STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345168	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 04/30/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Macgregor Downs Health Center by Harborview	**2910 Macgregor Downs Road , Greenville, North Carolina, 27834**

(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
E0000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 04/27/26 through 04/30/26. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 22F503-H1.	E0000		05/09/2026
F0000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 04/27/26 through 04/30/26. Event ID# 22F503-H1. The following intakes were investigated: 2993330, 2990852, 2992091, 2981328, 2979968, 2968819, 2743118, 2677716, 2657186, 2600095, 2596026, 2594284, 2581988, 771461, 771676, 771674, 771675, 771673, and 771677. 6 of the 44 complaint allegations resulted in deficiency.	F0000		05/28/2026
F0553 SS = D	Right to Participate in Planning Care CFR(s): 483.10(c)(2)(3) §483.10(c)(2) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to: (i) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings and the right to request revisions to the person-centered plan of care. (ii) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care. (iii) The right to be informed, in advance, of changes to the plan of care.	F0553	F0553 “The facility failed to honor a resident’s right to attend care plan meetings for 1 of 28 residents.” Immediate action(s) taken for the resident(s) found to have been affected include: Immediate one-to-one education was provided on 5/11/26 to the Social Worker by the Administrator to ensure that, going forward, all residents and/or their responsible parties are invited to each care conference that is held. Identification of other residents having the potential to be affected was: The facility has determined that all residents have the potential to be affected by the deficient practice. All scheduled care conferences were reviewed to ensure invitations were made to both the residents and responsible parties, as appropriate.	05/28/2026

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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F0553 SS = D	Continued from page 1 (iv) The right to receive the services and/or items included in the plan of care. (v) The right to see the care plan, including the right to sign after significant changes to the plan of care. §483.10(c)(3) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must- (i) Facilitate the inclusion of the resident and/or resident representative. (ii) Include an assessment of the resident's strengths and needs. (iii) Incorporate the resident's personal and cultural preferences in developing goals of care. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and resident interviews, the facility failed to honor a resident's right to attend care plan meetings for 1 of 28 residents reviewed for care planning (Resident #53). Findings included: Resident #53 was admitted to the facility on 2/9/24. The quarterly Minimum Data Set (MDS) assessment dated 3/26/26 indicated Resident #53 was moderately cognitively impaired. The care plan for Resident #53 was initiated on 2/12/24 and last revised on 3/26/26. Record review revealed a late entry note written by Social Worker #1 on 3/31/26 stated a care plan meeting was held with only the Interdisciplinary Team (IDT) (the facility Social Worker and the MDS Nurse) in attendance. The Responsible Party (RP) was invited but did not attend. The record also revealed advanced directives and code status were reviewed. An interview with Resident #53 was conducted on 4/27/26 at 11:26 AM. Resident #53 stated she did not get invited to care planning meetings. She went on to say she feels her RP is not acting in her best interest and attending care plan meetings would help her better understand her current situation.	F0553	Continued from page 1 Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/11/2026, education was provided by the Administrator to the entire Social Services Department, including the Social Services Director and two Social Workers, to ensure that, going forward, all residents and/or their responsible parties are invited to each care conference that is held. Any new Social Services hire will receive education upon hire to ensure that residents and/or responsible parties are invited to each resident care conference. Beginning 5/11/2026, random audits will be completed by the Administrator twice weekly, Monday through Friday, for 4 weeks to ensure that residents and/or their responsible parties have been invited to each resident care conference. The Administrator will verify on the resident's care plan attendance sheet that the resident and/or responsible party has signed the sheet verifying attendance. If the care conference is held via telephone due to resident and/or responsible party preference, the Social Worker will document in writing that the conference was held by phone and identify who participated. Any deficient practices identified will result in immediate corrective action. The audit findings will be reported by the Administrator at the monthly QAPI meeting for 1 month. Next QAPI Meeting: 5/27/2026, Compliance Date: 5/28/2026	05/28/2026

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F0553 SS = D	Continued from page 2 During an interview with Social Worker (SW) #1 on 4/28/26 at 3:43 PM, she said Resident #53 was not listed as her own responsible party (RP) and therefore would not have been invited to attend care plan meetings. She stated she only invited the individual listed as a RP to the care plan meetings. SW #1 indicated the only time a resident would be invited to attend was if a resident was listed as their own RP. SW #1 added that Resident #53's RP had been invited to attend care plan meetings, but she did not recall a time when the RP had attended. During an interview on 4/29/26 at 2:06 PM, the Administrator said he expected staff to send care plan meeting invitations to residents who had the cognitive ability to participate and for whom participation would have been meaningful.	F0553		05/28/2026
F0584 SS = D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition;	F0584	F0584 "The facility failed to clean and maintain window curtains, the flooring underneath the medical equipment, and the packaged terminal air conditioner (PTAC) in a resident's room for 1 of 28 resident rooms." Immediate action(s) taken for the resident(s) found to have been affected include: On 5/11/26, the Facilities Services Director had removed the curtains from Resident #6's room and replaced them with clean window curtains. Resident #6's room floor was then deep cleaned by the Facilities Services Director and housekeeping team, and the PTAC unit was thoroughly cleaned and made free of dust and debris. Identification of other residents having the potential to be affected was: The facility has determined that all residents have the potential to be affected by the deficient practice. The Administrator, Facilities Services Director, and Housekeeping Supervisor immediately rounded on all resident rooms to ensure the provision a safe, clean, comfortable and homelike environment. Issues requiring corrective action were brought to the attention of the Housekeeping team. Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/11/2026, the Administrator and Facilities Services Director educated the Housekeeping	05/28/2026

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F0584 SS = D	Continued from page 3 §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1, 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review, and staff interviews, the facility failed to clean and maintain window curtains, the flooring underneath medical equipment, and the packaged terminal air conditioner (PTAC) in a resident's room for 1 of 28 resident rooms (Resident #6) on 1 of 6 halls observed for environment. The findings included: Resident #6's quarterly Minimum Data Set (MDS) assessment dated 2/17/26 revealed that she was severely cognitively impaired. An observation of Resident #6's room on 4/27/26 at 1:45 PM revealed both (two in total) window curtains had scattered red stains on them. There were also two pools of brown liquid underneath the tube feeding pole to the right of the head of the bed. It was also observed that dust like black bits, fragments, and pieces were on top of and inside the PTAC near the insertion site of the filter. Additional observations of Resident #6's room were conducted on 4/28/26 at 8:13 AM and 4/29/26 at 9:07 AM both observations revealed the two window curtains had scattered red stains on them. There were also 2 pools of brown liquid underneath the tube feeding pole to the right of the head of the bed. It was also observed that dust like black bits, fragments, and pieces were on top of and inside the PTAC near the insertion site of the filter. An interview with Housekeeper #1 was conducted on	F0584	Continued from page 3 Supervisor and all Housekeeping staff on the importance of ensuring that each resident's room maintains a clean, homelike environment, including but not limited to: window curtains free of stains, PTAC units free of dust and debris, and room floors that are clean and dry. Any new environmental services hires will be educated by the Staff Development Director on the importance of ensuring that each resident's room maintains a clean, home-like environment, including but not limited to: window curtains free of stains, PTAC units free of dust and debris, and room floors that are clean and dry. Beginning 5/11/2026, the Administrator and/or Facilities Services Director, will perform random room audits of a total of 5 resident rooms daily, Monday through Friday, for 4 weeks to ensure that each room is maintained in a clean, home-like environment for each resident, including but not limited to: window curtains free of stains, PTAC units free of dust and debris, and room floors that are clean and dry. Any deficient practices identified will result in immediate corrective action. The audit findings will be reported by the Administrator at the monthly QAPI meeting for 1 month.	05/28/2026

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F0584 SS = D	Continued from page 4 4/29/26 at 9:47 AM. She revealed she was hired in August 2025 and mainly was assigned to Resident #6's hall. She was assigned to Resident #6's room on 4/27/26 and 4/29/26. Housekeeper #1 stated Housekeeper #2 was assigned to Resident #6's room on 4/28/26. When cleaning a resident's room, housekeepers were expected to take out the trash, sweep the floor, mop the floor only if there was a spill, clean the bathroom, change the hand sanitizer, and replenish bathroom supplies. Housekeeper #1 stated that she checked behind the beds every day because residents ate in their rooms. She indicated that housekeeping was responsible for seeing if the window curtains needed to be replaced or cleaned. If there was an issue or the window curtains displayed any stains, she would notify the Housekeeping Manager/Maintenance Director. The PTAC units were also cleaned by housekeeping. An observation of Resident #6's room was conducted during an interview with Housekeeper #1 on 4/29/26 at 9:56 AM. Housekeeper #1 confirmed that the window curtains had red stains on them, there were two pools of dried brown liquid under the tube feeding pole, and there was a dusty black substance on top of the PTAC and inside the vents. Housekeeper #1 stated she tried to get the two pools of brown liquid up off the floor by wiping and scraping but was unsuccessful because the floor wax caused the brown liquid to become stuck. She further stated that she was never instructed to inspect the window curtains, only the privacy curtains and did not know the protocol for window curtains. Housekeeper #1 indicated that when interviewed earlier, she thought the window curtains were the same as the privacy curtain. She could not explain why the PTAC unit was not cleaned earlier, but it was her responsibility. Housekeeper #2 was interviewed on 4/29/26 at 10:07 AM. She revealed that she only focused on the trash and flooring in Resident #6's room on 4/28/26. Housekeeper #2 stated that everything looked fine to her. The Housekeeping Manager/Maintenance Director was interviewed on 4/29/26 at 10:11 AM. He revealed that the previous Housekeeping Manager ended their employment on 4/24/26. The Housekeeping Manager/Maintenance Director stated that all cleanliness concerns in Resident #6's room should have been identified and cleaned. When trying to scrape up the hardened brown liquid, it	F0584		05/28/2026

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F0584 SS = D	Continued from page 5 often brought up the wax; however, Housekeeper #1 could have sprayed it and let it sit multiple times and then it would come up within a few days. Housekeeper #1 should have notified the Housekeeping Manager/Maintenance Director about the stained window curtains. They would have been washed in the washing machine and hung up wet because they would melt in the dryer. However, the facility was in the process of replacing all window curtains and the valances on top of the curtains because the window curtains were more than 20 years old. The interview further revealed replacing the window curtains was first spoken about 1.5 years ago, but other urgent matters have come up since then. The Administrator was interviewed on 4/29/26 at 2:54 PM. He revealed he was awaiting a final decision from the facility's interior designer about the window treatment replacements. Although no upright chairs were observed in Resident #6's room, the Administrator indicated that the bottom of the upright chairs produced a black substance that disintegrated when touched and could have contributed toward the PTAC dusty black substance. He stated that the brown pools of liquid underneath the tube feeding pole should have been cleaned as soon as they were identified.	F0584		05/28/2026
F0627 SS = D	Inappropriate Discharge CFR(s): 483.15(c)(1)(2)(i)(ii)(7)(e)(1)(2);483.21(c)(1)(2) §483.15(c) Transfer and discharge- §483.15(c)(1) Facility requirements- §483.15(c)(1)(i) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless- (A)The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility; (B)The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility; (C)The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident; (D)The health of individuals in the facility would	F0627	F0627 "The facility failed to allow Resident #129 to return to the facility after being transferred to the hospital for evaluation for 1 of 4 residents reviewed for discharge." Immediate action(s) taken for the resident(s) found to have been affected include: On 5/11/26, the Administrator and Director of Nursing were educated by the Regional Operations Director to ensure that, going forward, each resident discharge is appropriate, including but not limited to: providing proper notice of discharge with the right to appeal and allowing the resident to remain in the facility during the appeal process. Identification of other residents having the potential to be affected was: The facility has determined that all residents have the potential to be affected by the deficient practice. The Administrator and Director of Nursing conducted a review of the past 90 days, there have been no additional facility initiated unplanned discharges. For	05/28/2026

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F0627 SS = D	Continued from page 6 otherwise be endangered; (E)The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit the necessary paperwork for third party payment or after the third party, including Medicare or Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a facility, the facility may charge a resident only allowable charges under Medicaid; or (F)The facility ceases to operate. §483.15(c)(1)(ii) The facility may not transfer or discharge the resident while the appeal is pending, pursuant to § 431.230 of this chapter, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility pursuant to § 431.220(a)(3) of this chapter, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose. §483.15(c)(2) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in paragraphs (c)(1)(i)(A) through (F) of this section, the facility must ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. (i)Documentation in the resident's medical record must include: (A) The basis for the transfer per paragraph (c)(1)(i) of this section. (B) In the case of paragraph (c)(1)(i)(A) of this section, the specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s). (ii)The documentation required by paragraph (c)(2)(i) of this section must be made by- (A) The resident's physician when transfer or discharge is necessary under paragraph (c) (1) (A) or	F0627	Continued from page 6 all residents currently hospitalized, the Administrator and Director of Nursing confirmed that the next available beds will be offered to these residents when they are ready to return. Actions taken/systems put into place to reduce the risk of future occurrence include: On 5/11/2026, the entire Interdisciplinary Team (IDT) was educated by the Administrator to ensure that, going forward, each resident discharge is appropriate, including but not limited to: providing proper notice of discharge with the right to appeal and allowing the resident to remain in the facility during the appeal process. Any new facility leadership hired will be educated by the Staff Development Coordinator to ensure that, going forward, each resident discharge is appropriate, including but not limited to: providing proper notice of discharge with the right to appeal and allowing the resident to remain in the facility during the appeal process. Beginning 5/11/2026, the Administrator will perform random discharge audits twice weekly, Monday through Friday, for 4 weeks to ensure that facility discharges are in compliance with facility policy. Any deficient practices identified will result in immediate corrective action. The audit findings will be reported by the Administrator at the monthly QAPI meeting for 1 month. Next QAPI Meeting: 5/27/2026 Compliance Date: 5/28/2026	05/28/2026

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F0627 SS = D	Continued from page 7 (B) of this section; and (B) A physician when transfer or discharge is necessary under paragraph (c)(1)(i)(C) or (D) of this section. §483.15(c)(7) Orientation for transfer or discharge. A facility must provide and document sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form and manner that the resident can understand. §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 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. §483.21(c)(1) Discharge Planning Process	F0627		05/28/2026

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F0627 SS = D	Continued from page 8 The facility must develop and implement an effective discharge planning process that focuses on the resident's discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility's discharge planning process must be consistent with the discharge rights set forth at 483.15(b) as applicable and- (i) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident. (ii) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes. (iii) Involve the interdisciplinary team, as defined by §483.21(b)(2)(ii), in the ongoing process of developing the discharge plan. (iv) Consider caregiver/support person availability and the resident's or caregiver's/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs. (v) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan. (vi) Address the resident's goals of care and treatment preferences. (vii) Document that a resident has been asked about their interest in receiving information regarding returning to the community. (A) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose. (B) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities. (C) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why. (viii) For residents who are transferred to another	F0627		05/28/2026

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F0627 SS = D	Continued from page 9 SNF or who are discharged to a HHA, IRF, or LTCH, assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences. (ix) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer. §483.21(c)(2) Discharge Summary When the facility anticipates discharge, a resident must have a discharge summary that includes, but is not limited to, the following: (iv) A post-discharge plan of care that is developed with the participation of the resident and, with the resident's consent, the resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow up care and any post-discharge medical and non-medical services. This REQUIREMENT is NOT MET as evidenced by: Based on record review and interviews with staff, Nurse Practitioner, Physician, Responsible Party (RP), and Hospital Case Manager, the facility failed to allow Resident #129 to return the facility after being transferred to the hospital for evaluation for 1 of 4 residents reviewed for discharge (Resident #129). Finding included: Resident #129 was admitted to the facility on 4/13/26. His active diagnoses included Parkinson's disease, bilateral sensorineural hearing loss (a permanent type of hearing loss caused by inner ear	F0627		05/28/2026

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F0627 SS = D	Continued from page 10 damage), bilateral unqualified visual loss (significant vision reduction in both eyes that has not been specifically categorized as either low vision or blindness), hypertension, diabetes mellitus, hyperlipidemia, dementia, anxiety disorder, depression, and asthma. Medical record review from admission on 4/13/26 through 4/18/26 revealed no evidence of behaviors for Resident #129. A late entry progress note dated 4/20/26 completed by Nurse #1 revealed Resident #129 was observed kneeling on the floor over his roommate. He was very aggressive and appeared to intend harm to his roommate. The two were separated, assessed with no injuries noted, and the provider and RPs were notified. Resident #129 was sent to the hospital for evaluation. During an interview on 4/29/26 at 2:08 PM Nurse Aide #3 stated she was the nurse aide on the hall when the incident happened between Resident #129 and his roommate. She indicated she had just finished caring for another resident and left that room when she heard Nurse #1 shout for help from Resident #129's room. She entered and the nurse had already separated the two residents. The roommate had a small laceration to his left eye that healed within two days. She stated Resident #129 had been on her assignment previously but had never presented with any signs of aggression towards other residents and rarely became upset with staff. She explained that when he became upset with staff he would yell at them and make them leave but he had never been physically threatening that she was aware of. She indicated it was a surprise for him to behave this way toward another resident. Law enforcement was notified and Resident #129 was sent to the hospital. Upon discharge on 4/19/26, a transfer/discharge notice was provided to Resident #129. The reason for the transfer/discharge was documented to be necessary for Resident #129's welfare, his needs could not be met in the facility, and the safety of individuals in the facility was endangered due to the clinical or behavioral status of the resident. The hospital record from 4/19/26 through 4/21/26 indicated Resident #129 was sent to the Emergency Department (ED) for evaluation of agitation. A Psychiatry and Behavioral Medicine ED consultation note indicated the resident was noted with a history of Parkinson's disease with worsening confusion and no prior psychiatric history of	F0627		05/28/2026

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F0627 SS = D	Continued from page 11 aggression/agitation. The resident reported he had left his room and when he came back someone was in his bed and he got upset with them. The resident had no acute concerns for psychiatric illness and did not meet inpatient criteria. The ED's history of present illness indicated Resident #129 was blind and hard of hearing. ED Case Management notes indicated that initially the facility indicated the resident could return on 4/20/26 when a private room was available; and subsequently the facility indicated the resident could not return to the facility at all. The resident was discharged home with his spouse on 4/21/26 with home health services. During a phone interview on 4/29/26 at 3:46 PM the ED/Behavioral Health Case Manager stated the resident was sent to the hospital on 4/19/26 and was assessed and cleared to return to the facility for Skilled Nursing Facility (SNF) level of care by the providers in the ED that evening. She notified the Hospital Liaison for the facility who said Resident #129 could go back to the facility the following day (4/20/26) because they needed to prepare and admit Resident #129 into a private room. The ED/Behavioral Health Case Manager told the Hospital Liaison Resident #129 did not need to stay overnight in the hospital and questioned what the difference was between staying one more night or not. The ED was having capacity issues, and Resident #129 who was deemed appropriate for SNF care was taking up a bed needed for someone who had an actual reason to be in the hospital. The facility's Hospital Liaison said she would speak with the Administrator. That evening (4/19/26) around 5:00 PM, the facility's Hospital Liaison then notified the ED/Behavioral Health Case Manager that Resident #129 would not be allowed to return to the facility. She attempted to find Resident #129 placement in a SNF elsewhere but was unsuccessful. The RP came to the hospital and took him home 4/20/26. The ED/Behavioral Health Case Manager set up home health and ensured safety of the discharge, Resident #129's RP just wanted him to get therapy first before returning home. Resident #129 did not return to the facility. During a phone interview on 4/29/26 at 4:05 PM Resident #129's RP (his spouse) stated she was called by Resident #129's nurse on a Sunday (4/19/26) and was told he needed to be sent to the hospital due to confusion and delusions and needed the hospital to evaluate him. The nurse also indicated he had become very angry with his roommate and they had to be separated. He went to the hospital on Sunday 4/19/26 around 11:00 AM.	F0627		05/28/2026

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F0627 SS = D	Continued from page 12 The facility had asked for a psychiatric examination. The hospital did not identify any psychiatric illness, and a case manager from the hospital whose name she could not remember called and said Resident #129 needed to wait 24 hours for a private bed to open according to the facility. Then the hospital case manager called again and said the facility was not taking Resident #129 back and she would try to find another facility for him to go to. She was later told via phone by the ED/Behavioral Health Case Manager that other facilities were not accepting Resident #129, and it was late in the night on 4/19/26 when the hospital informed her the resident had to go home with her. She told them he could not return home that night. She was called at about 10:00 AM in the morning on 4/20/26 and she told them she was not sure it was safe for him to be discharged this way. She was then told by the hospital that he had to go home. She stated she spoke with the Director of Nursing at the facility and was told she had no appeal or recourse. When asked, she concluded she did not think Resident #129 had any psychosocial harm because he was “a very resilient fellow.” Resident #129 was currently living at home and being seen by home health. She reported that things were going okay but hated that Resident #129 did not receive a little more therapy before returning home. During an interview on 4/29/26 at 1:45 PM Nurse Aide #1 indicated she was familiar with Resident #129. She stated she was not involved in the incident in which Resident #129 became hostile to his roommate. She stated she had not observed any aggressive or violent behaviors toward other residents. She indicated that the resident could get irritable and yell at a staff member to leave the room at times but if he was given fifteen minutes and he would apologize to the staff. Nurse Aide #1 reported she was surprised to learn he had been aggressive toward his roommate, as he had never exhibited such behavior in the past when she took care of him on her assignment. During an interview on 4/29/26 at 1:48 PM Nurse Aide #2 stated she was familiar with Resident #129. She further stated she was not involved in the incident with Resident #129 and his roommate. She reported she had not had any indication of him being aggressive or violent to other residents and was surprised to hear he had been aggressive towards his roommate as he had never done anything like that in the past. During an interview on 4/28/26 at 10:46 AM, Social Worker #1 and Social Worker #2 stated they were	F0627		05/28/2026

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F0627 SS = D	Continued from page 13 not involved with any decision regarding whether a resident was allowed to return to the facility or not. They stated that decision was handled by the Admissions Department and the Director of Nursing if needed. During an interview on 4/28/26 at 10:50 AM the Admissions Director and the Admissions Ambassador stated they did not have any say on whether a resident was allowed to return to the facility or not. The decision in question was handled by the Administrator and Director of Nursing. The Admission Director stated the admissions department did not have any involvement in the decision. During an interview on 4/29/26 at 12:14 PM Nurse Practitioner #1 stated she arrived at the facility the morning after the incident happened (4/20/26) and she was informed Resident #129 had been uncharacteristically aggressive towards his roommate. She stated she was not involved in the decision not to allow Resident #129 back in the facility; however, she did agree they were unable to provide the level of care he needed at that time. Prior to this incident, Resident #129 did not display this level of cognitive decline and had not displayed similar behaviors. With this in mind, and his visual impairment, she believed he could have attacked someone else if he thought something was abnormal or believed he was under attack. She indicated in an environment where it could not be ensured that an individual would not approach, speak to, or touch Resident #129 without first explaining what they were doing, such as a roommate, visitor, or other resident as he was ambulatory and would walk the hall, she felt the facility could not ensure the safety of Resident #129 or the other residents in the facility who might not approach him as a medical professional would. During an interview on 4/29/26 at 1:09 PM Physician #1 stated he was familiar with Resident #129. He further stated the decision to not allow the resident to return was made by the Director of Nursing and Administrator without him and then after that decision had been made, he was updated on the status of the resident and agreed with the decision. The Physician stated that given Resident #129's visual and hearing impairment, he could have attacked another individual if he perceived something as abnormal or was under the impression he was under attack as happened with his roommate on 4/19/26. Physician #1 verbalized he was surprised when he heard about this incident as Resident #129 had not displayed this type of	F0627		05/28/2026

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F0627 SS = D	Continued from page 14 behavior previously. He concluded that while he agreed with the decision to not take the resident back, he was not involved in the decision and did not document anything regarding the facility not being able to care for Resident #129. During an interview on 4/28/26 at 11:03 AM the Administrator stated the decision not to allow Resident #129 back into the facility was made as a result of the incident on 4/19/26 and hospital records following the incident. She explained that the hospital records did not indicate the hospital had done anything for Resident #129 besides completing a psychiatric assessment and deeming him fit to return to the facility that same day. The Administrator felt the facility could not guarantee the safety of other residents if they allowed Resident #129 back into the facility. Nurse Practitioner #1 was made aware of the incident and the decision not to allow Resident #129 to return to the facility during a conversation with the Director of Nursing and the Administrator and she (Nurse Practitioner #1) agreed with the decision. The Medical Director was not involved in the decision but was informed later and agreed. The facility's Hospital Liaison informed the hospital Resident #129 would not be returning to the facility and Resident #129's RP was notified by the hospital. The Administrator stated he had not seen any behaviors of aggression towards other residents displayed by Resident #129 prior to 4/19/26.	F0627		05/28/2026