STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345555	A. Building B. Wing	12/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillcrest Raleigh at Crabtree Valley	3830 Blue Ridge Road Raleigh, NC 27612

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 - Minimal harm or potential for 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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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).Findings included:Resident #1 was admitted to the facility on [DATE] 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.Review of the quarterly Minimum Data Set (MDS) dated [DATE] 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.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.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.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.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 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.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.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.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