STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	**3864 Sweeten Creek Road , Arden, North Carolina, 28704**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0000	INITIAL COMMENTS An unannounced complaint survey was conducted on 5/5/2026. Additional information was obtained offsite on 5/6/2026 through 5/8/2026. The survey team returned to the facility on 5/12/2026 to validate the corrective action plan, therefore, the exit date was changed to 5/12/2026. The following intake was investigated #3000654 which resulted in immediate jeopardy. 1 of the 3 complaint allegations resulted in deficiency. Past noncompliance was identified at: CFR 483.25 at tag F684 at a scope and severity (J). CFR 483.25 at tag F689 at a scope and severity (J). The tags F684 and F689 constituted Substandard Quality of Care. A partial extended survey was conducted. Immediate Jeopardy for F684 began on 3/2/2026. The IJ removal date and substantial compliance date was 3/5/2026. Immediate Jeopardy for F689 began on 3/2/2026. The IJ removal date and substantial compliance date was 3/5/2026.	F0000		
F0684 SS = SQC-J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is NOT MET as evidenced by:	F0684	"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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F0684 SS = SQC-J	Continued from page 1 Based on record review, resident, staff, Nurse Practitioner and Medical Director interviews, Driver #1 failed to have Resident #1 assessed for injury by a qualified medical professional prior to moving the resident following a fall in the transportation van. Resident #1's wheelchair tipped over backwards with Resident #1 in the wheelchair resulting in the resident hitting his head on the van floor. Driver #1 lifted Resident #1 while in his wheelchair back to the upright position and returned to the facility without calling Emergency Medical Services for assistance. Driver #1 was not qualified to provide a comprehensive physical assessment to determine if Resident #1 had sustained any injuries. Upon arrival at the facility, Driver #1 did not notify the Administrator or Director of Nursing and returned Resident #1 back to his hall and told a staff member that Resident #1 had fallen backwards in the wheelchair on the facility transport van. When Medication Aide (MA) #1 gave Resident #1 a haircut, a raised area was noted on the back between the middle and top of Resident #1's head and Resident #1 reported what had occurred in the facility transport van. MA #1 then notified the Director of Nursing (DON) and Assistant Director of Nursing (ADON) of the injury. The Assistant Director of Nursing assessed Resident #1 who sustained a hematoma (a localized collection of blood that pools outside of a blood vessel, usually due to trauma or injury) and an abrasion to the mid to top area on the back of Resident #1's head. A computed tomography (CT) (imaging procedure) scan revealed Resident #1 had no intracranial injury (anything occurring within the skull). This deficient practice occurred for 1 of 3 sampled residents reviewed for quality of care (Resident #1). There was a high likelihood of further injury from moving a resident after a fall and prior to clinical assessment of injury and not immediately informing the Director of Nursing or a Nurse delayed the assessment of any injuries that Resident #1 may have sustained. The findings included: Resident #1 was admitted to the facility on 6/17/2025 with diagnoses that included type 2 diabetes mellitus, acute respiratory failure with hypoxia, cognitive communication deficit, acquired absence of left leg above knee, acquired absence of right hand, and acquired absence of left hand. The quarterly Minimum Data Set (MDS) assessment dated 12/18/2025 revealed Resident #1 was cognitively intact and had functional limitations in	F0684		

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F0684 SS = SQC-J	Continued from page 2 range of motion to both sides of upper and lower extremities. The assessment indicated Resident #1 required maximum assistance with transfers and locomotion via manual wheelchair. Resident #1 experienced no pain during the MDS look back period and had not received blood thinners. A facility incident report for Resident #1 dated 3/2/2026 written by the Assistant Director of Nursing (ADON) revealed the ADON was asked by a Nurse Aide (NA) to assess the back of Resident #1's head where he had hit it, and then the NA stated that Resident #1 fell out of his wheelchair in the facility transport van. The report indicated Driver #1 stated he was able to sit Resident #1 back up and re-secure him with wheelchair and seatbelt and Driver #1 brought Resident #1 immediately back to the facility. A change in condition progress note dated 3/2/2026 written by the ADON revealed Resident #1 was noted to have laceration/raised area to back of his head and stated he fell back in his wheelchair and hit his head. The note indicated Resident #1 had no pain. An interview was conducted with the ADON on 5/5/2026 at 2:40 PM that revealed the ADON was working on 3/2/2026 and was the nurse assigned to cover Resident #1's hall. The ADON stated she was asked to assess Resident #1 after MA #1 had cut his hair and noted an injury. The ADON stated she assessed Resident #1 on 3/2/2026 and noted a hematoma and abrasion to the back of Resident #1's head and neurological checks were initiated. The ADON stated she asked Resident #1 what happened and Resident #1 laughed and told her his wheelchair fell backwards in the van, then Driver #1 brought Resident #1 back to the facility. The ADON stated Resident #1's vital signs and neurological checks remained normal, and Resident #1 did not complain of pain. The ADON stated she notified the Nurse Practitioner (NP) and since Resident #1 was stable the NP recommended to continue to monitor and perform neurological checks. The ADON stated Resident #1's wife requested a head CT on 3/3/2026, and Resident #1 had a CT completed on 3/3/2026 and it was normal. The ADON stated Driver #1 should not have moved Resident #1 after the fall to prevent any further injury and Driver #1 should have called 911 so trained medical personnel could have assessed Resident #1 for injury. The ADON also stated Driver #1 should have reported the incident to the Administrator, DON or a nurse as	F0684		

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F0684 SS = SQC-J	Continued from page 3 soon as he was back at the facility so Resident #1 could have been assessed immediately. A telephone interview was conducted with MA#1 on 5/6/2026 at 8:37 AM, she stated she was familiar with Resident #1 and was assigned to the medication pass on Resident #1's hall on 3/2/2026. MA #1 stated on 3/2/2026 Resident #1 had asked her to cut his hair. MA #1 stated she took Resident #1 to the shower room; she did not recall the exact time and did not know Resident #1 had fallen in the facility van at that time. MA #1 stated she began to cut Resident #1's hair and noted a large bump to the back of Resident #1's head and asked Resident #1 what happened and Resident #1 stated he had fallen backwards in his wheelchair on the facility van and hit his head on the floor of the van. MA #1 stated she immediately reported the injury and what Resident #1 had said to the Director of Nursing (DON), and then the nurses began to assess Resident #1. MA #1 stated she did not see any bleeding on Resident #1's head, just the bump with an abrased area. A telephone interview was conducted with NA #1 on 5/6/2026 at 7:48 AM, she stated she was familiar with Resident #1 and verified she was assigned to Resident #1's hall on 3/2/2026. NA #1 stated she saw Resident #1 and asked him why he was back so early from his appointment, and he said his wheelchair tipped over, NA #1 did not recall the specific time this occurred. NA #1 stated she did not report the incident to a nurse because she did not think she was the first-person Driver #1 notified about the wheelchair falling backwards in the facility transport van and thought the nurses had already been notified when she became aware. An interview was conducted with Driver #1 on 5/5/2026 at 12:35 PM and Driver #1 stated he was the driver for the facility's transport van and was the driver for Resident #1's appointment on 3/2/2026. Driver #1 stated he accelerated slowly from a stop light and heard a loud bump sound and stopped the vehicle and saw Resident #1 had fallen backwards in his wheelchair, and Resident #1's head was on the van floor. Driver #1 stated he made his way back in the van next to Resident #1 and asked him if he was OK. Driver #1 stated Resident #1 was laughing and said he was fine. Driver #1 stated he raised Resident #1 back to a seated upright position in his wheelchair and returned Resident #1 to the facility. Driver #1 stated as he walked back	F0684		

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F0684 SS = SQC-J	Continued from page 4 into the facility, he informed the Receptionist that Resident #1 had fallen in the van and that's why they were back so soon and did not inform the Administrator because he was in a meeting. Driver #1 stated he took Resident #1 back to his hall. Driver #1 stated he thought he reported it to a nurse aide working on Resident #1's hall, but he recognized faces and didn't recall the names of the staff, so he did not recall the specific person he told. Driver #1 stated after he returned Resident #1 to his hall, Driver #1 went back to his regular work. Driver #1 stated the Administrator and Director of Nursing talked to him a little while later about the incident. Driver #1 stated he had not noticed any injury or bleeding to Resident #1, but a bump was found on his head later that day. Driver #1 stated he should not have moved Resident #1 because he was not qualified to assess Resident #1 for injury after a fall and could have caused further injury by moving Resident #1. Driver #1 stated he should have called 911 so Resident #1 could be assessed by trained medical personnel. Driver #1 stated he had been trained in February 2025 regarding calling for medical attention after an accident. Driver #1 stated he knew he should not have moved Resident #1 after the fall before he was assessed by medical personnel, but he panicked and since Resident #1 stated he was fine, Driver #1 just wanted to get the Resident back to the facility. Driver #1 verified he had no medical training that made him qualified to assess a resident for injury after a fall. A telephone interview was conducted with the Receptionist on 5/6/2026 at 9:54 AM, she stated she was responsible for making the appointments and transportation schedule for the facility transport van. The Receptionist stated on the morning of 3/2/2026 Driver #1 returned to the facility with Resident #1. The Receptionist stated she was on a phone call and Driver #1 stopped in her doorway and told her Resident #1 had fallen backward in his wheelchair in the facility transport van and Resident #1 had not made it to his appointment. The Receptionist called the doctor's office to let them know Resident #1 would not be making it to the appointment on 3/2/2026. Resident #1 went to a rescheduled appointment on 3/17/2026. The Receptionist stated she did not report the incident to anyone else because she thought Driver #1 had reported the incident. An interview was conducted with Resident #1 on 5/5/2026 at 9:45 AM. Resident #1 stated he remembered when his wheelchair fell backwards in	F0684		

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F0684 SS = SQC-J	Continued from page 5 the facility transport van and he hit his head on the van floor. Resident #1 stated Driver #1 lifted him and his wheelchair back up and brought him back to the facility. Resident #1 stated he did not experience any pain when he fell backwards in his wheelchair on the facility transport van on 3/2/2026. Review of the progress note dated 3/2/2026 written by the Nurse Practitioner (NP) revealed Resident #1 was assessed after a fall in the facility transport van and noted Resident #1 fell backwards in a transport van after the wheelchair arm detached. Resident #1 obtained a large hematoma to the posterior (back) occipital (relating to the back of the head or skull) scalp and noted the resident was alert and oriented. The plan included neurological checks initiated, family was notified and will follow up on 3/3/2026 to ensure no delayed symptoms developed. A telephone interview was conducted with the NP on 5/6/2026 at 2:33 PM, she stated she was very familiar with Resident #1. The NP stated she was in the Assistant Director of Nursing's (ADON) office on 3/2/2026 and sometime between 10:00 AM and 11:00 AM Resident #1 had returned from an appointment, and when a NA cut his hair and noted a large hematoma to the back of Resident #1's head. The NP stated she thought neurological checks were initiated and thought the resident had a CT scan the following day. The NP stated when she assessed Resident #1 on 3/2/2026 he was alert and oriented. The NP stated Driver #1 should not have moved Resident #1 after his wheelchair fell backwards on the facility transport van and should have called 911 to have Resident #1 assessed by emergency medical personnel, and Driver #1 should have reported the incident to the Administrator or DON as soon as possible. The NP stated it is not safe to move a resident after a fall until the resident has been assessed by trained medical personnel for injuries and to prevent further injury. Review of the physician progress note dated 3/3/2026 written by the Medical Director revealed Resident #1 was going to an appointment in the facility transport van seated in his wheelchair when the wheelchair fell backwards and Resident #1 hit his head on 3/2/2026 and had evidence of a hematoma in the occipital area which was resolved on 3/3/2026 with a healing wound on the skin. The note indicated a plan to obtain a CT scan to rule out any intracranial hemorrhage.	F0684		

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F0684 SS = SQC-J	Continued from page 6 Review of Resident #1's physicians' orders revealed an order dated 3/3/2026 that read CT of head without contrast rule out hemorrhage. Review of Resident #1's report from head CT dated 3/3/2026 revealed no acute intracranial abnormality. Review of Resident #1's medical record revealed neurological checks were initiated by the ADON on 03/2/2026 and completed on 3/5/2026 and were within normal limits. An interview was conducted with the Medical Director on 5/5/2026 at 11:40 AM he revealed Resident #1's family had requested a head CT be completed after Resident #1 had fallen backward in wheelchair on the transportation van to rule out intracranial hemorrhage. The Medical Director stated he ordered a CT on 3/3/2026. The Medical Director stated he thought it was appropriate that he was not sent to the hospital on 3/2/2026 due to Resident #1's neurological checks were stable and Resident #1 did not have anticoagulants (blood thinner) ordered. The Medical Director stated the CT showed no abnormality and the hematoma healed well. The Medical Director stated Resident #1 should have been assessed by emergency medical personnel prior to being moved after the fall in the facility transport van so he could be assessed for injury and to prevent the possibility of further injury. A telephone interview was conducted with the DON on 5/6/2026 at 9:03 AM and revealed she was familiar with Resident #1. The DON stated she, the ADON and NP were notified by MA #1 around 10:30 AM on 3/2/2026 that Resident #1 reported falling backwards in the facility transport van and hit his head. The DON stated Resident #1 was assessed by the ADON and the NP and was found to have a slightly raised, reddish area with an abrasion to the back center area of his head. The DON stated she and the Administrator had talked to Driver #1 after they became aware of the van incident, and she was not sure why Driver #1 did not immediately call 911. The DON stated Driver #1 should have immediately called 911 when he saw Resident #1 had fallen backwards in his wheelchair so he could be assessed by emergency medical personnel for injuries and to prevent further injury.	F0684		

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F0684 SS = SQC-J	Continued from page 7 An interview with the Administrator was conducted on 5/5/2026 at 4:40 PM revealed he was familiar with Resident #1. The Administrator stated on 3/2/2026 Resident #1 was being transported to a medical appointment in the facility transport van by Driver #1. The Administrator stated Driver #1 had not properly secured Resident #1 in his wheelchair prior to leaving the facility and on the way to the appointment Resident #1's wheelchair tipped backwards on the facility transport van and Resident #1 hit his head on the van floor. The Administrator stated Driver #1 had been educated in February 2025 on Defensive Driving Basics, Provide Safe Transportation, and Transport Vehicle Lift Operation. The Administrator stated he expected Driver #1 to call 911 to assess a resident after a van accident or resident fall on the van, and for the driver not to move a resident after a fall until the resident was assessed by emergency medical personnel. The Administrator verified Driver #1 had been trained in February 2025, and the training included the reporting procedure in the case of an accident, which included calling for medical attention. The facility was notified of immediate jeopardy on 5/6/2026 at 10:35 AM. The facility provided the following corrective action plan: Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On March 2, 2026, Driver #1 failed to follow company Transportation policy by returning Resident #1 to the facility after an incident in the van when he should have immediately called emergency services so the resident could be evaluated by emergency medical services. He also did not notify the Director of Nursing or Executive Director of the incident when he returned the resident to the building resulting in a delay in the facility's ability to properly provide adequate care to Resident #1. On March 2, 2026, Driver #1 returned Resident #1 to the facility after a van incident that occurred around 9:30am. On March 2, 2026, at 10:30am Executive Director and Director of Nursing were notified by a Certified Nurse Assistant of the incident.	F0684		

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F0684 SS = SQC-J	Continued from page 8 March 2, 2026, at 10:30am Resident #1 was assessed by Director of Nursing and Assistant Director of Nursing. March 2, 2026, at 11:30 Director of Nursing had Nurse Practitioner evaluate Resident #1. Nurse Practitioner determined that he was stable at that time and determined that he needed no further treatment. On March 2, 2026, Executive Director provided education to the Driver #1 using facility policy and procedure for accidents and incidents on stopping the van in a safe location and calling 911 and waiting till emergency medical services arrives to assess the resident. The education also included notifying the Executive Director and Director of Nursing immediately of any incident involving a resident. On March 3, 2026, facility physician also evaluated Resident #1 with request for Computed Tomography scan to rule out any intracranial hemorrhage which resulted in “no acute inner-cranial abnormalities.” Neurological checks initiated on 3/2/2026 by the ADON and completed on 3/5/2026 with no negative findings noted. Address how the facility will identify other residents having the potential to be affected by the same practice. On March 2, 2026 through March 3, 2026, Director of Nursing and Assistant Director of Nursing completed audit of current residents for the past 30 days including incidents, accidents, change in condition reported as soon as possible, situation background assessment recommendation completed, family/responsible party notified, physician order for treatment if indicated, appropriate documentation, interventions to prevent further changes and/or worsening of conditions, and appropriate care plan interventions put in place if indicated. No other residents determined to be at risk. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. On March 2, 2026, Executive Director provided education to the van driver using facility policy and procedure for accidents and incidents on stopping the van in a safe location and calling 911 and waiting till emergency medical services arrives to assess the	F0684		

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F0684 SS = SQC-J	Continued from page 9 resident. The education also included notifying the Executive Director and Director of Nursing immediately of any incident involving a resident. March 3, 2026, through March 4, 2026, re-education by Director of Nursing, Assistant Director of Nursing, and Executive Director to all current staff including department leaders, dietary, housekeeping and laundry, therapy, and nursing was performed regarding immediate reporting of any accident or incident to Director of Nursing and Executive Director using facility policy and procedure for accidents and supervision, and incidents and accidents to ensure that the Director of Nursing and/or designee can ensure assessments have been completed. March 3, 2026 through March 4, 2026, nursing department staff including Registered Nurses, Certified Nursing Assistants, Licensed Practical Nurses, and Medication Aides were provided re-education regarding immediate reporting of any accident or incident to Director of Nursing and/or Executive Director, changes in condition reported as soon as possible, situation background assessment recommendation completed, physician notification, physician order if indicated, treatments have been performed per physician's order and documented, physician and responsible party notification of changes, appropriate care plan in place, accurate documentation, and continued monitoring for change of condition to ensure that the Director or Nursing and/or designee can ensure assessments have been completed. This education was provided in a group setting by the Director of Nursing and Executive Director with verbal education and question and answer with the staff. As needed staff or staff on vacation at the time were called on the telephone and educated verbally by the Executive Director and the Scheduling Coordinator as a witness. On March 3, 2026, Executive Director notified the Director of Nursing of the responsibility that all newly hired staff including van drivers, Registered Nurses, Licensed Practical Nurses, medication aides, certified nursing assistants, department leaders, will be educated during the Orientation process on facility policy and procedure for immediately reporting incidents and accidents. This education will be provided by the Director of Nursing and/or Assistant Director of Nursing going forward. The facility does not use contract agency staff. In the event of the facility using contract van transportation, Executive Director or designee will ensure that the resident is safely secured in the	F0684		

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F0684 SS = SQC-J	Continued from page 10 contract transportation vehicle and that the driver is informed on the facility policy and procedure for notifying the Director of Nursing and Executive Director in the event of an incident or accident. Indicate how the facility plans to monitor its performance to ensure that the solutions are sustained. Starting on March 3, 2026, the Director of Nursing and/or designee will perform Quality Improvement monitoring for notification to the Director of Nursing and/or Executive Director of all residents who experienced an accident or incident. The audit will include regarding immediate reporting of any accident or incident to Director of Nursing and Executive Director, changes in condition reported as soon as possible, situation background assessment recommendation completed, physician notification, physician order if indicated, treatments have been performed per physician's order and documented, physician and responsible party notification of changes, appropriate care plan in place, accurate documentation, and continued monitoring for change of condition. Monitoring to be completed five times a week for four weeks, then twice a week for four weeks, then once a week for four weeks. The Director of Nursing and Executive Director introduced the plan of correction to the Ad-Hoc Quality Assurance Performance Improvement Committee on March 2, 2026. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by Quality Assurance Performance Improvement Committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nurse Assistant, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and Minimum Data Set Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Alleged date of immediate jeopardy removal and compliance: 3/5/2026 The facility's corrective action plan was validated on	F0684		

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F0684 SS = SQC-J	Continued from page 11 5/12/2026 by the following: Interviews with facility staff revealed all facility staff, including facility van drivers had received education on proper procedures if a resident was to have a fall, injury, or accident in the facility van, that 911 was to be called immediately, do not move resident until assessed by a medical professional and to notify the Administrator or DON immediately of an incident. The education was included as a component of the orientation for new hires. Review of the incident/accident logs was completed with no issues noted. Interviews were also conducted with alert and oriented residents who had been transported since 3/5/2026 with no concerns, incidents or accidents identified. Review of the facility audits revealed no issues. The facility's immediate jeopardy removal and compliance date of 3/5/2026 was validated.	F0684		
F0689 SS = SQC-J	Free of Accident Hazards/Supervision/Devices CFR(s): 483.25(d)(1)(2) §483.25(d) Accidents. The facility must ensure that - §483.25(d)(1) The resident environment remains as free of accident hazards as is possible; and §483.25(d)(2)Each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and interviews with resident, staff, Nurse Practitioner and Medical Director, Driver #1 failed to provide safe transportation on 03/02/2026 when Resident #1's lap belt and front retractor tie-downs (retractor tie-down systems are often called a 4-point securement system) were not correctly applied per manufacturer's instructions leaving Resident #1 not fully secured while in his wheelchair in the facility transport van. Resident #1, who only had one leg, and no hands, was being transported to a medical appointment by Driver #1. As the vehicle accelerated from a full stop at a traffic light, Resident #1's wheelchair tipped over backward with Resident #1 in the wheelchair resulting in the resident hitting his head on the van floor. Resident #1 sustained a hematoma (a localized collection of blood that pools outside of a blood vessel, usually due to trauma or injury) and abrasion to the mid to top area on the back of his head. A computed tomography (CT) scan	F0689	"Past Noncompliance - no plan of correction required"	

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F0689 SS = SQC-J	Continued from page 12 revealed Resident #1 had no intracranial injury (no recent or urgent problems inside the skull). This non-compliance had a high likelihood of resulting in serious injury, harm, impairment, or death. The deficient practice occurred for 1 of 3 sampled residents reviewed for accidents (Resident #1). The findings included: Review of the manufacturer instructions for the operation of the facility van's wheelchair securement system dated February 2011 indicated the following: - Attach to Wheelchair: Starting with the rear retractors, pull out the webbing (the heavy-duty, high-strength strap that connects the wheelchair's frame to the vehicle floor) and place the S-hook securely around a structural member (the wheelchairs welded main frame) of the wheelchair. Pull on the S-hook to ensure full engagement around the structural member. Repeat procedure for other retractors. Tension the front or rear retractors as needed by turning the handles until the tie-downs are tight. - Caution: Do not attach tie-downs to the wheels or any detachable portion of the wheelchair. Tie-down must have a clear, straight path from floor to where it attaches to the wheelchair. Do not allow tie-downs to conform or bend around any object, for example the wheels or footrests. Keep tie-downs away from sharp edges or corners. - Tension the Lap Belt: Insert the buckle connector into the push-button buckle. Tension the buckle connector belt comfortably using the web adjuster. Ensure the lap belt is worn low across the front of the pelvis, bearing upon the bony structure of the body and that the push button buckle is located near the occupant's hip opposite of the side from where the shoulder belt is anchored. Pull on the lap belt to ensure attachment of the triangular fittings to the rear retractor studs and the connection of the push button buckle and buckle connector. - Caution: Always ensure that the shoulder belt is properly extended over the shoulder and across the upper torso the occupant. When connecting the shoulder belt to the lap belt, always ensure that the push-button buckle and buckle connector are located at the occupant's hip opposite of the vehicle	F0689		

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F0689 SS = SQC-J	Continued from page 13 sidewall where the shoulder belt anchorage is installed. Ensure that the lap belt buckle is located in such a way that it is clear and is not in contact with any of the wheelchair components or any structures during operation as to minimize any potential contact during its use or in case of an accident. - Never place the lap belt over the wheelchair arm rests and side panels or above the occupant's abdominal area. - Adjust occupant restraints as firmly as possible consistent with user comfort. Do not twist webbing from sharp edges and corners. Resident #1 was admitted to the facility on 6/17/2025 with diagnoses that included type 2 diabetes mellitus, acute respiratory failure with hypoxia, cognitive communication deficit, acquired absence of left leg above knee, acquired absence of right hand, and acquired absence of left hand. The quarterly Minimum Data Set (MDS) assessment dated 12/18/2025 revealed Resident #1 was cognitively intact and had functional limitations in range of motion to both sides of upper and lower extremities. Resident #1 required substantial/maximum assistance with transfers and locomotion via manual wheelchair. Resident #1 experienced no pain during the MDS look back period and had not received blood thinners. A telephone interview was conducted with Nurse Aide (NA) #1 on 5/6/2026 at 7:48 AM, she stated she was familiar with Resident #1 and she was assigned to Resident #1's hall on 3/2/2026. NA #1 stated she saw Resident #1 on 3/2/2026 and asked him why he was back so early from his appointment, and he said his wheelchair tipped over in the van. NA #1 stated she did not report the fall to anyone because she thought Driver #1 had reported it. An interview was conducted with Driver #1 on 5/5/2026 at 12:35 PM and Driver #1 stated he was the driver for the facility's transport van and was the driver for Resident #1's appointment on 3/2/2026. Driver #1 stated he was in a hurry on the morning of 3/2/2026 when he loaded Resident #1 onto the facility transport van. Driver #1 stated due	F0689		

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F0689 SS = SQC-J	Continued from page 14 to being in a hurry he didn't realize one of wheelchair retractor tie-downs was loose, and he had not secured the lap belt around Resident #1 properly due to placing the belt through the opening in the side panels of the wheelchair rather than placing the lap belt directly next to the resident. Driver #1 stated while driving to Resident #1's appointment, not far from the facility, he (Driver #1) came to a stop at a stop light, and when it was clear to proceed Driver #1 accelerated slowly and then heard a loud bump sound. He indicated he stopped the vehicle as far over on the roadway as he was able to, explaining that there was a sidewalk beside the road. He revealed he saw Resident #1 had fallen backwards in his wheelchair, and Resident #1's head was on the van floor. Driver #1 stated he made his way to the back of the van next to Resident #1 and asked him if he was OK. Driver #1 stated Resident #1 was laughing and said he was fine. Driver #1 stated he raised Resident #1 back to a seated upright position in his wheelchair. Driver #1 stated that Resident #1 was laughing and repeated that he was fine when Driver #1 lifted him up. Driver #1 stated when he lifted Resident #1 and his wheelchair up, he noted the wheelchair's right arm rest panel was not in place and was loose. Driver #1 stated he panicked when he saw Resident #1 had fallen backwards, and since Resident #1 was laughing and said he was fine, Driver #1 resecured Resident #1 and returned to the facility. Driver #1 indicated he did not recall all the specifics related to how he secured the resident for the trip back to the facility. Driver #1 stated he took Resident #1 back to his hall and reported what happened to a staff member on the hall. Driver #1 stated he thought he reported the incident to an NA working on Resident #1's hall, but he recognized faces and didn't recall the names of the staff, so he did not recall the specific person he told. Driver #1 stated he did not see any injury or bleeding to Resident #1, but a bump was found on his head later that day. Driver #1 stated he could not remember the exact date he became the van driver at the facility but thought it was around June of 2025. Driver #1 stated he did some education on the computer regarding driving, and the former driver showed him how to secure wheelchairs in the facility transport van, but Driver #1 stated he had not completed a return demonstration for the former driver when he was initially trained. Driver #1 verified after review of his education record with the surveyor during this interview, that he had received training in February of 2025 that included Defensive Driving Basics, Provide Safe Transportation, and Transport Vehicle Lift Operation.	F0689		

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F0689 SS = SQC-J	Continued from page 15 A telephone interview was conducted with Medication Aide (MA) #1 on 5/6/2026 at 8:37 AM. She stated she was familiar with Resident #1 and was assigned to medication pass on Resident #1's hall on 3/2/2026. MA #1 stated on 3/2/2026 Resident #1 had asked her to cut his hair which was not unusual as she often cut Resident #1's hair at his request. MA #1 stated she took Resident #1 to the shower room, she did not recall the exact time and did not know Resident #1 had fallen in the facility van at that time. MA #1 stated she began to cut Resident #1's hair and noted a large bump to the back of Resident #1's head, asked Resident #1 what happened and Resident #1 stated he had fallen backwards in his wheelchair on the facility van and hit his head. MA #1 stated she immediately reported the injury and what Resident #1 had said to the Director of Nursing (DON) and then nurses began to assess Resident #1. MA #1 stated she did not see any bleeding on Resident #1's head, just the bump with an abrased area. A facility incident report for Resident #1 dated 3/2/2026 written by the Assistant Director of Nursing (ADON) revealed the ADON was asked by MA #1 to assess the back of Resident #1's head where he had hit it, and then the NA stated that Resident #1 fell out of his wheelchair in the facility transport van. The report indicated Resident #1 stated the arm of his wheelchair pulled up when the driver started moving forward in the van, which caused Resident #1 to fall backward in his wheelchair and hit his head on the van floor. Driver #1 stated he was able to sit Resident #1 back up and re-secure him with wheelchair and seatbelt and Driver #1 brought Resident #1 immediately back to the facility. A change in condition progress note dated 3/2/2026 written by the ADON revealed Resident #1 was noted to have laceration/raised area to back of his head and stated he fell back in his wheelchair and hit his head. The note indicated Resident #1 had no pain. An interview was conducted with the ADON on 5/5/2026 at 2:40 PM that revealed the ADON was working on 3/2/2026 and was the nurse assigned to cover Resident #1's hall. The ADON stated she was asked to assess Resident #1 after MA #1 had cut his hair and noted an injury. The ADON stated she assessed Resident #1, noted a hematoma and abrasion to the back of Resident #1's head and	F0689		

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F0689 SS = SQC-J	Continued from page 16 neurochecks were initiated. The ADON verified she had documented a laceration in the chart, but that was in error and it was an abrasion on the hematoma. The ADON stated she asked Resident #1 what happened and Resident #1 laughed and told her his wheelchair fell backwards in the van. The ADON stated Resident #1's vitals and neurochecks were normal and Resident #1 did not complain of pain. The ADON stated she notified the Nurse Practitioner (NP) and since Resident #1 was stable the NP recommended to continue to monitor and perform neurochecks. A progress note dated 3/2/2026 written by the Nurse Practitioner revealed Resident #1 was assessed after a fall in the facility transport van and noted Resident #1 fell backwards in a transport van after the wheelchair arm detached. Resident #1 obtained a large hematoma to posterior (back) occipital scalp region (relating to the back of the head or skull) and noted resident was alert and oriented. Plan included neurological checks initiated, family was notified and the resident will have a follow up on 3/3/2026 to ensure no delayed symptoms developed. An interview was conducted with Resident #1 on 5/5/2026 at 9:45 AM. Resident #1 stated he remembered when his wheelchair fell backwards in the facility transport van and stated he had hit his head on the floor of the van when his wheelchair fell backwards. Resident #1 stated Driver #1 was not driving bad or too fast and that the wheelchair fell backwards when Driver #1 pulled out from a stop light not far from the facility. Resident #1 stated there were no other issues with his transport to appointments and he had gone to appointments since that time without any issues. Resident #1 stated he had a bump on the back of his head after he fell backwards in the wheelchair, but it was better now. Resident #1 stated he did not experience pain when he fell backwards in his wheelchair on the facility transport van. A physician progress note dated 3/3/2026 written by the Medical Director revealed Resident #1 was going to an appointment in the facility transport van seated in his wheelchair when the wheelchair fell backwards and Resident #1 hit his head on 3/2/2026 and had evidence of a hematoma in the occipital area which was resolved on 3/3/2026 with a healing wound on the skin. The note indicated a plan to obtain a CT scan to rule out any intracranial hemorrhage (brain	F0689		

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F0689 SS = SQC-J	Continued from page 17 bleed). During an interview with the ADON on 5/5/2026 at 2:40 PM she indicated Resident #1's family requested a head CT on 3/3/2026, and Resident #1 had a CT completed on 3/3/2026 and it was normal. Resident #1's physicians' orders revealed an order dated 3/3/2026 that read CT of head without contrast to rule out hemorrhage. Resident #1's report from the head CT dated 3/3/2026 revealed no acute intracranial abnormality. Resident #1's Medication Administration Record (MAR) dated 3/2/2026 through 3/9/2026 revealed Resident #1 reported a pain level of zero (on a scale of 0 to 10 with 0 being no pain and 10 being the worst pain possible). An observation of the facility transport van with Driver #1 was conducted in conjunction with a follow up interview on 5/5/2026 at 4:30 PM. Driver #1 demonstrated how Resident #1 was improperly secured on 3/2/2026. Driver #1 stated and demonstrated he attached the rear retractors and then the front retractors to the resident's wheelchair. Driver #1 stated on 3/2/2026 he incorrectly attached the front retractors to the outer structure of the wheelchair rather than on a secure structure underneath the wheelchair. Driver #1 stated and demonstrated that on 3/2/2026 he placed the tension lap belt though the opening located on the side panels of the wheelchair instead of directly next to the resident. Driver #1 stated when he saw Resident #1's wheelchair tipped backwards he noted the right-side panel of the wheelchair's arm rest had come loose and the front right wheel retractor webbing was loose. A telephone interview was conducted with the Nurse Practitioner (NP) on 5/6/2026 at 2:33 PM, she stated she was very familiar with Resident #1. The NP stated she was in the ADON's office on 3/2/2026 and sometime between 10:00 AM and 11:00 AM Resident #1 had returned from an appointment, and when an MA cut his hair and noted a large hematoma to the back of Resident #1's head. The NP stated she thought neurochecks were initiated and thought the resident had a CT scan the	F0689		

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F0689 SS = SQC-J	Continued from page 18 following day. The NP stated when she assessed Resident #1 on 3/2/2026 he was alert and oriented. The NP stated Resident #1's cognition varied day to day and stated Resident #1 sometimes had hallucinations. An interview was conducted with the Medical Director on 5/5/2026 at 11:40 AM. He revealed Resident #1's family had requested a head CT be completed after the fall, and to rule out intracranial hemorrhage a CT was ordered the day after Resident #1 had fallen in the wheelchair van. The Medical Director stated he thought it was appropriate that the resident was not sent to the hospital on 3/2/2026 due to Resident #1's neurochecks being stable and Resident #1 did not have anticoagulants ordered. The Medical Director stated the CT showed no abnormality and the hematoma healed well. A telephone interview conducted with the Director of Nursing (DON) on 5/6/2026 at 9:03 AM revealed she was familiar with Resident #1. The DON stated she, the ADON and NP were notified by MA #1 around 10:30 AM on 3/2/2026 that Resident #1 reported falling backwards in the facility transport van and hit his head. The DON stated Resident #1 was assessed by the ADON and the NP and was found to have a slightly raised, reddish area with an abrasion to the back center area of his head. The DON stated she and the Administrator had talked to Driver #1 after they became aware of the van incident, and she thought the reason Resident #1's wheelchair fell backwards on the facility transport van was due to the wheelchair not being secured properly by Driver #1. An interview with the Administrator conducted on 5/5/2026 at 4:40 PM revealed he was familiar with Resident #1. The Administrator stated on 3/2/2026 Resident #1 was being transported to a medical appointment in the facility transport van by Driver #1. The Administrator stated Driver #1 had not properly secured Resident #1 in his wheelchair prior to leaving the facility and on the way to the appointment Resident #1's wheelchair tipped backwards on the facility transport van and Resident #1 hit his head on the van floor. The Administrator stated after the van incident on 3/2/2026 Driver #1 demonstrated how he had secured Resident #1 on the morning of 3/2/2026 and it was noted that Driver #1 had incorrectly secured the right front retractor and the lap belt prior to leaving the facility with Resident #1. The Administrator stated Driver #1 had	F0689		

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F0689 SS = SQC-J	Continued from page 19 been educated in February 2025 on Defensive Driving Basics, Provide Safe Transportation, and Transport Vehicle Lift Operation. The Administrator stated he thought Driver #1 had been instructed on correct procedures per manufacturer's instructions for securing residents in wheelchairs in the facility transport ban by the previous van driver. The Administrator stated he expected van drivers to ensure residents were properly secured in the facility transport van prior to each van transport. The facility was notified of immediate jeopardy on 5/6/2026 at 10:35 AM. The facility provided the following corrective action plan: How will corrective action be accomplished for those residents affected by the deficient practice? On March 2, 2026, Driver #1 failed to follow established transportation safety procedures when Resident #1 was being transported in the facility van and failed to secure the resident's wheelchair with all 4 tie-downs and improperly secured the resident with the safety belt and shoulder belt per manufacturer instruction during transportation to an appointment. This deviation from the policy created an avoidable risk to Resident #1's safety and resulted in a minor head contusion and hematoma when Resident #1's wheelchair fell backwards causing Resident #1 to hit his head on the van floor. March 2, 2026, the Driver #1 returned Resident #1 to the facility after a van incident that occurred around 9:30am. March 2, 2026, at 10:30am Executive Director and Director of Nursing were notified by a Certified Nurse Assistant of the incident. March 2, 2026, at 10:30am Resident #1 was assessed by Director of Nursing and Assistant Director of Nursing. March 2, 2026, at 11:30 Director of Nursing had Nurse Practitioner evaluate Resident #1. Nurse Practitioner determined that Resident #1 was stable at that time and determined that he needed no further treatment. March 3, 2026, Medical Director evaluated Resident #1 with request for computed tomography scan to	F0689		

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F0689 SS = SQC-J	Continued from page 20 rule out any intracranial hemorrhage. March 3, 2026, Resident #1 received a computed tomography scan with results of this scan revealing “no acute inner-cranial abnormalities.” Neurological checks completed by Director of Nursing on March 3, March 4, and March 5 with no negative findings noted. March 2, 2026, Driver #1 was removed from transport duties pending investigation and provided immediate re-education by Executive Director on securement and safety protocols including verbalization and return demonstration on how passengers are to be secured before transport per manufacturer instructions and emergency procedures during trips. Education materials included the facility policy and procedure for resident transportation, transport van securement checklist, and manufacturer instructions on proper securement of the wheelchair and proper use of lap belt and shoulder belt. March 2, 2026, van securement system including tie-downs, belts, shoulder harnesses, and lift were all inspected by Executive Director and Maintenance Director and placed back in service only after passing function check. No deficient or non-functioning equipment was noted. March 3, 2026, the transportation vehicle safety equipment was scheduled to be inspected by a company that is certified to inspect, install, and service wheelchair van lift and securement equipment. March 4, 2026, transportation van lift and securement equipment was inspected and determined to be functional and properly operational. How will the facility identify other residents having the potential to be affected by the same deficient practice? March 4, 2026, using the transportation schedule, all residents transported on the facility van over the past 30 days were interviewed to identify any concerns, issues, or incidents by the Social Services Director. No negative findings were noted as a result of this audit. March 2, 2026, van driver was interviewed by the Executive Director and the van driver confirmed that he had no other incidents or accidents with any other residents prior to the incident on March 2, 2026.	F0689		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345477	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 05/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Biltmore Haven Nursing and Rehabilitation	**3864 Sweeten Creek Road , Arden, North Carolina, 28704**

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F0689 SS = SQC-J	Continued from page 21 What measures or Systemic Changes have been made to Prevent Recurrence? March 2, 2026, Driver #1 was provided immediate re-education by Executive Director on securement and safety protocols including verbalization and return demonstration on how passengers are to be secured before transport and emergency procedures during trips. Education materials included the facility policy and procedure for resident transportation, transport van securement checklist, and manufacturer instructions on proper securement of the wheelchair and proper use of lap belt and shoulder belt. March 2, 2026, transportation binder was implemented by the Executive Director to include the transportation safety policy, a step-by-step guide and checklist for wheelchair securement, seatbelt and shoulder belt application, all per manufacturer instructions. This binder was placed in the van for the driver to complete the checklists for every resident transportation. Executive Director notified the Driver #1 on March 3, 2026, of this new process. March 3, 2026, Maintenance Director was notified of the responsibility by the Executive Director to ensure all new hire van drivers are to be educated in-person on the proper use of wheelchair securement system and seatbelt and shoulder belt to secure residents during transport per manufacturer instructions. New van drivers will perform a return demonstration to ensure he/she has a good understanding of how to properly implement safety equipment in the van per manufacturer instructions. As of March 2, 2026, except for the Executive Director, the facility only utilizes Driver #1 as a van driver. How will the facility monitor its corrective actions to ensure the deficient practice will not recur? March 2, 2026, the Executive Director notified the Maintenance Director and Receptionist who manages the transportation schedule of this monitoring responsibility. Using the weekly transportation schedule, Executive Director, Maintenance Director, and/or designee will ensure all residents transported in the van are in a standard wheelchair, are secured correctly using the four-point wheelchair securement system and seatbelt/shoulder belt is secured correctly by the van driver, per manufacturer instructions, by direct	F0689		

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F0689 SS = SQC-J	Continued from page 22 observation 3x per week for 4 weeks, 2x per week for 4 weeks, then 1x per week for 4 weeks, then 1x per month for 3 months. Results will be reported to interdisciplinary team during Quality Assurance Performance Improvement each month for 12 months for continued compliance and/or further revision. In the event of the facility using contract van transportation, Executive Director or designee will ensure that the resident is safely secured in the contract transportation vehicle. The Director of Nursing and Executive Director introduced the plan of correction to the Ad-Hoc Quality Assurance Performance Improvement Committee on March 2, 2026. The Director of Nursing is responsible for implementing this plan. Findings will be reviewed by Quality Assurance Performance Improvement Committee monthly and Quality monitoring (audit) updated if changes are needed based on findings. The Quality Assurance Performance Improvement Committee consists of but not limited to the Executive Director, Director of Nursing, Assistant Director of Nursing, Social Services Manager, Business Office Manager, Activities Director, Human Resources, Pharmacist, Medical Director, Certified Nurse Assistant, Dietary Manager, Maintenance Director, Housekeeping Supervisor, Admissions, Medical Records, and Minimum Data Set Nurse. The Quality Assurance Performance Improvement Committee meets monthly and quarterly at a minimum. Alleged date of immediate jeopardy removal and compliance: March 5, 2026 The facility's corrective action plan was validated by the following: Interview with facility transport van drivers revealed they had received education on the restraint system in the facility transport van and how to properly secure a resident in the van as well as the driver safety checklist that was to be completed prior to leaving facility with residents. The facility transport van drivers also stated they had to verbalize their understanding of the education they had received and complete a demonstration showing they were capable of securing residents in the facility transport van properly for transport. Review of facility orientation paperwork for new facility van drivers verified the Maintenance Director now included in-person education on the proper use of wheelchair securement system and seatbelt and shoulder belt to secure residents during transport per manufacturer instructions. New van drivers will	F0689		

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F0689 SS = SQC-J	Continued from page 23 perform a return demonstration to ensure they have a good understanding of how to properly implement safety equipment in the van per manufacturer instructions. Review of the audit tools and driver safety checklist was completed with no issues noted. An observation was made on 5/5/2026 of a resident in their wheelchair in the facility van secured by Driver #1 in accordance with the manufacturer's operation instructions with no issues identified. Interviews were conducted with alert and oriented residents who had been transported since 3/5/2026 with no concerns identified. No additional transportation incidents were identified since 3/5/2026. Review of the facility audits revealed no issues. The facility's immediate jeopardy removal date and compliance date of 3/5/2026 was validated.	F0689		