STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	2401 Wayne Memorial Drive Goldsboro, NC 27534

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0684 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with staff and the Medical Director, the facility failed to notify a nurse after an assisted fall and not move the resident after a fall before a licensed nurse's assessment. On 12/11/25, at approximately 1:45 PM, Resident #1 returned to the facility from dialysis, ate lunch, and then requested to be put back into bed. Nursing Assistant #1 (NA) entered Resident #1's room at approximately 2:45 PM. NA #1 attempted to complete a stand pivot transfer from the wheelchair to the bed. Resident #1's legs gave out, and NA #1 lowered the resident to the floor. NA #1 then assisted the resident back into the wheelchair. NA #1 did not report the assisted fall to a nurse and did not get a nurse to assess the resident before transferring to the wheelchair. At approximately 2:50 PM NA #1 asked NA #2 and Medication Aide for assistance with transferring the resident from the wheelchair to the bed; however, NA #1 did not inform NA #2, or the Medication Aide of the resident's assisted fall to the floor. When Resident #1 was assisted into bed, she complained of right shoulder pain. The pain was treated with as needed pain medication; however, it was ineffective. An x-ray ordered for the right arm and shoulder was negative for a fracture. At approximately 7:20 PM, Resident #1 was noted to have a softball size area on her upper chest and when palpated, the resident stated it hurt. New orders were received to send the resident to the hospital emergency department (ED) for evaluation and treatment. The ED Physician documented there was acute swelling of the right chest wall and the exam revealed a large tense hematoma approximately the size of a grapefruit. The results of the chest x-ray revealed a right chest wall hematoma (localized collection of blood that has leaked from damaged blood vessels into the tissues of the chest wall) with active bleeding. On 12/12/25 at 11:28 AM Resident #1 was transferred to the second hospital with a higher level of care and that same day underwent a VIR (Vascular and Interventional Radiology) embolization (minimally invasive procedure performed by vascular and interventional radiologists to block or close off a specific blood vessel using embolic agents, often guided by real-time imaging such as fluoroscopy, CT, or ultrasound). Resident #1 developed repeat bleeding concerns 12/14/25 and stabilized without intervention. On 12/18/25 trauma surgery performed a hematoma evacuation (a surgical procedure to remove a localized collection of blood outside blood vessels, often necessary when a hematoma causes pressure or complications). The hospital discharge summary indicated resident was discharged back to the facility on [DATE] with an appointment to follow up with the surgeon on 12/30/25 for follow up of the right breast hematoma with drain placement. The deficient practice occurred for 1 of 3 residents reviewed for quality of care (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia, end stage renal disease (ESRD) with dependence on dialysis (HD), and diabetes. Resident #1 was sent to the hospital on [DATE] and was transferred to a higher-level care hospital on [DATE]. She returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 was cognitively intact, had moderate difficulty (continued on next page)

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

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F 0684 Level of Harm - Actual harm Residents Affected - Few	hearing, and severely impaired vision. She was totally dependent on staff for transfers. Resident #1 received as needed pain medication, and pain presence was occasional. Review of the Resident Care Guide implemented on 11/13/23 and contained in the care plan revealed that Resident #1 required a mechanical lift of one person assist with all transfers. The sling size was medium. The care plan was revised on 1/16/25 and included the problem of activities of daily living (ADL)/personal care. Interventions included: Mechanical lift. Review of physician orders for Resident #1 revealed Oxycodone (opioid pain medication) 5 milligram (mg) tablet to be given every 4 hours as needed for pain was ordered from 7/22/25 through 12/19/25. Resident #1 also received Eliquis (blood thinner medication which raises the risk of bruising and bleeding) 2.5mg tablet to be given twice daily for history of portal vein thrombus (blood clot that obstructs the vein carrying blood to the liver). NA #1 was interviewed on 2/11/26 at 11:58 AM. She revealed that the Resident Care Guide contained resident transfer details and typically if she witnessed a fall, she would leave the resident on the floor, call code green, and wait for a nurse to assist. NA #1 stated that Resident #1 was alert most of the time and required a mechanical lift for all transfers. NA #1 explained on 12/11/25 around 12:00 PM, Resident #1 returned from dialysis while NA #1 was in the middle of lunch meal service. Resident #1 requested to be transferred to bed because she was tired and hurting, which was usual for her after dialysis. NA #1 told Resident #1 that she could help her after meal service was complete. When NA #1 went to retrieve the mechanical lift, the two lifts in her section did not have any charge. NA #1 stated she told Resident #1 that she would have to wait a little longer since both mechanical lifts were not available at the time. Resident #1 was adamant about being transferred to bed immediately. Around 2:45 PM, NA #1 decided to accommodate Resident #1's request without a mechanical lift. As soon as NA #1 lifted Resident #1 out of the wheelchair, Resident #1 complained about her legs and began to panic. Resident #1 put all her weight on NA #1, and NA #1 assisted Resident #1 to the floor. NA #1 stated she did not want to leave Resident #1 on the floor and felt she needed to get her off the floor, so she lifted Resident #1 from the floor back to the wheelchair. However, Resident #1 appeared slumped in the wheelchair, and NA #1 pulled her more upright in the wheelchair. NA #1 then called for help and the Medication Aide and NA #2 entered the room. All three staff members lifted Resident #1 into the bed. NA #1 stated she then went and told the Unit Manager about the assisted fall. When the Unit Manager came to the room, she asked Resident #1 if she was hurting. Resident #1 responded that she felt pain in her right arm. The Unit Manager assessed her right arm and found no injuries. The Medication Aide provided Resident #1 with as needed pain medication. NA #1 stated that she received education on12/12/25 related to fall protocol and to always follow the Resident Care Guide. During a follow up telephone interview with NA #1 on 2/11/26 at 4:09 PM, she revealed that Resident #1 was normally transferred from a stretcher to the bed by transportation personnel after all dialysis appointments. NA #1 stated that on 12/11/25, it was the first time she ever transferred Resident #1 to bed after dialysis. However, this day was different because a different transportation vendor was used to bring Resident #1 to/from dialysis on 12/11/25. Since Resident #1 refused to wait for an available mechanical lift on 12/11/25, NA #1 stated she just wanted to get Resident #1 in bed before shift change at 3:00 PM. She further stated that she already knew a mechanical lift was required to transfer Resident #1. When she assisted Resident #1 to the floor, she did not think at the time and did not want to leave her on the floor even though that was the protocol. NA #1 indicated that she told the Medication Aide that Resident #1 had an assisted fall prior to lifting Resident #1 into bed with the Medication Aide and NA #2. NA #1 stated she transferred Resident #1 to the bed because her goal was to get Resident #1 in the bed as soon as she was assisted to the floor. NA #1 explained she wanted to (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	make Resident #1 comfortable and not in pain anymore. NA #2 was interviewed via telephone on 2/11/26 at 12:29 PM. She revealed that she was sitting at the nurses' station on 12/11/25 around 2:45 PM when NA #1 called for help. When NA #2 came into the room, she saw Resident #1 sitting and slightly slanted in the wheelchair. The Medication Aide then came into the room. NA #2 indicated she (NA #2), NA #1, and the Medication Aide transferred Resident #1 to the bed. The Medication Aide and NA #1 held each of Resident #1's armpits, and NA #2 held her legs. Resident #1 was not screaming in pain or reporting pain. When the Medication Aide asked Resident #1 if she was ok, she said I'm ok, but can you give me some Tylenol? NA #2 then left the room. NA #2 stated that she was educated on 12/12/25 about fall protocol and the importance of following the Resident Care Guide details. During a follow up telephone interview with NA #2 on 2/11/26 at 4:38 PM, she revealed that she was unaware Resident #1 had an assisted fall prior to her assisting with transfer to bed. NA #2 stated if she knew about the assisted fall beforehand, she would never have transferred Resident #1 to bed and waited for a nurse's assistance. The Medication Aide was interviewed on 2/11/26 at 11:24 AM. She revealed that Resident #1 returned to the facility around 12:00 PM on 12/11/25 and Resident #1 said she was ready to go back to bed and asked NA #1, who was passing meal trays to help her. NA #1 told Resident #1 she would do so after meal service. Resident #1 yelled again, and the Medication Aide told Resident #1 that NA #1 was busy with another resident. Then around 2:45 PM, NA #1 was in Resident #1's room yelling for help. When the Medication Aide came to the room, Resident #1 appeared slumped in her wheelchair, and it looked as though Resident #1 moved one inch she would fall. The Medication Aide stated she did not call for a nurse because Resident #1 was in the wheelchair, and the Medication Aide did not witness a fall. There were not any mechanical lifts available at the time. After she saw Resident #1 slumped in the wheelchair, she and two other staff members (NA #1 and NA #2) helped Resident #1 into bed. NA #1 then retrieved the Unit Manager who came to assess Resident #1 and Resident #1 expressed 10/10 pain (a pain scale of 0 (zero) is no pain and a pain scale of 10 is the worst pain possible) in her right shoulder. The Medication Aide then administered 5mg of oxycodone. The Medication Aide indicated every time Resident #1 returned from dialysis, Resident #1 requested a pain pill due to 10/10 on the pain scale. The pain medication was effective on 12/11/25 at 2:47 PM, and there were no further issues with Resident #1 prior to shift change at 7:00 PM when she gave report to the oncoming nurse. During a follow up interview with the Medication Aide on 2/11/26 at 3:30 PM, she revealed that the reason why she, NA #1, and NA #2 transferred Resident #1 from the wheelchair to the bed after the assisted fall was because she was not aware Resident #1 had an assisted fall until after the transfer from the wheelchair to the bed. The Medication Aide stated her first thought was to get Resident #1 in bed and did not think about adjusting Resident #1 in the wheelchair first. A nursing note dated 12/11/25 at 4:53 PM and completed by the Unit Manager revealed that she was made aware that Resident #1 had an assisted fall around 2:45 PM. Upon entering the room, Resident #1 was assisted back to bed by NA #1, NA #2, and the Medication Aide. Resident was noted in the center of the bed holding her right shoulder with the left hand. Resident stated, I was yelling because I wanted to get back in bed because I was hurting. The girl sat me on the floor. The Unit Manager assessed Resident #1, vital signs were obtained, and a head-to-toe evaluation was completed. No new skin issues were noted. Oxycodone 5mg was administered. The on-call provider was contacted, and an order for x-ray of the right arm and right shoulder was entered. A change of condition assessment dated [DATE] at 1:00 PM completed by the Unit Manager revealed that after the on-call provider was contacted due to new acute pain, they recommended an x-ray to Resident #1's right shoulder and right arm and as needed pain medication. An electronic medication administration record note dated 12/11/25 at 2:47 PM and (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	completed by the Medication Aide revealed that Resident #1 received 5mg of Oxycodone for pain and was effective. A telehealth on-call provider note dated 12/11/25 (no time specified) revealed that the Unit Manager reported Resident #1 had an assisted fall and now complaining of 10/10 pain in her right shoulder. Oxycodone 5mg was administered for pain, along with an order given for an x-ray of the right shoulder and right arm. Rounding provider to follow up. A physician order for a 2-view portable x-ray of the right shoulder and right arm one time only for pain was entered on 12/11/25. The x-ray report of Resident #1's right shoulder and right arm dated 12/11/25 showed no fractures or breaks. An electronic Medication Administration Record note dated 12/11/25 at 2:47 PM and completed by the Medication Aide revealed that Resident #1 received 5mg of Oxycodone for pain and was effective. The Unit Manager was interviewed on 2/11/26 at 12:36 PM. She revealed that if a resident had a fall, she would assess the resident to ensure there were no injuries before moving the resident. On 12/11/25 around 2:45 PM, she was made aware of Resident #1's assisted fall from NA #1. Once she arrived at the room, Resident #1 was already back in bed, and the Unit Manager assessed her. When asked what happened, Resident #1 told her that she was lowered to the floor earlier. Resident #1 reported 10/10 pain to her right shoulder and received pain medication. A head-to-toe skin assessment revealed no concerns or injuries. The Unit Manager indicated Resident #1 had a history of pain, but the shoulder pain was new. The Unit Manager stated she did not hear of any further concerns with Resident #1 when she left the facility at 5:00 PM that evening. Education was provided to all staff on 12/12/25 related to following the Resident Care Guide and fall protocol. She could not recall if any nursing staff reported any issues with the mechanical lifts on 12/11/25. During a follow-up interview with the Unit Manager on 2/11/26 at 3:25 PM, she revealed that a licensed nurse must assess a resident after a fall prior to staff moving them. The Unit Manager stated that NA #1 should not have moved Resident #1 after the assisted fall, and all three nursing staff should not have transferred Resident #1 to bed before the Unit Manager arrived at the room. Verbal education was provided to all three staff members (NA #1, NA #2, and the Medication Aide) immediately after the incident about waiting for a nurse to assess the resident after a fall. A nursing progress note dated 12/11/25 at 10:39 PM by Nurse #1 revealed that Nurse #1 went into Resident #1's room during rounds around 7:20 PM. Resident #1 complained of pain to her right shoulder and back after the assisted fall earlier in the day. A large soft ball sized area to the upper right part of her chest was observed. When the area was palpated, Resident #1 stated, yea that's where it hurts. The on-call provider was contacted at 7:30 PM and gave a verbal order to transfer Resident #1 to the emergency department (ED) for further evaluation. A telehealth on-call provider note dated 12/11/25 (no time specified) revealed that Nurse #1 reported that Resident #1 complained of 10/10 pain adjacent to her right shoulder and now has a large hematoma forming above the dialysis site on the right arm. Orders were given for Resident #1 to be transferred to the ED. A Change in Condition Evaluation dated 12/11/25 at 9:00 PM by Nurse #1 revealed that Resident #1 had swelling noted to the right side of her chest below the shoulder. Resident #1 expressed a 10/10 pain scale due to acute musculoskeletal pain. Oxycodone 5mg was administered but ineffective. The on-call provider was notified at 7:30 PM to send Resident #1 to the ED for further evaluation. An ED provider note from the hospital dated 12/11/25 revealed Resident #1 presented with acute swelling of the right chest wall and the exam revealed a large, tense hematoma approximately the size of a grapefruit. There were no complications to Resident #1's dialysis access site on her right arm. Her hemoglobin was low at 9.0 grams/deciliter, but she remained stable in the ED. An x-ray of Resident #1's right breast showed a hematoma that measured 8 cm (centimeters) by 8 cm by 9 cm with active bleeding. The ED Physician further documented he had contacted another hospital with a higher (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	level of care for possible transfer for interventional radiology services for potential embolization of blood vessels. On 12/12/25 at 11:28 AM Resident #1 was transferred to the second hospital. A hospital Discharge summary dated [DATE] revealed that Resident #1 was admitted on [DATE] and the principal problem was an arterial (the blood vessels that carry oxygen rich blood away from the heart) hemorrhage. On 12/12/25 Resident #1 underwent a VIR (Vascular and Interventional Radiology) embolization (minimally invasive procedure performed by vascular and interventional radiologists to block or close off a specific blood vessel using embolic agents, often guided by real-time imaging such as fluoroscopy, CT, or ultrasound). Resident #1 developed repeat bleeding concerns 12/14/25 and stabilized without intervention. On 12/18/25 trauma surgery performed a hematoma evacuation (a surgical procedure to remove a localized collection of blood outside blood vessels, often necessary when a hematoma causes pressure or complications). The hospital discharge summary indicated resident was discharged back to the facility on [DATE] with an appointment to follow up with the surgeon on 12/30/25 for follow up of the right breast hematoma with drain placement. An interview was attempted with Resident #1 on 2/11/26 at 11:18 AM; however, she was not alert and oriented and refused to answer any questions related to the incident on 12/11/25. Interim Administrator #2 was interviewed via telephone on 2/12/26 at 8:09 AM. She revealed that the focus of the incident with Resident #1 after an investigation revealed that nursing staff must notify a licensed nurse if a resident fell, so that the resident could be assessed prior to transfer/movement. Education to all nursing staff included following the Resident Care Guide for all details, including transfers with a mechanical lift, as well as following fall protocol. The Director of Nursing (DON) was interviewed on 2/11/26 at 2:20 PM. The DON stated NA #1 was new to the facility and tried to transfer Resident #1 back to bed with a stand pivot transfer on 12/11/25, and Resident #1 could not support herself on her feet. NA #1 stated she assisted Resident #1 to the floor. NA #1 indicated she lifted Resident #1 back up into the wheelchair and then NA #1 went to get assistance from NA #2 and the Medication Aide. All three staff members transferred Resident #1 back to bed. After Resident #1 was transferred back to bed, the Medication Aide was told by NA #1 that Resident #1 had an assisted fall, and the Unit Manager was retrieved by NA #1. The DON stated that NA #1 should not have done a stand pivot transfer with Resident #1 and was expected to follow the Resident Care Guide for all transfer details. After the assisted fall, Resident #1 should have been left on the ground until a nurse arrived to assess. NA #1, NA #2, and the Medication Aide transferred Resident #1 from the wheelchair to the bed because it looked like Resident #1 was going to fall out of the chair. The DON stated Resident #1 should have been adjusted in the wheelchair so that she was safe instead of being transferred back to bed. The DON further stated that nothing was said to her about the mechanical lift batteries dead on 12/11/25. However, NA #1 did say that she could not locate a free mechanical lift when Resident #1 wanted to be transferred to bed. The interview further revealed education provided to all nursing staff on 12/12/25 and included what to do after a fall, how to use the Resident Care Guide, and fall prevention. Included in the fall protocol was if an NA found a resident on the floor or assisted a resident to the floor, they were instructed not to move them before a licensed nurse assessed the resident. During a joint interview with the DON and interim Administrator #1 on 2/11/26 at 4:35 PM, they revealed that NA #1 should have notified a nurse immediately when the assisted fall took place. NA #1 should not have moved or transferred Resident #1 prior to a nurses' assessment. The facility provided the following corrective action plan with a completion date of 12/17/25: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident # 1 was admitted to the facility on [DATE] with a diagnosis of dementia, portal vein thrombosis, aneurysm of the upper (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	extremity artery, end stage renal disease on hemodialysis, and diabetes. Medications included anticoagulants. Resident #1 was alert, oriented and able to make needs known. On 12/11/25, at approximately 1:45 PM, Resident #1 returned to the facility from dialysis, ate lunch, and then requested to be put back into bed. The assigned Nursing Assistant #1 (NA) entered Resident #1's room at approximately 2:45 PM. Resident #1 requested to be put to bed and despite knowing that Resident #1 required a lift for transfer, NA #1 attempted to complete a stand pivot transfer from the wheelchair to the bed. Resident #1 was unable to complete the transfer; NA #1 lowered the resident safely to the floor. The resident had no complaints about pain. NA #1 then assisted Resident #1 back into the wheelchair by placing her arms under the resident's arms and her knees against the resident's knees and lifted the resident slightly back into the wheelchair sitting on the edge of the seat of the wheelchair. NA #1 did not report the assisted fall to the nurse and did not get a nurse to assess the resident before moving Resident #1 to the wheelchair. At approximately 2:50pm NA #1 asked NA #2 and the Medication Aide for assistance with transferring Resident #1 from the wheelchair to the bed. NA #1 did not inform NA #2, or the Medication Aide of Resident #1's assisted fall to the floor. After transferring Resident #1 to the bed, NA #1 then advised the Medication Aide that prior to transferring from the chair to bed, Resident #1 had been assisted to the floor. The Medication Aide did not get a nurse to assess the resident before moving the resident to bed. The Medication Aide immediately reported the fall to the Unit Manager. The Unit Manager completed an assessment of the resident with no visible injury. At approximately 3:05 pm, the Unit Manager notified the on-call provider of Resident #1's assisted fall and complaints of right arm pain. The on-call provider ordered an x-ray for the right arm and shoulder. The resident representative (RR) was unable to be reached, and a detailed message was left to return call to facility. At approximately 7:00 PM, the x-ray was completed with no fractures identified. During the evening shift, at approximately 7:20 PM, Nurse #1 assessed Resident #1 and noted a softball size area on her upper chest. When palpated, Resident #1 stated it hurt. Nurse #1 notified a different on-call provider with new orders to send Resident #1 to the hospital for evaluation and treatment. At approximately 7:33pm, the resident representative was updated on Resident #1's condition and the order to transfer to the hospital. Diagnosis at the hospital was a right chest wall hematoma. On 12/12/25, Resident #1 was taken to Interventional Radiology for embolization to control bleeding. On 12/18/25, Resident #1 was taken back to the operating room for a surgical procedure to remove the hematoma and remained hemodynamically stable. Address how the facility will identify other residents having the potential to be affected by the same deficient practice. On 12/12/25, interim Administrator #2 completed an audit of all incident reports for the past 30 days. This audit was to ensure staff immediately notified the nurse of all falls (assisted or unassisted) and not moved a resident until assessed by the nurse. There were no additional concerns identified. On 12/12/25, interim Administrator #2, Staff Development Coordinator, Nurse Supervisor, Unit Manager, and the Director of Nursing (DON) initiated questionnaires with all nurses and nursing assistants regarding transfers. The questionnaires include (1) Do you know of any incidents during a transfer that has not been reported or addressed? (2) Where do you access the resident care guide? (3) when should you check the resident care guide for transfers? Interim Administrator #2, Staff Development Coordinator, Nurse Supervisor, Unit Manager, and/or DON addressed all concerns identified during the audit to include training of staff. The questionnaires were completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who had not worked or completed the questionnaire completed it prior to the next scheduled work shift. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On 12/12/25, interim Administrator #2, Staff Development (continued on next page)

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F 0684 Level of Harm - Actual harm Residents Affected - Few	Coordinator, Nurse Supervisor, Unit Manager, and the Director of Nursing (DON) initiated questionnaires with all nurses and nursing assistants regarding transfers. The questionnaires include (1) Do you know of any incidents during a transfer that has not been reported or addressed? (2) Where do you access the resident care guide? (3) when should you check the resident care guide for transfers? Interim Administrator #2, Staff Development Coordinator, Nurse Supervisor, Unit Manager, and/or DON addressed all concerns identified during the audit to include training of staff. The questionnaires were completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who had not worked or completed the questionnaire completed it prior to the next scheduled work shift. On 12/12/25, the DON, SDC, Nurse Supervisor, and Unit Manager initiated an in-service with all nurses and NAs to include NA #1 and agency regarding Fall Protocol with emphasis on (1) Definition of a fall (2) immediately notifying the nurse of a fall (assisted or unassisted) or a near miss fall and (3) never moving a resident following a fall until assessed by the nurse. The in-service was completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who did not complete the training completed it upon the next scheduled work shift. All newly hired nurses and/or NAs to include agency staff will be educated during orientation by the SDC, DON, or Unit Managers. On 12/12/25, interim Administrator #2 notified the DON of the responsibility to monitor completion of all in-services and questionnaires to ensure compliance for resident safety. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained. On 12/12/25, the decision was made by interim Administrator #2 to monitor the plan for immediate notification of the nurse of resident falls and to ensure residents are not moved until assessed by a nurse and presented the plan of correction to the Quality Assurance Performance Improvement (QAPI) committee to include the Assistant Administrator, Director of Nursing, Unit Managers, Quality Assurance nurse, Staff Development Coordinator, Medical Records, Social Worker, and Minimum Data Set Nurse on 12/12/25. The DON will complete review 5% of residents falls weekly x 4 weeks then monthly x 2 months to ensure the staff immediately notified the nurse of all incidents to include falls and that the residents were not moved following a fall until assessed by the nurse. The DON will address all concerns identified during the audit to include but not limited to re-training of staff. The DON forwarded the Incident Review to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months for review and determination of trends and/or issues that may need further interventions put into place to determine the need for further and/or frequency of monitoring. Alleged date of compliance: 12/17/25 The facility's corrective action plan was validated on 2/11/26. The validation process included staff interviews, record reviews, review of education provided to nursing staff, and review of initial auditing and monitoring audits. The training for staff included fall protocol (notification to a licensed nurse and no movement of resident until assessed), following the Resident Care Guide (including which residents required a mechanical lift), and how to use/where to find the mechanical lifts. During interviews staff confirmed they had received the education and were able to verbalize an accurate summary of the education. Review of incident report audits and nursing staff questionnaires revealed that they were completed as specified in the plan of correction and resulted with no issues. Observations of resident transfers revealed no concerns. The facility's corrective action plan compliance date of 12/17/25 was validated.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345113	A. Building B. Wing	02/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Willow Creek Nursing and Rehabilitation Center	2401 Wayne Memorial Drive Goldsboro, NC 27534

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with staff and Medical Director, the facility failed to follow the Resident Care Guide and use a mechanical lift prior to the transfer of a resident (Resident #1). On 12/11/25, at approximately 1:45 PM, Resident #1 returned to the facility from dialysis, ate lunch, and then requested to be put back into bed. Nursing Assistant #1 (NA) did not see any mechanical lifts immediately available and entered Resident #1's room at approximately 2:45 PM. Despite knowing that Resident #1 required a mechanical lift for all transfers, NA #1 attempted to complete a stand pivot transfer from the wheelchair to the bed. Resident #1's legs gave out and NA #1 lowered the resident to the floor. NA #1 then assisted the resident back into the wheelchair. At approximately 2:50 PM NA #1 asked NA #2 and Medication Aide for assistance with transferring the resident from the wheelchair to the bed. When Resident #1 was assisted into bed without a mechanical lift, she complained of right shoulder pain. The pain was treated with as needed pain medication; however, it was ineffective. An x-ray ordered for the right arm and shoulder did not result in a fracture. At approximately 7:20 PM, Resident #1 was noted to have a softball size area on her upper chest and when palpated and the resident stated it hurt. New orders were received to send the resident to the hospital emergency department (ED) for evaluation and treatment. The ED Physician documented there was acute swelling of the right chest wall and the exam revealed a large tense hematoma approximately the size of a grapefruit. The results of the chest x-ray revealed a right chest wall hematoma (localized collection of blood that has leaked from damaged blood vessels into the tissues of the chest wall) with active bleeding. On 12/12/25 at 11:28 AM Resident #1 was transferred to the second hospital with a higher level of care and that same day underwent a VIR (Vascular and Interventional Radiology) embolization (minimally invasive procedure performed by vascular and interventional radiologists to block or close off a specific blood vessel using embolic agents, often guided by real-time imaging such as fluoroscopy, CT, or ultrasound). Resident #1 developed repeat bleeding concerns 12/14/25 and stabilized without intervention. On 12/18/25 trauma surgery performed a hematoma evacuation (a surgical procedure to remove a localized collection of blood outside blood vessels, often necessary when a hematoma causes pressure or complications). The hospital discharge summary indicated resident was discharged back to the facility on [DATE] with an appointment to follow up with the surgeon on 12/30/25 for follow up of the right breast hematoma with drain placement. The deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #1). Findings included: Resident #1 was admitted to the facility on [DATE] with diagnoses including dementia, end stage renal disease (ESRD) with dependence on dialysis (HD), and diabetes. Resident #1 was sent to the hospital on [DATE] and was transferred to a higher-level care hospital on [DATE]. She returned to the facility on [DATE]. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #1 was cognitively intact, had moderate difficulty hearing, and severely impaired vision. She was totally dependent on staff for transfers. Resident #1 received as needed pain medication, and pain presence was occasional. Review of the Resident Care Guide implemented on 11/13/23 and contained in the care plan revealed that Resident #1 required a mechanical lift of one person assist with all transfers. The sling size was medium. The care plan was revised on 1/16/25 and included the problem of activities of daily living (ADL)/personal care. Interventions included: Mechanical lift. Review of physician orders for Resident #1 revealed Oxycodone (opioid pain medication) 5 milligram (mg) tablet to be given every 4 hours as needed for pain was ordered from 7/22/25 through 12/19/25. Resident #1 also received Eliquis (blood thinner medication which raises the risk of bruising and bleeding) 2.5mg tablet to be given (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	twice daily for history of portal vein thrombus (blood clot that obstructs the vein carrying blood to the liver). NA #1 was interviewed on 2/11/26 at 11:58 AM. She revealed that the Resident Care Guide contained resident transfer details. NA #1 stated that Resident #1 was alert most of the time and required a mechanical lift for all transfers. On 12/11/25 around 12:00 PM, Resident #1 returned from dialysis while NA #1 was in the middle of lunch meal service. Resident #1 requested to be transferred to bed because she was tired and hurting, which was usual for her after dialysis. NA #1 told Resident #1 that she could help her after meal service was complete. When NA #1 went to retrieve the mechanical lift, the two lifts in her section did not have any charge. NA #1 stated she told Resident #1 that she would have to wait a little longer since both mechanical lifts were not available at the time. Resident #1 was adamant about being transferred to bed immediately. Around 2:45 PM, NA #1 decided to accommodate Resident #1's request without a mechanical lift. As soon as NA #1 lifted Resident #1 out of the wheelchair, Resident #1 complained about her legs and began to panic. Resident #1 put all her weight on NA #1, and NA #1 assisted Resident #1 to the floor. NA #1 stated she did not want to leave Resident #1 on the floor and felt she needed to get her off the floor, so she lifted Resident #1 from the floor back to the wheelchair. However, Resident #1 appeared slumped in the wheelchair, and NA #1 pulled her more upright in the wheelchair. NA #1 then called for help and the Medication Aide and NA #2 entered the room. All three staff members lifted Resident #1 into the bed. NA #1 stated she then went and told the Unit Manager about the assisted fall. When the Unit Manager came to the room, she asked Resident #1 if she was hurting. Resident #1 responded that she felt pain in her right arm. The Unit Manager assessed her right arm and found no injuries. The Medication Aide provided Resident #1 with as needed pain medication. NA #1 stated that she received education on 12/12/25 to always follow the Resident Care Guide, including the use of a mechanical lift for Resident #1 with all transfers. During a follow up telephone interview with NA #1 on 2/11/26 at 4:09 PM, she revealed that Resident #1 was normally transferred from a stretcher to the bed by transportation personnel after all dialysis appointments. NA #1 stated that on 12/11/25, it was the first time she ever transferred Resident #1 to bed after dialysis. However, this day was different because a different transportation vendor was used to bring Resident #1 to/from dialysis on 12/11/25. Since Resident #1 refused to wait for an available mechanical lift on 12/11/25, NA #1 stated she just wanted to get Resident #1 in bed before shift change at 3:00 PM. She further stated that she already knew a mechanical lift was required to transfer Resident #1. NA #2 was interviewed via telephone on 2/11/26 at 12:29 PM. She revealed that she was sitting at the nurses' station on 12/11/25 around 2:45 PM when NA #1 called for help. When NA #2 came into the room, she saw Resident #1 sitting and slightly slanted in the wheelchair. The Medication Aide then came into the room. NA #2, NA #1, and the Medication Aide transferred Resident #1 to the bed. The Medication Aide and NA #1 held each of Resident #1's armpits, and NA #2 held her legs. Resident #1 was not screaming in pain or reporting pain. When the Medication Aide asked Resident #1 if she was ok, she said I'm ok, but can you give me some Tylenol? NA #2 then left the room. NA #2 stated that she was educated on 12/12/25 about fall protocol and the importance of following the Resident Care Guide details. The Medication Aide was interviewed on 2/11/26 at 11:24 AM. She revealed that Resident #1 returned to the facility around 12:00 PM on 12/11/25. Resident #1 said she was ready to go back to bed and asked NA #1, who was passing meal trays, to help her. NA #1 told Resident #1 she would do so after meal service. Resident #1 yelled again, and the Medication Aide told Resident #1 that NA #1 was busy with another resident. Then around 2:30 PM, NA #1 was in Resident #1's room yelling for help. When the Medication Aide came to the room, Resident #1 appeared slumped in her wheelchair, and it looked as though Resident #1 moved one inch she would fall. (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	There were not any mechanical lifts available at the time. After she saw Resident #1 slumped in the wheelchair, she and two other staff members (NA #1 and NA #2) helped Resident #1 into bed. A nursing note dated 12/11/25 at 4:53 PM and completed by the Unit Manager revealed that she was made aware that Resident #1 had an assisted fall around 2:45 PM. Upon entering the room, Resident #1 was assisted back to bed by NA #1, NA #2, and the Medication Aide. Resident was noted in the center of the bed holding her right shoulder with the left hand. Resident stated, I was yelling because I wanted to get back in bed because I was hurting. The girl sat me on the floor. The Unit Manager assessed Resident #1, vital signs were obtained, and a head-to-toe evaluation was completed. No new skin issues were noted. Oxycodone 5mg was administered. The on-call provider was contacted, and an order for x-ray of the right arm and right shoulder was entered. During an interview with the Unit Manager on 2/11/26 at 3:25 PM, she revealed that if a mechanical lift battery was dead, she would expect nursing staff to find another lift battery for replacement. If none were charged, staff should let the resident know, or whoever requested the transfer, and check back on the charge in 30-60 minutes. When they finished using a mechanical lift, nursing staff were expected to plug it back in. Verbal education was provided to all 3 staff members (NA #1, NA #2, and the Medication Aide) immediately after the incident about waiting or a lift to be available prior to transferring a resident whose Resident Care Guide stated a lift was required. A change of condition assessment dated [DATE] at 1:00 PM completed by the Unit Manager revealed that after the on-call provider was contacted due to new acute pain, they recommended an x-ray to Resident #1's right shoulder and right arm and as needed pain medication. An electronic medication administration record note dated 12/11/25 at 2:47 PM and completed by the Medication Aide revealed that Resident #1 received 5mg of Oxycodone for pain and was effective. A telehealth on-call provider note dated 12/11/25 (no time specified) revealed that the Unit Manager reported Resident #1 had an assisted fall and now complaining of 10/10 pain in her right shoulder. Oxycodone 5mg was administered for pain, along with an order given for an x-ray of the right shoulder and right arm. Rounding provider to follow up. A physician order for a 2-view portable x-ray of the right shoulder and right arm one time only for pain was entered on 12/11/25. The x-ray report of Resident #1's right shoulder and right arm dated 12/11/25 showed no fractures or breaks. A nursing progress note dated 12/11/25 at 10:39 PM by Nurse #1 revealed that Nurse #1 went into Resident #1's room during rounds around 7:20 PM. Resident #1 complained of pain to her right shoulder and back after the assisted fall earlier in the day. A large soft ball sized area to the upper right part of her chest was observed. When the area was palpated, Resident #1 stated, yea that's where it hurts. The on-call provider was contacted at 7:30 PM and gave a verbal order to transfer Resident #1 to the emergency department (ED) for further evaluation. A telehealth on-call provider note dated 12/11/25 (no time specified) revealed that Nurse #1 reported that Resident #1 complained of 10/10 (a pain scale of 0 (zero) is no pain and a pain scale of 10 is the worst pain possible) pain adjacent to her right shoulder and now has a large hematoma forming above the dialysis site on the right arm. Orders were given for Resident #1 to be transferred to the ED. A Change in Condition Evaluation dated 12/11/25 at 9:00 PM by Nurse #1 revealed that Resident #1 had swelling noted to the right side of her chest below the shoulder. Resident #1 expressed a 10/10 pain scale due to acute musculoskeletal pain. Oxycodone 5mg was administered but ineffective. The on-call provider was notified at 7:30 PM to send Resident #1 to the ED for further evaluation. An ED provider note from the hospital dated 12/11/25 revealed Resident #1 presented with acute swelling of the right chest wall and the exam revealed a large, tense hematoma approximately the size of a grapefruit. There were no complications to Resident #1's dialysis access site on her right arm. Her hemoglobin was low at 9.0 grams/deciliter, but she remained (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	stable in the ED. An x-ray of Resident #1's right breast showed a hematoma that measured 8 cm (centimeters) by 8 cm by 9 cm with active bleeding. The ED Physician further documented he had contacted another hospital with a higher level of care for possible transfer for interventional radiology services for potential embolization of blood vessels. On 12/12/25 at 11:28 AM Resident #1 was transferred to the second hospital. A hospital Discharge summary dated [DATE] revealed that Resident #1 was admitted on [DATE] and the principal problem was an arterial (the blood vessels that carry oxygen rich blood away from the heart) hemorrhage. On 12/12/25 Resident #1 underwent a VIR (Vascular and Interventional Radiology) embolization (minimally invasive procedure performed by vascular and interventional radiologists to block or close off a specific blood vessel using embolic agents, often guided by real-time imaging such as fluoroscopy, CT, or ultrasound). Resident #1 developed repeat bleeding concerns 12/14/25 and stabilized without intervention. On 12/18/25 trauma surgery performed a hematoma evacuation (a surgical procedure to remove a localized collection of blood outside blood vessels, often necessary when a hematoma causes pressure or complications). The hospital discharge summary indicated resident was discharged back to the facility on [DATE] with an appointment to follow up with the surgeon on 12/30/25 for follow up of the right breast hematoma with drain placement. An interview was attempted with Resident #1 on 2/11/26 at 11:18 AM; however, she was not alert and oriented and refused to answer any questions related to the incident on 12/11/25. Interim Administrator #2 was interviewed via telephone on 2/12/26 at 8:09 AM. She revealed that the focus of the incident after an investigation revealed that nursing staff must use a mechanical lift for all required residents. Education for all nursing staff included following the Resident Care Guide for all details, including transfers with a mechanical lift. The Medical Director was interviewed via telephone on 2/11/26 at 2:32 PM. He revealed that hematomas could occur adjacent to the area affected or touched and the hematoma could have taken days to develop. If pressure was applied to Resident #1's armpit, it could have caused hematoma. Also, regular contact with pressure could cause a hematoma. More than likely, the injury did not occur because of the fall but rather how she was transferred. The Medical Director stated that the hematoma was not preventable due to the extent of Resident #1's medical conditions and fragility. The Director of Nursing (DON) was interviewed on 2/11/26 at 2:20 PM. The DON stated that NA #1 should not have done a stand pivot transfer with Resident #1 and was expected to follow the Resident Care Guide for all transfer details. After the assisted fall, Resident #1 should have been left on the ground until a nurse arrived to assess. NA #1, NA #2, and the Medication Aide transferred Resident #1 from the wheelchair to the bed because it looked like Resident #1 was going to fall out of the chair. At that time, the DON stated Resident #1 should have been adjusted in the wheelchair, so that she was safe. The DON further stated that nothing was said to her about the mechanical lift batteries being dead on 12/11/25. However, NA #1 did say that she could not locate a free mechanical lift when Resident #1 wanted to be transferred to bed. During a joint interview with the DON and interim Administrator #1 on 2/11/26 at 4:35 PM, they revealed that NA #1 should have followed the Resident Care Guide and not attempted to transfer Resident #1 without a mechanical lift. During a follow up telephone interview with the DON on 2/13/26 at 10:25AM, she revealed that NA #1 should have looked at other nurse stations for an available mechanical lift. The DON stated NA #1 only checked the area was she was assigned. If a mechanical lift was not available immediately, NA #1 should have notified Resident #1 and waited until a mechanical lift became available. NA #1 could have asked other nursing staff to assist her with finding a mechanical lift or notify the Unit Manager. The facility provided the following corrective action plan with a completion date of 12/17/25: Address how corrective action will be accomplished for those residents found to have been affected by the (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	deficient practice. Resident #1 was alert, oriented and able to make her needs known. On 12/11/25, at approximately 1:45 PM, Resident #1 returned to the facility from dialysis, ate lunch, and then requested to be put back into bed. The assigned Nursing Assistant #1 (NA) entered Resident #1's room at approximately 2:45 PM. Resident requested to be put to bed and despite knowing that resident required a lift for transfer, NA #1 attempted to complete a stand pivot transfer from the wheelchair to the bed. Resident #1 was unable to complete the transfer; NA #1 lowered the resident safely to the floor. The resident had no complaints about pain. NA #1 then assisted the resident back into the wheelchair by placing her arms under the resident's arms and her knees against the resident's knees and lifted the resident slightly back into the wheelchair sitting on the edge of the seat of the wheelchair. NA #1 did not report the assisted fall to the floor to the nurse prior to moving the resident back to the wheelchair. At approximately 2:50pm NA #1 asked NA #2 and the Medication Aide for assistance with transferring the resident from the wheelchair to the bed. NA #1 did not inform NA #2, or the Medication Aide of the resident's assisted fall to the floor. Two staff were placed at the resident's upper body, and the third staff member was at the resident's feet. The three staff lifted the resident up out of the chair and onto the bed instead of utilizing the lift due to the positioning of the resident on the edge of the wheelchair seat and the potential risk of falling. After the resident was transferred, the resident was observed holding her arm and complaining of pain. NA #1 then advised the Medication Aide that prior to transferring from chair to bed, the resident had been assisted to the floor. The Medication Aide immediately reported the fall to the Unit Manager. The Unit Manager completed an assessment of the resident with no visible injury. At approximately 3:05 pm Nurse #1 notified the on-call provider of Resident #1's assisted fall and complaints of right arm pain. The on-call provider ordered an x-ray for right arm and shoulder. The resident representative (RR) was unable to be reached, and a detailed message was left to return call to facility. At approximately 7:00 PM, the x-ray was completed with no fractures identified. During the evening shift, at approximately 7:20 PM, Nurse #1 assessed Resident #1 and noted a softball size area on her upper chest. When palpated, Resident #1 stated that it hurt. Nurse #1 notified the on-call provider with new orders to send Resident #1 to the hospital for evaluation and treatment. At approximately 7:33pm, the resident representative was updated on Resident #1's condition and the order to transfer to the hospital. Diagnosis at the hospital was a right chest wall hematoma.Address how the facility will identify other residents having the potential to be affected by the same deficient practice.On 12/12/25, the treatment nurses completed skin checks of all residents not able to report for acute changes to include injuries not reported or addressed. There were no additional concerns identified. On 12/15/25, the Social Worker (SW) initiated resident questionnaires with current alert and oriented residents to identify any concerns related to transfer that had not been previously reported or addressed. The questionnaires were completed on 12/16/25. There were no concerns identified. On 12/12/25, the Minimum Data Set Nurse under the supervision of the Director of Nursing completed an audit of all resident care plans/ care guides. This audit was to ensure the care plan/ care guide included the appropriate transfer status and/ or use of positioning devices for resident safety. There were no concerns identified during the audit. On 12/12/25, interim Administrator #2 completed an audit of all incident reports for the past 30 days. This audit was to identify any incidents related to safe handling/not following care guide. There were no additional concerns identified.On 12/16/25, the Maintenance Director completed an audit of all mechanical lifts. This audit was to ensure the facility had adequate lifts for resident care and that all lifts were functioning properly to include a fully charged battery. There were no identified concerns.On 12/12/25 Interim Administrator #2, Staff Development (continued on next page)

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F 0689 Level of Harm - Actual harm Residents Affected - Few	Coordinator (SDC), Nurse Supervisor, Unit Manager, and the Director of Nursing initiated questionnaires with all nurses and nursing assistants regarding transfers. The questionnaires include (1) Do you know of any incidents during a transfer that has not been reported or addressed (2) where do you access the resident care guide (3) when you should check the resident care guide for transfers. Interim Administrator #2, Staff Development Coordinator, Nurse Supervisor, Unit Manager, and/ or DON addressed all concerns identified during the audit to include training of staff. The questionnaires were completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who had not worked or completed the questionnaire completed it prior to the next scheduled work shift. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur.On 12/12/25, the Quality Assurance nurse educated NA #1 on safe handling with emphasis on reading and following care guide for transfers, immediately notifying the nurse of all incidents during transfer to include but not limited to falls, never moving a resident until assessed by the nurse and what to do if appropriate equipment for transfer is not available. On 12/12/25, the DON, SDC, Nurse Supervisor, and Unit Manager initiated an in-service with all nurses and NAs to include NA #1 and agency regarding Safe Handling with emphasis on (1) reading the care guide on the iPad prior to transferring a resident for the correct transfer method (2) always following care guide when providing resident care to include method of transfer (3) what to do if they do not feel the current transfer method is safe or appropriate equipment is not available (4) to ensure that the equipment/aides are stored conveniently and safely to include charging batteries when not in use and (5) consequences for failure to follow safe handling policy. The in-service included a return demonstration on how to identify the resident transfer status on the iPad and to validate staff knowledge and understanding of appropriate techniques for transferring a resident. I-pads were in all nursing stations for certified nursing assistants to complete required shift documentation. Care plan/care guides were updated automatically whenever Registered Nurse updates resident care plan in facility software, Point Click Care (PCC). The in-service and return demonstration were completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who had not completed the training with a return demonstration completed it upon the next scheduled work shift. All newly hired nurses and/or NAs to include agency staff were educated with return demonstrations during orientation by the SDC, DON, or Unit Managers. On 12/12/25, the DON, SDC, and the Unit Managers initiated quizzes with all nurses and nursing assistants regarding transfers to include (1) How do you determine the transfer status of a resident? (2) It is alright to transfer a resident using a different transfer method than listed on the care guide (3) When should you check the resident care guide? (4) What should you do if you feel the transfer status on the care guide is not accurate/ safe? And (5) What should you do if a resident complains of pain during/ following transfer? The quiz was to validate staff knowledge and understanding of education on safe handling and following care guides. Quizzes were completed by 12/16/25. After 12/16/25, any nurse or nursing assistant who had not worked or completed the quiz completed it upon the next scheduled work shift. On 12/12/25, interim Administrator #2 notified the DON of the responsibility to monitor completion of all in-serves, return demonstrations, questionnaires, and quizzes to ensure compliance for resident safety. Indicate how the facility plans to monitor its performance to make sure that solutions are sustained.On 12/12/25, the decision was made by interim Administrator #2 to monitor the plan for safe handling of residents and presented the plan of correction to the Quality Assurance Performance Improvement (QAPI) committee to include the Assistant Administrator, Director of Nursing, Unit Managers, Quality Assurance nurse, Staff Development Coordinator, Medical Records, Social Worker, and Minimum Data Set Nurse on 12/12/25. The DON and/or SDC completed 5 observations of (continued on next page)

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For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	transfers weekly for 4 weeks then monthly for 2 months to include all shifts and transfer methods with nurses and nursing assistants. This audit was to ensure sure staff followed safe handling procedures to include checking care guide prior to care to identify transfer status indicated, that the staff used appropriate technique/equipment during transfer and staff notified the nurse for any concerns identified to include falls or near miss falls. Interim Administrator #2 and/or DON reviewed all observations weekly x 4 weeks them monthly x 2 months to ensure all concerns are addressed. There were no concerns. The DON forwarded the Resident Care Transfer Audit Tools to the Quality Assurance and Performance Improvement (QAPI) Committee monthly x 3 months for review and determination of trends and/or issues that may need further interventions put into place to determine the need for further and/or frequency of monitoring. Alleged date of compliance:12/17/25The facility's corrective action plan was validated on 2/11/26. The validation process included staff interviews, record reviews, review of education provided to nursing staff, and review of initial auditing and monitoring audits. The training for staff included fall protocol (notification to a licensed nurse and no movement of resident until assessed), following the Resident Care Guide (including which residents required a mechanical lift), and how to use/where to find the mechanical lifts. During interviews staff confirmed they had received the education and were able to verbalize an accurate summary of the education. Review of incident report audits and nursing staff questionnaires revealed that they were completed as specified in the plan of correction and resulted with no issues. Observations of resident transfers revealed no concerns. The facility's corrective action plan compliance date of 12/17/25 was validated.