STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345405	A. BUILDING _____ B. WING _____	C 02/21/2025

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F 000	INITIAL COMMENTS An onsite complaint investigation was conducted on 02/18/25, additional information was obtained offsite 02/19/25 through 02/21/25. Therefore, the exit date was changed to 02/21/25. Event ID# 9S9311. The following intakes were investigated NC00225887, NC00226269, NC00226495, NC00226782, NC00227464 and NC00226968. 3 of the 15 complaint allegations resulted in deficiency.	F 000		
F 600 SS=G	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on record reviews, and Psychiatric Mental Health Nurse Practitioner, Resident Representative (RR) and staff interviews, the facility failed to protect a resident's right to be free from resident-to-resident abuse. In January	F 600	The facility sets forth the following plan of correction to remain in compliance with all federal and state regulations. The facility has taken or will take the actions set forth in the plan of correction. The following	3/11/25

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

Electronically Signed | 03/11/2025

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F 600	Continued From page 1 2025, Resident # 2 was observed touching Resident # 1's breasts. On Saturday, 2/1/25 Resident #1 was positioned in a reclining wheelchair in the dayroom when Resident #2 was observed sitting next to Resident #1 with his right arm on her reclining wheelchair in the day room. Nurse Aide (NA) #1 intervened asking Resident #2 to give Resident #1 space and observed the blanket used to cover Resident #1 had been removed, Resident #1's pants and brief were pulled down, the brief was torn on the right-side exposing Resident #1's private area. Resident #1 was severely cognitively impaired and her ability to speak was rare according to the most recent Minimum Data Set (MDS). Resident #1's Representative stated Resident #1 would feel completely violated. A reasonable person would expect to be free from abuse in their own home and could experience trauma, fear and anxiety. This affected 1 of 3 residents reviewed for abuse (Resident #1). The findings included: Resident #1 was admitted to the facility on 4/26/24. Diagnoses included Alzheimer's disease and degeneration of nervous system. Resident #1 was under Hospice care. The quarterly Minimum Data Set (MDS) dated 11/27/24 indicated Resident #1 was severely cognitively impaired and her ability to speak was coded as rare or never understood and her ability to understand speech was coded as rare or never understood. Resident #1 was dependent on staff for all Activities of Daily Living (ADL). A review of Resident #1's care plan revised on 2/26/24 indicated she was at risk for	F 600	plan of correction constitutes the facility□s allegation of compliance. All deficiencies cited have been or will be corrected by the date or dates indicated. F 600 1. Resident #2 was placed on 1:1 supervision on 2/1/2025 at the time of observation 2. An audit has been completed of previous 14 days of mental health nurse practitioner notes. This has been completed by the Director of Nursing on 3/10/2025 3. The Administrator educated the Mental Health Nurse Practitioner on the facility abuse policy and when to notify the Administrator when there is a significant event that is brought to her attention. The Administrator educated current staff on the abuse policy and when to report a resident inappropriately touching another resident or staff member. This was completed by 2/7/2025. Staff members who have not received this education will not be allowed to work until education is completed. New hires will receive this education by the Administrator during classroom orientation. 4. The Director of Nursing or designee will audit the incidents and accidents and progress notes 5 x weekly for 2 weeks, 3x weekly for 4 weeks, 1x weekly for 4 weeks. The Director of Nursing or designee will audit mental health notes 5 x weekly for 2 weeks, 3 x weekly for 4 weeks, 1x weekly for 4 weeks 5. Results will be reported by the Director of Nursing to the quality assurance	

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F 600	Continued From page 2 complications related to communication impairment due to impaired cognition and was rarely or never understood. Interventions included anticipating needs and observing for nonverbal cues which may indicate care needs. Resident #2 was admitted to the facility on 11/24/24. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left side, cognitive communication deficit, and hypertension. The admission MDS dated 12/2/24 indicated Resident #2 was cognitively intact and used a wheelchair for mobility. A review of Resident #2's care plan revised 12/2/24 indicated he required assistance with Activities of Daily Living (ADL) and the interventions included two-person assistance for bed mobility, mechanical lift for all transfers. Resident #2's care plan did not indicate any problem areas pertaining to behaviors. An interview with Housekeeper #1 on 2/19/25 at 2:55 PM revealed she saw Resident #2 touching Resident #1's chest area in the day room. She stated that she could not remember the exact date but stated it was the beginning to middle of January 2025. She stated she immediately let the nursing staff, which included NA #3, at the nurse's desk know and the residents were separated. She stated she never saw Resident #2 touching Resident #1 after this incident but stated Resident #2 stared at Resident #1 quite often. Housekeeper #1 stated she watched out for Resident #1 after this incident. A second telephone interview with Housekeeper	F 600	meeting x1 month for further resolution as needed. 6. Date of compliance: 3/11/2025	

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#1 occurred on 2/20/25 at 3:52 PM. She stated when she witnessed Resident #2 touching Resident #1 in early to mid-January, he touched her on the outside of her shirt with his left hand rubbing across her chest and breasts. She explained Resident #1 was sitting next to a table in the day room and Resident # 2 was sitting next to her.

A telephone interview with NA #3 on 2/20/25 at 2:14 PM revealed she was standing at the nurse's desk when Housekeeper #1 alerted them to Resident #2 touching Resident #1's breasts. NA #3 responded and went down to the dayroom. She could not recall the date but stated it occurred the beginning or middle of January 2025. NA #3 did not indicate if she reported this incident or not. She stated she kept an eye on Resident #2 and would often tell him to leave Resident #1 alone when they were in common areas.

A review of a Psychiatric Mental Health Nurse Practitioner's note on 1/16/25 revealed Resident #2 exhibited increased sexual behaviors towards female peers and he had touched a female peer's breasts.

A telephone interview with the Psychiatric Mental Health Nurse Practitioner on 2/18/25 at 3:36 PM revealed she visited Resident #2 on 1/16/25 for sexual misconduct as he had touched a female resident's breasts and exposed himself to female staff at the facility. The Psychiatric Mental Health Nurse Practitioner suggested supervision and an increase in medication to address Resident #2's depression.

A telephone interview with the Psychiatric Nurse

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F 600	Continued From page 4	F 600		

Practitioner occurred on 2/18/25 at 4:54 PM. She stated on her visit to Resident #2 on 1/16/25, a nurse verbally told her about Resident #2's sexually inappropriate behaviors directed at another female resident. She could not recall who told her and she was not aware of the name of the female resident.

A review of the initial allegation report submitted by the facility to the Division of Health Service Regulation (DHSR) revealed an allegation type of resident abuse on 2/1/25. The allegation details noted Nurse Aide (NA) #1 observed Resident #2 sitting next to Resident #1 in the day room with his hand in her lap. NA #1 removed Resident #2 immediately. Resident #2 was placed on one-to-one supervision. Resident #1 was sent to the hospital for further evaluation.

A written statement from NA #1 written on 2/1/25 from the facility's investigation submitted to DHSR on 2/5/25 was reviewed. The statement read, in part, that NA #1 walked past the day room on 2/1/25 and saw Resident #2 sitting close to Resident #1 with his hand resting on the right side of her reclining wheelchair. NA #1 stated she asked Resident #2 to back up and when she walked closer to Resident #1, she noted her pants were pulled down some and her incontinence brief tabs on the right side were undone and she was exposed.

A telephone interview with NA #1 on 2/18/25 at 2:21 PM revealed she was walking down the hallway when she noticed Resident #2 sitting next to Resident #1 with his right arm on the left side of her reclining wheelchair. She stopped and asked Resident #2 to back up and give Resident #1 some space. Resident #2 backed away and

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F 600	Continued From page 5	F 600		

she noticed Resident #1's pants were pulled down and her incontinence brief tab closure was undone on the right side. NA #1 noted that Resident #1 was completely asleep and was unable to move any aspects of her clothes or blanket. NA #1 stated she immediately reported the incident to Nurse #1 and Resident #1 was sent to the hospital for evaluation.

A written statement from NA #2 written on 2/1/25 from the facility's investigation submitted to DHSR on 2/5/25 was reviewed. The statement read, in part, that NA #2 had assisted Resident #1 to transfer to her reclining wheelchair earlier on 2/1/25 and was asleep in the chair in the day room. She was called into the day room and Resident #2 exited the room stating that he did nothing. NA #2 stated when she walked towards Resident #1, her pants appeared disheveled, and her brief was open on the right side and her private area was exposed. She also noted the sheet Resident #1 was covered with, was pulled away from her lap. NA #2 stated Resident #1's clothing and sheet covering her were not left that way 20 minutes prior when Resident #1 was transferred to her reclining wheelchair.

A telephone interview with NA #2 on 2/18/25 at 1:49 PM revealed she fed Resident #1 lunch in the day room and she transferred her to a reclining wheelchair after lunch so she could rest in the day room. NA #2 indicated she covered Resident #1, who was fully dressed, with a blanket. NA #2 stated NA #1 called her to the day room approximately 20 minutes later and found Resident #2 leaving promptly saying he didn't do anything. NA #2 stated Resident #1's incontinence brief was pulled down, torn on the side and her pubic hair was visible. NA #2 stated

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she did not see Resident #2 touch Resident #1 when she arrived to the day room.

A telephone interview with Nurse #1 occurred on 2/20/25 at 12:51 PM. She stated she was at the nurse's station on 2/1/25 when she was alerted by NA #1 of the incident. She noted she did not see Resident #2 do anything, but stated Resident #1's pants were pulled down and incontinence brief was open, and Resident #2 exited the day room. She stated Resident #1 was sent to the hospital immediately for evaluation and Resident #2 went back to his room. She stated Resident #2 was placed with a one-on-one sitter on 2/1/25 after the incident. Nurse #1 stated she was not aware of any previous inappropriate sexual behaviors toward female residents or staff exhibited by Resident #2.

A review of the staffing schedules was conducted and revealed Resident #2 was placed under one-to-one supervision from staff from 2/1/25 after the incident until his transfer to the hospital on 2/3/25.

A review of a progress note written by the Psychiatric Mental Health Nurse Practitioner, dated 2/3/25 read, in part that Resident #2 was no longer appropriate to live at the facility after recent inappropriate sexual behavior with Resident #1. She further wrote that Resident #2 was a threat to female peers and to facility staff due to recent and past inappropriate behaviors. The Psychiatric Mental Health Nurse Practitioner indicated Resident #2 would be more appropriate in an all-male facility wherein other patient's safety would not be a factor.

A telephone interview with the Psychiatric Mental

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F 600	Continued From page 7	F 600		

Health Nurse Practitioner occurred on 2/18/25 at 3:36 PM. She stated she wrote a progress note on 2/3/25 that Resident #2 was not appropriate for the facility due to the incident involving Resident #2 exhibiting inappropriate sexual behaviors towards Resident #1 on 2/1/25. She suggested Resident #2 be discharged to the hospital for psychological evaluation.

A nursing progress note dated 2/3/25 written by the Director of Nursing (DON) revealed Resident #2 was sent to the hospital for evaluation and management per Psychiatric Mental Health Nurse Practitioner's recommendation on 2/3/25.

The DON was not available to interview during the survey.

A telephone interview with Resident #1's Representative occurred on 2/20/25 at 2:51 PM. She stated Resident #1 was very modest and would often try to cover herself when care was being provided. Resident #1's Representative stated if Resident #1 was able to speak for herself, she would feel completely violated if she knew about the incident where Resident #2 allegedly touched her. She further indicated Resident #1 was very protective of her private areas.

An interview with the Administrator on 2/18/25 at 4:57 PM revealed she was not aware of any inappropriate sexual behaviors directed to female residents by Resident #2 before the incident on 2/1/25. She stated she was not aware of the Psychiatric Mental Health Nurse Practitioner's note dated 1/16/25 until after the incident on 2/1/25 when she was compiling her investigation to submit to the state agency. The Administrator

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F 600	Continued From page 8 also added that she could not determine who reported Resident #2's inappropriate sexual behaviors to the Psychiatric Mental Health Nurse Practitioner on 1/16/25.	F 600		
F 623 SS=D	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman. (ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and (iii) Include in the notice the items described in paragraph (c)(5) of this section. §483.15(c)(4) Timing of the notice. (i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged. (ii) Notice must be made as soon as practicable before transfer or discharge when- (A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section; (B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;	F 623		3/11/25

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(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the

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F 623	Continued From page 10 agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act. §483.15(c)(6) Changes to the notice. If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available. §483.15(c)(8) Notice in advance of facility closure In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(k). This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Adult Care Home Admission Director, and Ombudsman interviews, the facility failed to provide a complete written notice of transfer/discharge including a statement of the resident's appeal rights for 1 of 3 residents (Resident #2) reviewed for discharge. The findings included: Resident #2 was admitted to the facility on 11/24/24. The admission Minimum Data Set dated 12/2/24 indicated Resident #2 was cognitively intact.	F 623	F623 1. Education was given to the Social Services Director on how to properly fill out a discharge notice by the Administrator. 2. An audit has been completed of the last 14 days of facility generated discharge notices. This audit was completed by the Administrator on 3/10/2025. 3. Education was provided on 3/7/2025 by the Administrator on how to properly fill out a discharge notice before it is issued to a resident or responsible party. Any new social services employee will be	

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F 623	Continued From page 11 A nursing progress note dated 2/3/25 revealed Resident #2 was discharged to the hospital on 2/3/25. Resident #2 did not return to the facility. A review of Resident #2's medical record revealed a notice of transfer/discharge form was completed by the Administrator on 2/3/25 with the discharge location of a local adult care home, not the hospital. The form was issued without the second page entitled Nursing Home Hearing Request form which included instructions for Resident #2 to request an administrative hearing to appeal the discharge. A review of an email from the Ombudsman to the Social Worker (SW) dated 2/5/25 revealed the second page of the notice of transfer/discharge entitled Nursing Home Hearing Request Form was attached and sent to the SW. The Ombudsman indicated both forms would need to be issued together to Resident #2 and she stated the facility would need to reissue the notice of Transfer/Discharge. A telephone interview was conducted with the Ombudsman on 2/21/25 at 2:10 PM. She stated she received an email from the Social Worker on 2/4/25 with the notice of transfer/discharge for Resident #2 and the second page was missing. The Ombudsman explained to SW that the second page was the Hearing Request form and contained the instructions to request an administrative hearing to appeal the discharge. She informed the SW that both pages were required and without the second page Resident #2 would not be able to appeal the notice. The Ombudsman stated she asked the SW to reissue the notice of transfer/discharge to Resident #2.	F 623	educated by the administrator during the orientation process. 4. An audit will be completed by the Regional Director of Social Services to review all discharge notices 5x weekly x 12 weeks. 5. Results will be reported by the Social Services Director to the quality assurance meeting x1 month for further resolution as needed 6. Date of compliance: 3/11/2025	

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CHARLOTTE HEALTH & REHABILITATION CENTER	1735 TODDVILLE ROAD CHARLOTTE, NC 28214

(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
F 623	Continued From page 12	F 623		

An interview with the SW occurred on 2/20/25 at 5:33 PM. She stated the notice of transfer/discharge was written before Resident #2 was sent to the hospital. The SW explained she delivered the notice to Resident #2 and the staff at the hospital on 2/3/25. She stated the notice of transfer/discharge did not include the second page. The SW was not aware she needed to include the second page until she received the email from the Ombudsman. She stated the Ombudsman was supposed to send the second page to her. The SW explained the notice was not reissued to Resident #2. The SW stated someone at the facility started a conversation with the adult care home listed on the notice as the discharge location, but she did not know who it was.

A telephone interview with the Admission Director at the adult care home listed on the notice of transfer/discharge on 2/20/25 at 4:54 PM revealed Resident #2's name was not in their system as a possible resident. They had not received any referrals with his name.

A telephone interview was conducted with the Administrator on 2/20/25 at 3:58 PM. The Administrator stated Resident #2 was sent to the hospital due his inappropriate behaviors and putting female residents at risk. She stated the Psychiatric Mental Health Nurse Practitioner stated Resident #2 was not appropriate for the facility.

A second telephone interview with the Administrator on 2/20/25 at 5:42 PM revealed she was aware of the notice of transfer/discharge given to Resident #2 by the SW who typically handled these notices. She stated the adult care

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F 623	Continued From page 13 home listed on the notice of transfer/discharge given to Resident #2 did not currently have a bed open for him. She was not aware Resident #2 did not receive the second page of the notice of transfer/discharge.	F 623		
F 626 SS=D	Permitting Residents to Return to Facility CFR(s): 483.15(e)(1)(2) §483.15(e)(1) Permitting residents to return to facility. A facility must establish and follow a written policy on permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following. (i) A resident, whose hospitalization or therapeutic leave exceeds the bed-hold period under the State plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room if the resident- (A) Requires the services provided by the facility; and (B) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services. (ii) If the facility that determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements of paragraph (c) as they apply to discharges. §483.15(e)(2) Readmission to a composite distinct part. When the facility to which a resident returns is a composite distinct part (as defined in § 483.5), the resident must be permitted to return to an available bed in the particular location of the	F 626		3/11/25

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F 626	Continued From page 14 composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there. This REQUIREMENT is not met as evidenced by: Based on record review, and Hospital Case Manager, Resident Representative, and staff interviews, the facility failed to allow a resident to return to the facility after being sent to the hospital for evaluation using the resident's inappropriate sexual behaviors prior to discharge as a basis for their decision for 1 of 3 residents reviewed for transfer and discharge (Resident #2). The findings included: Resident #2 was admitted to the facility on 11/24/25. Diagnoses included hemiplegia and hemiparesis following cerebral infarction affecting left side and hypertension. The admission Minimum Data Set dated 12/2/24 indicated Resident #2 was cognitively intact. Resident #2 was discharged to the hospital on 2/3/25 and did not return to the facility. A review of Resident #2 electronic medical record (EMR) revealed he had a Resident Representative listed as a contact. A review of a progress note written by the Psychiatric Mental Health Nurse Practitioner, dated 2/3/25 read, in part that Resident #2 was no longer appropriate to live at the facility after recent inappropriate sexual behavior with Resident #1. She further wrote that Resident #2	F 626	F626 1. Resident #2 was readmitted to Charlotte Health and Rehab on 2/25/2025 once the first available male bed was open. 2. An audit has been completed of the last 14 days of hospital admissions to ensure that return bed offers have been made. This audit was completed by the Administrator on 3/10/2025. 3. The Administrator educated the Admissions Director and Admission Coordinator on 3/7/2025 on the importance of admitting residents back to the facility one they have went to the hospital. Any new admission team employee will receive education during the orientation process by the administrator. 4. The Administrator will audit hospital transfers to ensure they are offered a bed once one is available at the facility 5x weekly for 4 weeks, 3x weekly for 4 weeks, 1 x weekly for 4 weeks 5. Results will be reported by the Adminsitrator to the quality assurance meeting x1 month for further resolution as needed 6. Date of compliance: 3/11/2025	

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was a threat to female peers and to facility staff due to recent and past inappropriate behaviors. The Psychiatric Mental Health Nurse Practitioner indicated Resident #2 would be more appropriate in an all-male facility wherein other patient's safety would not be a factor.

A telephone interview with the Psychiatric Mental Health Nurse Practitioner occurred on 2/18/25 at 3:36 PM. She stated she wrote a progress note on 2/3/25 that Resident #2 was not appropriate for the facility due to the incident involving Resident #2 exhibiting inappropriate sexual behaviors towards Resident #1 on 2/1/25. She suggested Resident #2 be discharged to the hospital for psychological evaluation.

A nursing progress note dated 2/3/25 written by the Director of Nursing revealed Resident #2 was sent to the hospital for evaluation and management per Psychiatric Mental Health Nurse Practitioner's recommendation on 2/3/25.

A telephone interview occurred with Resident #2's Resident Representative on 2/20/25 at 11:27 AM. He stated he was told by the facility he would have a 30-day notice for his discharge, but stated Resident #2 was still in the hospital and the facility would not let him return. He stated many other facilities have come to the hospital to evaluate Resident #2, but there have been no offers for placement.

A telephone interview with the Hospital Case Manager on 2/20/25 at 2:30 PM revealed hospital case management called the facility on 2/3/25 immediately after Resident #2 was sent to the hospital emergency room. She stated the facility Social Worker (SW) dropped off a notice of

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transfer/discharge to Resident #2. The facility was called about the readmission of Resident #2 on 2/3/25 at 6:38 PM and the facility refused to readmit Resident #2.

An interview with the facility SW on 2/20/25 at 5:33 PM revealed she delivered the notice of transfer/discharge to Resident #2 on 2/3/25 at the hospital.

A telephone interview with the facility Admission Liaison on 2/20/25 at 4:24 PM revealed the hospital case manager reached out for the facility to readmit Resident #2. She stated the facility would not readmit him per the Psychiatric Nurse Practitioner stating he was not appropriate for the facility due to his behaviors,

The Director of Nursing was not available during the survey to interview.

A telephone interview with the Administrator on 2/20/25 at 3:58 PM revealed she did not speak to the hospital case managers regarding Resident #2. She stated the Admission Liaison spoke to the hospital and they pushed to have Resident #2 readmitted. She stated Resident #2 was sent out due to his inappropriate sexual behaviors and the Psychiatric Mental Health Nurse Practitioners stated he was not appropriate for their facility. The Administrator understood from the case managers that they would look for placement in another facility for him.

The Administrator was notified by the survey team by telephone on 2/20/25 at 5:41 PM there was an expectation Resident #2 would be readmitted to the facility with appropriate supervision.

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F 626	Continued From page 17 The Administrator notified the survey team by email on 2/20/25 at 5:57 PM that the facility would readmit Resident #2 to the facility when a male bed was available.	F 626		