

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345555	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 12/09/2025
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NAME OF PROVIDER OR SUPPLIER Hillcrest Raleigh at Crabtree Valley	STREET ADDRESS, CITY, STATE, ZIP CODE 3830 Blue Ridge Road , Raleigh, North Carolina, 27612
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F0000	<p>INITIAL COMMENTS</p> <p>A complaint survey was conducted from 12/3/2025 to 12/4/2025. Additional information was obtained offsite on 12/5/2025, 12/8/2025, and 12/9/2025. Therefore, the exit date was 12/9/2025. Event ID # 1DD2A7-H1. The following intakes were investigated 2672644, 2652954, 2642772, 2572803, and 773729.</p> <p>One of ten allegations resulted in a deficiency.</p>	F0000		
F0689 SS = D	<p>Free of Accident Hazards/Supervision/Devices</p> <p>CFR(s): 483.25(d)(1)(2)</p> <p>§483.25(d) Accidents.</p> <p>The facility must ensure that -</p> <p>§483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and</p> <p>§483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observation, record review, and interviews with staff, Director of Nursing, and Medical Director, the facility failed to transfer Resident #1 safely with a mechanical lift which resulted in an avoidable injury. Resident #1 had right sided hemiplegia (severe paralysis on the right side of the body) and right foot drop (difficulty lifting the front part of the right foot). While Nurse Aide (NA) #1 and NA #5 were transferring Resident #1 her paralyzed right foot got caught in the recliner footrest. Emergency room X-rays results noted a closed fracture of proximal end of the right tibia (fracture of the upper shin bone, just below the knee). Resident #1 was evaluated in the emergency department where nonoperative management with a knee immobilizer was determined and a follow-up with orthopedics. The deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents (Resident #1).</p>	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 = D	<p>Continued from page 1</p> <p>Findings included:</p> <p>Resident #1 was admitted to the facility on 4/15/2013 with a diagnosis of right sided hemiplegia and hemiparesis (one-sided muscle weakness) following a cerebrovascular accident, aphasia (communication/language disorder), osteoporosis, neuropathy, and a viral infection that significantly weakened bones.</p> <p>Review of the quarterly Minimum Data Set (MDS) dated 9/10/2025 revealed that Resident #1 was coded as moderately cognitively impaired, with range of motion impairment affecting one upper extremity and both lower extremities. Resident #1 was non-ambulatory and dependent on staff for transfers.</p> <p>A physician's order dated 9/29/2025 directed that Resident #1 be placed in a reclining chair before lunch every Tuesday and Thursday for two to three hours or as tolerated.</p> <p>Resident #1 had a physician's order initiated on 9/29/2025 for the as needed administration of 325 milligrams of Acetaminophen given as two tablets every two hours for general discomfort.</p> <p>Review of a care plan focus area initiated on 12/4/2024 revealed Resident #1 had an activity of daily living self-care performance deficit related to hemiplegia and stroke. One of the interventions under this focus area was to transfer Resident #1 with a mechanical lift.</p> <p>An interview was conducted with Nurse Aide (NA) #1 on 12/3/2025 at 11:37 AM. NA #1 reported she worked on the 7:00 PM to 3:00 PM shift on 11/6/2025 and was assigned to care for Resident #1. After providing morning care to Resident #1, NA #1 requested the assistance of NA #5 with transferring Resident #1 to her reclining chair with a mechanical lift. NA #1 explained she was using the controls on the lift to raise Resident #1 up in the air while NA #5 was on the other side of the resident for the purpose of guiding Resident #1 into the recliner. NA #1 further explained that as she was lowering Resident #1 down onto the recliner, they heard Resident #1 say "Ouch." NA #1 said she immediately stopped the mechanical lift, and it was noted Resident #1's right foot was in between the footrest and the seat of the recliner. Resident #1's foot was removed and she was lifted back up with the mechanical lift. Resident #1 did not express any other pain or vocalizations. Resident #1 was then lowered into the recliner with her legs positioned out and a pillow put</p>	F0689		

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F0689 SS = D	<p>Continued from page 2 underneath her lower legs. NA #1 reported that she did not think Resident #1 was injured or hurt in any way, so she did not notify the nurse of the occurrence on 11/6/2025. NA #1 indicated she found out the next day that Resident #1 had fractured her leg, and she felt obligated to report Resident #1's foot getting caught on the previous day.</p> <p>Interview with NA #5 on 12/3/2025 at 3:52 PM confirmed she assisted NA #1 with the transfer on 11/6/2025. NA #5 reported Resident #1 said "Ouch" during the transfer, and her right foot was observed caught in the crease of the recliner. The foot was repositioned, and Resident #1 was lowered into the chair without further complaint. NA #5 stated Resident #1 appeared content for the remainder of the shift.</p> <p>NA #3 worked on 12/6/2025 and was assigned to care for Resident #1 during the 3:00 PM to 11:00 PM shift. Interview with NA #3 on 12/3/2025 at 2:31 PM revealed Resident #1 appeared sleepy in the recliner, and NA #2 and NA #3 assisted Resident #1 with a transfer to bed using the mechanical lift. NA #3 reported Resident #1 was lifted into the air in a sling using the mechanical lift and transferred to bed without incident. NA #3 stated that when they started to reposition Resident #1 in bed for peri-care, it was noted her right leg was swollen and red. Nurse #1 was notified. NA #3 revealed that Resident #1 was always happy and smiling and was never moaning or yelling in pain. NA #3 did not recall the exact time Resident #1 was transferred back to bed on 11/6/2025 but knew it was before the evening meal.</p> <p>NA #2 worked on 11/6/2025 during the 3:00 PM to 11:00 PM shift and was not assigned to care for Resident #1. Interview with NA #2 on 12/3/2025 at 1:59 PM revealed she assisted NA #3 in transferring Resident #1 from the recliner to bed on 11/6/2025 using a sling and a mechanical lift. NA #2 reported the transfer of Resident #1 to the bed occurred without incident. NA #2 reported Resident #1 made unusual moaning sounds during repositioning while on the bed, and Nurse #1 was notified. NA #2 did not recall what time Resident #1 was transferred back to bed on 11/6/2025.</p> <p>Review of a health status note dated 11/6/2025 at 5:47 PM, written by Nurse #1, revealed staff had transferred Resident #1 from the recliner to bed using a mechanical lift at approximately 5:00 PM. Following the transfer, Resident #1 was observed with swelling, redness, and discoloration below the right knee. Due to aphasia, Resident #1 was unable to verbalize details of the incident but was able to respond to yes/no questions. When asked if she recalled hitting her leg during</p>	F0689		

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F0689 SS = D	<p>Continued from page 3</p> <p>transfers, Resident #1 responded "No." Resident #1 exhibited pain upon palpation of the affected area, and acetaminophen was administered with relief. The physician was notified and ordered diagnostic x-rays of the right knee and tibia/fibula. The Responsible Party was informed and agreed with the treatment plan.</p> <p>During an interview on 12/3/2025 at 11:13 AM, Nurse #1 reported Resident #1 had been seated in her recliner near the nurses' station prior to lunch on 11/6/2025 without signs of pain or injury. Nurse #1 stated that Resident #1 was laughing, smiling, and appeared happy as she sat in her recliner that morning and early afternoon. Nurse #1 stated Resident #1 appeared uncomfortable and was transferred back to bed by Nurse Aide (NA) #2 and NA #3 after 3:00 PM. Nurse #1 did not recall the exact time Resident #1 was noted to be uncomfortable on 11/6/2025 but knew it was after the start of the 3:00 PM to 11:00 PM shift. While providing incontinence care, NA #2 and NA #3 observed redness and swelling of Resident #1's right leg below the knee and notified Nurse #1. Nurse #1 confirmed the Responsible Party was immediately notified but stated she did not know the cause of the injury at that time. Nurse #1 confirmed that the Medical Director was called and x-rays were ordered. Nurse #1 stated she administered pain medication to Resident #1 after she observed the bruising as a preventative measure in case she felt any pain.</p> <p>Review of a health status note dated 11/6/2025 at 9:46 PM, written by Nurse #3, revealed Resident #1's right leg was assessed to have dark purple bruising on the right shin that was tender to touch. The physician was notified and an x-ray of the right shin was ordered to rule out fracture. An ice pack was applied, and the leg was elevated to reduce swelling and for comfort.</p> <p>During an interview on 12/3/2025 at 1:13 PM, Nurse #3 stated the x-ray was ordered on the evening of 11/6/2025 but was not performed until the next day in the facility.</p> <p>Initial X-ray results which were performed at the bedside on 11/7/2025 revealed Resident #1 had acute proximal tibia and fibula head fractures. An acute proximal tibia and fibula head fractures are a break in the upper parts of the shin and calf bones, near the knee joint.</p> <p>Review of the November Medication Administration Record revealed Resident #1 did not receive any as needed pain medication on the 11:00 PM to 7:00 AM shift ending on 11/7/2025.</p>	F0689		

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F0689 SS = D	<p>Continued from page 4</p> <p>Nurse #5 was assigned to care for Resident #1 on 11/7/2025 for the 7:00 AM to 3:00 PM shift. Nurse #5 was interviewed on 12/3/2025 at 4:31 PM. Nurse #5 stated she received the information in a nursing report from the night shift on 11/7/2025 that Resident #1 slept through the night and had no complaints of pain or discomfort. Nurse #5 stated that Resident #1 was always very happy and smiling. Nurse #5 explained that after the x-ray results were received on 11/7/2025, the responsible party for Resident #1 requested she be sent to the emergency room for evaluation. Nurse #5 stated Resident #1 was not in any pain or discomfort from the fracture, but she did not want anyone to touch her leg.</p> <p>Review of the November Medication Administration Record revealed Resident #1 received Acetaminophen on 11/7/2025 at 8:58 AM for right lower leg pain per an administration note with the same date and time.</p> <p>Review of a health status note dated 11/7/2025 at 2:17 PM, written by the Director of Nursing, revealed x-ray results identified proximal tibia and fibula head fractures. The Responsible Party was notified and requested transfer of Resident #1 to the emergency room for evaluation and treatment.</p> <p>A subsequent health status note dated 11/7/2025 at 2:19 PM documented the Responsible Party requested clarification regarding the cause of the fracture. The Director of Nursing interviewed staff who had transferred Resident #1 from bed to recliner on 11/5/2025. One aide reported Resident #1 said "ouch" during the transfer, and her right foot was noted to be bent in the crease of the recliner footrest. The foot was repositioned, and no further complaints were noted.</p> <p>Review of an emergency department encounter dated 11/7/2025 revealed Resident #1 was diagnosed with a closed fracture of proximal end of the right tibia (the upper shin bone, just below the knee, was broken). Orthopedics was consulted and after discussion with the Responsible Party the decision was made for nonoperative management with a knee immobilizer and a follow-up with orthopedics. There were no additional orders for pain medication after the emergency room visit.</p> <p>Review of a health status note dated 11/7/2025 at 9:56 PM documented Resident #1 returned to the facility from the emergency room with a knee immobilizer in place to the right leg, acetaminophen administered as needed for pain, and ice application for 10 to 20 minutes while awake.</p>	F0689		

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F0689 SS = D	<p>Continued from page 5</p> <p>Review of the November Medication Administration Record revealed Resident #1 received Acetaminophen on 11/7/2025 at 8:59 PM and 11/8/2025 at 9:26 AM with effective results.</p> <p>Interview with the Director of Nursing on 12/3/2025 at 12:15 PM revealed she was notified of Resident #1's bruising and swelling on 11/6/2025. The Responsible Party requested clarification regarding the injury. The Director of Nursing obtained statements from staff and confirmed NA #1 and NA #5 reported Resident #1's foot had been caught in the recliner during transfer with the mechanical lift 11/6/2025 on the 7:00 AM to 3:00 PM shift. The Director of Nursing further explained that NA #1 and NA #5 verbally told her what had happened and she had them write statements. The Director of Nursing stated it was likely this incident resulted in the fracture. The Director of Nursing confirmed the nurse aides should have been watching Resident #1's extremities while moving her in the mechanical lift due to her immobility. The Director of Nursing stated that Resident #1 was always happy and had not changed from her baseline since the fracture occurred. The Director of Nursing confirmed Resident #1's foot was caught in the recliner on 11/6/2025 and not 11/5/2025.</p> <p>An observation and interview were conducted with the Medical Director, of Resident #1's right leg as she was lying in bed on her back in bed on 12/3/2025 at 1:21 PM. Resident #1 was smiling and acknowledged she was happy to see the Medical Director. The Medical Director stated that Resident #1 had "foot drop" on the right side with an inability to lift her right foot. Resident #1's right foot was observed to turn inward and down while resting in bed. In a subsequent interview in another room directly after the observation, the Medical Director revealed Resident #1's comorbidities, including osteoporosis, neuropathy and a viral infection, resulting in weakened bones and diminished pain perception. The Medical Director stated that when Resident #1's right foot was caught in the recliner, the fracture below the knee occurred due to bone fragility and neuropathy, preventing her from perceiving pain as a healthy individual would.</p> <p>The facility submitted the following corrective action plan on 12/3/2025 with a completion date of 11/10/2025.</p> <p>1. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice.</p>	F0689		

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F0689 SS = D	<p>Continued from page 6</p> <p>On 11/6/2025, Resident #1 was being transferred with a mechanical lift by NA #1 and NA #5 during the 7:00 AM to 3:00 PM shift. During the transfer, Resident #1 stated "ouch." Upon assessment, NA #5 noted the resident's right foot was slightly bent in the crease of the reclining chair where the footrest extends. NA #1 and NA #5 immediately stopped the transfer and repositioned the resident's foot onto the footrest. Resident #1 denied further pain or discomfort for the remainder of the shift.</p> <p>During routine care on the 3:00 PM to 11:00 PM shift, NA #2 and NA #3 noted slight redness and bruising to Resident #1's right lower extremity (RLE). Nurse #1 was notified. Resident #1 was assessed by Nurse #1 and acetaminophen was administered for potential unrecognized pain. The physician was notified and ordered an X-ray. On 11/7/2025, results showed a proximal tibial head fracture. The physician and the Responsible Party were informed. The physician issued a new order to send the resident to the emergency room for evaluation and treatment.</p> <p>2. Address how the facility will identify other residents having the potential to be affected by the same deficient practice.</p> <p>All current residents requiring mechanical lift transfers were identified by the Director of Nursing on 11/7/2025. Skin assessments were completed on all current residents requiring mechanical lift transfers to identify any potential skin impairments or injuries by the charge nurses on 11/7/2025. No additional unknown skin impairments or injuries were identified.</p> <p>3. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.</p> <p>All nursing staff working on 11/7/25 were immediately re-educated on the proper use of mechanical lifts to include being mindful of the resident's position, balance, and limbs. The re-education also included reporting incidents to licensed nursing staff. All nursing staff scheduled to work all shifts between 11/8/25 and 11/10/25 were re-educated before starting their next shift. Remaining nursing staff, including full-time, part-time, and as needed employees, received reeducation prior to their next scheduled shift. This</p>	F0689		

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F0689 SS = D	<p>Continued from page 7 education was provided either in person to nursing staff by the staff development coordinator or through a series of 5-part text messages sent by the Director of Nursing with a required response of receipt on 11/7/2025. The 5-part text message included a series of text messages with detailed information on the use of the mechanical lift and the importance of reporting incidents and accidents to the nurse. The nursing staff were required to reply to the 5-part text messages on mechanical lift and reporting incidents and accidents with a "yes" to acknowledge the information was received. The nursing staff would not be able to work until they completed the in-service training on using the mechanical lift and reporting incidents and accidents either in person or via text message. New hires will receive mechanical lift training during orientation. Annual re-education on mechanical lift safety for licensed nurses and nurse aides will occur during the Educational Fair or as needed based on audit findings or identified needs by the Staff Development Coordinator. The Staff Development Coordinator was notified of this responsibility on 11/7/2025. Nurse Aide #1 and Nurse Aide #5 involved in the transfer incident with Resident #1 completed a Mechanical Lift Competency Assessment before returning to work on their next scheduled shift by the Director of Nursing.</p> <p>4. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.</p> <p>The interdisciplinary team decided to implement the Quality Assurance and Performance Improvement (QAPI) Plan regarding mechanical lift transfers on 11/7/25. The Director of Nursing (DON) or designee will conduct random observation audits of mechanical lift transfers on all shifts and different nursing staff members: Weekly x 4 weeks, Bi-weekly x 2 months and Monthly x 1 month. Monitoring will begin the week of 11/10/2025. Findings will be documented and reviewed for trends, compliance, and opportunities for improvement. The Interdisciplinary team will follow up on the scheduled QAPI meeting 1/21/2026. The QAPI meeting will include a review of completed audits of staff interviews/observations of mechanical lift transfers to confirm staff competency and compliance. The QAPI team will decide if additional education, competencies, or continued audits are needed based on findings.</p> <p>Compliance date of 11/10/2025.</p> <p>Validation of the corrective action plan was completed</p>	F0689		

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F0689 SS = D	Continued from page 8 on 12/3/2025. The Quality Assessment and Performance Improvement (QAPI) Plan was reviewed, each intervention had corresponding documentation to support the actions taken by the facility. Staff members were observed while demonstrating the use of mechanical lifts. Two staff members managed the lift with one operating the mechanical component and the other in front for support and positioning of the resident. Staff members checked for positioning and safety of the lift pad, positioning of the resident's body in the lift pad and functioning of the equipment. Staff members were interviewed and reported they were provided with in-service training on resident transfers with the use of a mechanical lift and reporting of incidents and accidents. The training documentation was reviewed to confirm all nursing staff were trained as of 11/10/2025. Competency assessments on using the mechanical lift were reviewed for NA #1 and NA #5 and confirmed a return demonstration was required of them. QAPI data collection forms, used for auditing proper mechanical lift transfers, were reviewed for continued compliance after 11/10/2025. The compliance date of 11/10/2025 was validated.	F0689		