STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345522	A. Building B. Wing	12/12/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Fletcher Rehabilitation and Healthcare Center	86 Old Airport Road Fletcher, NC 28732

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. (continued on next page)

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 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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(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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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:Resident #1 was admitted to the facility on [DATE] 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.The quarterly Minimum Data Set (MDS) assessment dated [DATE] 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.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. Review of Resident #1's electronic health record revealed Resident #1 was not prescribed an anticoagulant. 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. 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.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 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.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. 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