident #1 using a mechanical lift without additional staff assistance. She recalled NA #1 explained that when lowering Resident #1 into the reclining wheelchair, the sling bar swung and hit Resident #1 in the face causing a laceration that required stitches to be repaired. The Administrator stated NA #1 informed the nurse right away and recalled NA #1 felt very remorseful about the incident. The Administrator verified that NA #1 had received training, along with other nursing staff, back in April 2025 regarding the facility's policy on safe transfers using a mechanical lift that required 2-person assistance. The Administrator stated she felt it was an unfortunate accident. She explained although NA #1 was a good NA, she made a bad decision not to follow facility policy by transferring Resident #1 independently with the mechanical lift and that was why the decision was made to terminate NA #1's employment. The Administrator verified on 11/18/25 they held an Ad Hoc QAPI meeting to discuss the incident and the decision was made to implement an internal plan of correction that included staff re-education, audits and monitoring with no further concerns identified.</p> <p>The facility provided the following Corrective Action Plan with a completion date of 11/20/25:</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p> <p>On 11/18/25, Nursing Aide (NA) #1 transferred Resident #1 independently, not following the facility policy. During transfer the lift tilted, causing the arm to hit Resident #1 in the left eye which caused a laceration head injury during transfer. Resident #1 was assessed by the nurse and transferred to the hospital for higher level of care. Nursing Aide (NA) #1 was re-educated by the Director of Nursing on the facility mechanical lift</p>	F0689		

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F0689 SS = G	<p>Continued from page 5 policy and safe lifting policy on 11/18/25. NA #1's employment was terminated on 11/21/25.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All residents using mechanical lifts have the potential to be affected. This was determined utilizing the transfer evaluation/therapy recommendations. Transfer evaluation assessments were reviewed in the individual electronic medical record for each resident to ensure mechanical lifts status were updated and correct. Therapy recommendations were reviewed for each resident to ensure transfer evaluation and therapy recommendations were updated and correct. No concerns were identified. Audits were completed on 11/18/2025 by the Director of Nursing.</p> <p>The Director of Nursing/Designee completed skin assessments on all residents that required mechanical lifts. No concerns were identified. Audits were completed on 11/18/2025.</p> <p>Residents that use mechanical lifts with a Brief Interview for Mental Status (BIMs) score of 13 or higher were interviewed by the Social Service Director to ensure they did not have any concerns with use of mechanical lift. No concerns were identified. Audits were completed on 11/18/25.</p> <p>The Regional Clinical Director reviewed all incident reports for the last 30 days to ensure there were no issues with transfers using mechanical lifts. No concerns were identified. This audit was completed on 11/19/2025.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>On 11/18/25, the Director of Nursing or Designee educated all nursing staff, including agency staff on the facility mechanical lift policy and safe lifting policy with emphasis on ensuring 2 staff were present with all lift transfers. All Nursing Staff including Licensed Nurses and Nursing Aide (NA) will perform mechanical lift use competency prior to the start of their shift which will be completed by the Director of Nursing/Nursing Administration. This education was completed on 11/18/25. This education will be added to the facility orientation program for all newly hired nursing staff, including new agency staff and will be the responsibility of the Director of Nursing.</p>	F0689		

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F0689 SS = G	<p>Continued from page 6</p> <p>An ADHOC Quality Assurance Performance Improvement Committee Meeting was held on 11/18/2025 to discuss, review and approve the plan that had been initiated and implemented by the Director of Nursing on 11/18/2025. The Quality Assurance Performance Improvement Committee also reviewed the policy and procedure for mechanical Lift and Safe Lifting Policy. The decision to monitor the plan was also decided during the Quality Assurance Performance Improvement Committee meeting on 11/18/2025. Root Cause Analysis was completed and determined that the Nurse Aide failed to follow the facility policy and procedure for mechanical Lift use.</p> <p>Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. Include dates when corrective action will be completed.</p> <p>To monitor and maintain ongoing compliance, the Director of Nursing or designee will observe 2 lift transfers randomly on all shifts weekly for 8 weeks to ensure proper use of mechanical lift and to ensure that 2 staff members are present. The Director of Nursing or designee will interview 3 residents with a Brief Interview for Mental Status (BIMs) of 13 or higher on lift use weekly for 8 weeks. The Director of Nursing or designee will randomly interview 4 staff members on all shifts weekly for 8 weeks. These audits will be completed by January 27, 2026.</p> <p>The DON or designee will be responsible for reporting results of these audits to the facility's monthly QAPI committee meeting for 3 months. The QAPI committee will make recommendations and changes as indicated based upon the findings of these audits.</p> <p>Compliance Date: 11/20/2025.</p> <p>The Corrective Action plan was validated on 12/12/25 and concluded the facility had implemented an acceptable corrective action plan on 11/20/25. Alert and oriented residents who required a mechanical lift for transfers were interviewed and confirmed there were 2-staff present when utilizing the mechanical lift. Nursing staff interviewed on all shifts confirmed receipt of education on the facility's mechanical lift policy that included performing a return demonstration. Nursing staff were able to verbalize how to prepare for and perform a safe transfer using a mechanical lift and that all mechanical lift transfers required 2-person assistance. Staff also verbalized they would wait for someone to assist before attempting a mechanical lift</p>	F0689		

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F0689 SS = G	Continued from page 7 transfer. Review of the audits and monitoring tools revealed they were completed as outlined in the facility's corrective action plan with no concerns noted as identified. The corrective action plan date completion date of 11/20/25 was validated.	F0689		