STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345544	A. Building B. Wing	09/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Asbury Health and Rehabilitation Center	3211 Bishops Way Lane Charlotte, NC 28215

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 observations, record review, and resident, staff and Medical Director interviews, the facility failed to provide safe transfers using a mechanical lift. Resident #79 was dependent on staff and required the use of a mechanical lift for transfers. On 8/30/25 Nursing Assistant (NA) #1 transferred the resident twice. Resident #79 complained of left leg pain with notable swelling to her left leg and knee. X-rays obtained in the facility indicated Resident #79 had a fracture of the left distal femur (lower thigh bone near the knee joint) and she was transferred to the emergency department (ED) for further evaluation. An x-ray and computed tomography (CT) scan obtained in the ED revealed Resident #79 had an acute comminuted (broken in multiple pieces) mildly displaced (misaligned) and impacted (the broken ends of the bone jam together) fracture of the left distal femur. Resident #79 was admitted to the hospital and surgery was performed on 9/02/25 to repair the fracture. The deficient practice occurred for 1 of 3 residents reviewed for accidents (Resident #79).The findings included: Resident #79 was admitted to the facility on [DATE] with diagnoses including multiple sclerosis, quadriplegia, vitamin D deficiency and essential hypertension. The quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #79 was cognitively intact, always incontinent of bowel and bladder, dependent on staff for activities of daily living (ADL) including toileting hygiene, bathing, and transfers. Resident #79 was coded for having upper and lower extremity impairment on both sides and used a motorized wheelchair with set up assistance. The MDS further revealed Resident #79's speech was unclear but usually understood. The care plan dated 8/16/25 indicated Resident #79 had limited physical mobility due to a diagnosis of multiple sclerosis, utilized a powered wheelchair for mobility and required 2-person assistance and the use of a mechanical lift for all transfers. An interview conducted with NA #1 on 9/24/25 at 9:16 AM revealed she was working on the 400-hall and assigned to Resident #79 during first shift (7:00 AM to 3:00 PM) on 8/30/25. She stated Resident #79 was dependent on staff for all care, was non-ambulatory and was transferred with the mechanical lift. She stated Resident #79 made no attempts to get up on her own and she was not aware of any recent falls or incidents. NA #1 revealed on 8/30/25 at approximately 7:00 AM Resident #79 was in bed and she assisted her with morning care. She indicated at approximately 7:30 AM NA #2 assisted her with transferring Resident #79 from the bed to her motorized wheelchair using the mechanical lift and Resident #79 drove herself to the dining room for breakfast. She indicated at approximately 11:00 AM she and NA #2 used the mechanical lift to transfer Resident #79 to the bed to provide incontinent care and then back into the wheelchair. NA #1 revealed at approximately 11:30 AM Resident #79 went to lunch in the dining room with her Responsible Party and was with her RP until she went to Bingo around 1:30 PM. She stated Resident #79 remained in Bingo until after her shift ended at 3:00 PM and she did not provide any care for Resident #79 after 11:30 AM. NA #1 revealed she was not aware of any staff training or safety interventions that were put in place regarding Resident #79 using the motorized wheelchair. An interview with NA #2 on 9/24/25 at 11:20 AM revealed she was working on the 400-hall during first shift on 8/30/25 but was not assigned to Resident #79. She stated Resident #79 was dependent on staff for care and was unable to roll in bed or get up without assistance. NA #2 revealed that Resident #79 was transferred using the mechanical lift and required the assistance of two people. She stated on 8/30/25 NA #1 did not ask for her assistance with transferring Resident #79 at any time during her shift, nor did she assist with any of Resident #79's care. She stated at approximately 1:15 PM the RP requested for Resident #79 to lay down before Bingo, so she went with Nurse #2 to assist with the transfer. NA #2 revealed when they went to Resident #79's room the Activities Director arrived a few minutes later to take her to Bingo so they did not transfer her, and she remained in her motorized wheelchair. A follow-up interview was conducted with NA #1 on 9/25/25 at 12:03 PM. She stated on 8/30/25 at approximately 7:30 AM she transferred Resident #79 from the bed into the wheelchair using the mechanical lift without the assistance of another staff member. She revealed at approximately 11:00 AM she transferred Resident #79 from the wheelchair to the bed to provide incontinent care and then transferred her from the bed back to the wheelchair using the mechanical lift without the assistance of a second person. She stated no incidents or injuries to Resident #79 occurred during the transfers nor did she complain of any pain or discomfort. NA #1 indicated she should have requested a second person assist her with the transfers however she felt comfortable transferring Resident #79 using the lift alone and did not request assistance from any other staff members. A phone interview with the Activities Director on 9/24/25 at 10:14 PM revealed