STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	235262	A. Building B. Wing	03/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
West Hickory Haven	3310 W Commerce Rd Milford, MI 48380

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure the transfer/discharge meets the resident's needs/preferences and that the resident is prepared for a safe transfer/discharge. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint 2797202.Based on interview and record review, the facility failed to permit a resident to return to the facility following a transfer to hospital for one (R902) of four residents reviewed for discharge. Findings include:Review of a complaint reported to the State Agency included allegations that the facility sent R902 to the hospital on 3/5/26 and refused to allow them to return, and the family never received written discharge notices as required.Review of the clinical record revealed R902 was initially admitted into the facility on 2/19/26 and was discharged to hospital on 3/5/26 and had not returned. Diagnoses included: chronic kidney disease stage 3A, anxiety disorder, personal history of traumatic brain injury, vascular dementia severe with other behavioral disturbance, dementia in other diseases classified elsewhere, severe, with other behavioral disturbance, mild cognitive impairment of uncertain or unknown etiology, and age-related cognitive decline. The clinical record further identified that R902's wife was their responsible party, emergency contact #1, and power of attorney for care and financial decisions.According to the admission Minimum Data Set (MDS) assessment dated [DATE], R902 had severe cognitive impairment, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed towards others, which occurred 1 to 3 days that significantly interfered with the resident's care and significantly interfered with the resident's participation in activities or social interactions, put others at significant risk of physical injury, significantly disrupted care or living environment, and had wandering behavior that placed the resident at significant risk of getting to a potentially dangerous place or significantly intruded on the privacy or activities of others, was independent with mobility, required supervision or touching assistance with walking at least 10-150, and was frequently incontinent of bowel and bladder.Review of the hospital documentation provided to the facility prior to R902's admission included: .History of Present Illness Patient is a [AGE] year old male with a past medical history of Cognitive impairment.that presents to [hospital name] on 01/20/2026 with chronic dementia, agitation, need for inpatient psychiatry evaluation and placement.All of the following history was obtained from patient's son at bedside and best attempt was made at accuracy. Son states that his dad was originally admitted on [DATE] following a behavioral outburst at home. He requires 24-hour care at baseline at home due to his cognitive impairment and that is mostly done by his wife, including feeding, medication administration, personal hygiene, toileting, fecal and urinary incontinence measures. He started having behavioral outburst lasting 8 hours including shouting nonsensical words, slamming doors and tipping over family's table. This event prompted family to seek nursing home/psychiatric facility placement for him. He reports he previously had 10-minute spells of similar behavior. He reports that his dad has had cognitive decline over the past 20 years.Hospital discharge notes: Son reports that patient routinely requests his wife to shower with him, becomes aggressive, and she feels that she does not want to do so. Per son, patient's wife feels that she is overwhelmed with taking care of the patient's needs. Per son, history is complicated with previous discharge from [hospital name] psychiatric health facility, and they were unaware that patient had been discharged . Family is not planning on discharge home (continued on next page)

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

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	however facility had dropped off the patient back at their house, not appropriately dressed for 15 degree weather. House was found locked up, so taxi driver took patient back to [psychiatric hospital] facility where he was rejected. From there, family tried frantically calling the facility however were not able to reach them in a timely manner. Patient was found by a random stranger who happened to know of a group home; she took care of the patient for short while, provided clothes, food and other necessities. After some time in the AFC (Adult [NAME] Care) however the patient escaped left the facility without permission, and per son was not allowed back in the facility. At that time, the group home decided that the patient would not be a good candidate to live in the facility alongside other residents. That is when the two sons [NAME] the patient into the hospital. His son reports that his father is mostly bedbound, requires constant support to get out of bed. He routinely urinates on himself and requires people to help him change clothes. He is also frequently incontinent routinely.One-to-one ordered. Patient had previously escaped the ED (Emergency Department).Psychiatry consulted.PSYCH Consulted. Agitation/Neurocognitive disorder -Continue Seroquel 25mg (milligrams) pO (by mouth) BID (Twice a Day) - RECOMMEND CLOSE Follow up PSYCH at Discharge. His condition improved, symptoms improved, mentation improved to baseline and remained stable.This documentation confirmed the facility had been aware of R902's extensive history of behaviors which included aggression, wandering and non-compliance and continued to accept the resident for admission into their facility.Further review of the progress notes included multiple incidents of R902 exhibiting exit seeking and physical behaviors (swinging, kicking, spitting, swearing) in which nursing staff obtained additional intramuscular (IM) psychotropic medication to administer to R902.Progress notes entries included:An entry on 3/6/26 at 1:36 AM by Nurse ?H' read: Ems (Emergency Medical Services) attempted return of resident at this time staff nurses made Ems aware that we could not provide care for resident d/t (due to) his behavior [name redacted] from [name of local hospital resident was sent to] called to inquire why resident was refused writer explained that order were given for a do not return r/t (related to) facility unable to maintain his needs r/t aggressive and combative behavior and that resident has again attacked a staff member, he was given Admin (Administrator) and [NAME] (Director of Nursing) information and stated he would reach out to facility in the am (morning).Review of a form titled, FACILITY-INITIATED TRANSFER FOR NURSING HOMES dated 3/5/26 was noted as Reason(s) for facility-initiated transfer.Behavioral needs cannot be met in the nursing home.Explanation for the reasons identified above: combative with STAFF hitting, kicking, spitting, had her shirt collar and pulling her shirt up around her neck.On 3/9/26 at 10:06 AM, an interview was conducted with the facility's social services staff (SS ?C'). When asked if they were involved in the admission process for consideration of R902's placement in the facility, SS ?C' reported they were not. When asked about R902's behaviors, SS ?C' reported they assumed he had front lobe dementia, exit seeked, yelled, spit and towards the end was getting aggressive with staff. They reported they were not there when R902 became physical with staff.SS ?C' further reported they believed the resident's admission status was completely different than what they received. When asked what that meant, SS ?C' reported they said he couldn't walk but he could walk just fine. They reported the resident had been followed by psych while at the facility and they had conversation with R902's son about medication requests, but that was up to the psych provider who chose not to order what the family wanted.When asked if they were involved in the discussion with Administration to not allow R902 to return, SS ?C' reported they were not but was aware it was due to exit seeking and aggression. SS ?C' reported they did have discussion with the family about more appropriate placement such as a locked memory unit and they did not want to do that. When asked why the facility would accept R902 given the extensive behaviors that were available, SS ?C' reported they think the facility focused on the fact R902 was bedbound and thought we could handle this.SS ?C' also reported at the time the admission person (Staff ?E') went to see R902 and R902 was just loud and stated he had dementia. When asked when the facility initiated one to one assigned staff, SS ?C' reported that was after his exit seeking behaviors and the night of the transfer, he beat (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	up the one to one and that's when we discharged him and said he was unsafe here for my staff and other residents. When asked about the process for discharge notifications, especially involuntary discharges, SS ?C' deferred to their Director of Nursing (DON).On 3/9/26 at 10:30 AM, an interview was conducted with the DON. When asked if they were involved in R902's transfer to the hospital, the DON reported they were not but did report they received a call after 10:00 PM that he was sent out after assaulting staff.When asked if they had spoken to anyone about not allowing R902 to return, the DON reported (name of hospital) called and asked if we would take them back and we said no. We also called the ombudsman and spoke with Ombudsman ?J' and let her know we were not accepting R902 back. The DON reported Ombudsman ?J' reported they would have to advocate for R902.When asked if they were involved in the admission process, the DON reported their facility's process had a green, yellow, red light for what they could take and believe a corporate person reviews that and notifies the facility and the Administrator decides as to if they can handle the resident. The DON reported they thought someone did onsite him which wasn't done for everyone but was for him.When asked if the facility had been aware of R902's extensive behavior history and was evaluated and determined they could accept the resident, how was it now determined they could not, the DON reported they were aware R902 had those behaviors at home but believed at the hospital the resident was stable. The DON reported when R902 arrived to their facility, he was able to ambulate independently and they thought within 12 hours of arrival, R902 was kicking at the doors.On 3/9/26 at 11:50 AM, Ombudsman ?J' was attempted to be contacted by phone and a message was left to return the call. There was no return call by the end of the survey.On 3/9/26 at 12:45 PM, a phone interview was conducted with Nurse ?F'. When asked to recall the events from the night R902 was sent out, Nurse ?F? reported the same events as their documented progress note. Nurse ?F' was asked about the documentation of the transfer packet and they reported they sent all of the packet with R902. When asked about the section of the discharge documentation that included a second nurse witness signature, Nurse ?F' reported their understanding was that was something the business office follows-up. Nurse ?F' was asked if family was present at the time of discharge and they reported there was no family around at that time.When asked if they had spoken to anyone that night about not allowing R902 to return, Nurse ?F' reported they had spoken to R902's wife that night and verbally told her we will not be accepting him back because the abuse that night was very dangerous, and was not sure what she didn't understand. Nurse ?F' further reported they spoke to the wife on the phone and gave her a call back because she said she was unfamiliar with the area so they called her back and gave address and phone number to where R902 was discharged .Nurse ?F' further reported the family questioned about the facility not taking R902 back and they said that was for management to explain and their orders from the DON and Administrator were R902 to be sent out with a no return.On 3/9/26 at 12:36 PM, the facility was requested by email to provide policies for Facility Initiated Discharges, Bed Hold, Hospital and Therapeutic Leave, Re-Admission, and Notice of Transfer or Discharge.On 3/9/26 at 12:59 PM, Admissions/Financial Staff 'E' was attempted to be contacted by phone, and a message was left to return the call.Review of the documentation provided by the Administrator included:A policy titled, Bed Hold Hospital and Therapeutic Leave re-admission dated 8/2017 documented, in part: .When a resident has a temporary absence from the facility for emergency medical treatment, the facility will hold a bed open for ten (10) days for that resident's absence .The facility will re-admit a discharged resident who has an expectation of returning to the facility unless .The discharge was necessary of the resident's welfare and the needs of the resident cannot be met in the facility .The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident . It should be noted that this policy included references of specific federal regulations that were obsolete and had not been updated with current regulatory references.A policy titled, Notice of Transfer or discharge date d July 2023 documented, in part: .Facility Initiated transfer or discharge: A transfer or discharge to which the resident objects, did not originate through a resident's verbal or written request, and / or is not in alignment with the residents stated goals for care and preferences .Facility (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- Initiated Transfer (FIT) .The FIT-100 form and process will be used when there is a transfer of a resident from the federally certified nursing home to another facility, such as acute care hospital, with the expectation that the resident will return to the federally certified nursing home .Prepare .FIT-100 .Provide the FIT-100 form to the resident and / or authorized representative along with an envelope and postage for an appeal request .A copy of this notice will be placed in the resident's medical record .Involuntary Transfer or Discharge (IDT) and Facility-Initiated Discharge .Prepare the ITD-100 form - Have an initial discussion with he <sic> resident and / or authorized representative to assist in identification of transfer or discharge location .If the destination changes and this change was initiated by the facility, and updated notice with the new destination will be issued. The change restarts the 30-day timeline for transfer or discharge .Provide the completed ITD-100 form to the resident and / or authorized representative at least 30-days prior to an involuntary transfer or discharge along with an envelope and postage for appeal request .A copy of the ITD-100 form must be submitted to Licensing and Regulatory Affairs ([NAME]) .A copy of the ITD-100 form must be included in the resident's medical record .The resident shall not be transferred or discharged from the facility .Before the 34th day following receipt of the notice or the 10th day following appeal hearing decision, whichever is later, and .Without [NAME] approval of the proposed transfer or discharge plan .[NAME] will provide written approval of acceptance of the proposed transfer or discharge plan .The approval of the proposed transfer or discharge plan shall be placed in the residents' medical record .On 3/9/26 at approximately 1:30 PM, an exit conference was conducted with the Administrator and DON. When informed of the concerns about R902's discharge and the facility's decision not to allow R902 to return, the Administrator reported the facility could not meet R902's needs. The Administrator was asked to review the documentation included with the transfer packet which was left incomplete and confirmed the same missing documentation. When asked if they had notified the ombudsman in writing of R902's transfer and decision not to readmit, the Administrator reported they had a phone conversation, but notification did not include the written notification. The Administrator was further informed of the concern that the documentation of the specific local ombudsman had not been updated to reflect the current ombudsman, as well as their policy provided referenced outdated regulations and had not been updated since 8/2017.On 3/9/26 at 2:13 PM, a phone interview was conducted with the Admissions/Financial Staff ?E'. When asked what they could recall regarding the details of R902 not being allowed to return to the facility, Staff ?E' reported they'd been out of the facility since Friday (3/6/26) and wasn't there for a majority of it. When asked if they were involved in the involuntary discharge process, Staff ?E' reported they were not, unless it was due to a financial reason.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to complaint 2797202.Based on interview and record review, the facility failed to provide the legal representative a written notice of transfer/discharge and send a copy to the Ombudsman for one (R902) of four residents reviewed for discharge. Findings include:Review of a complaint reported to the State Agency included allegations that the facility sent R902 to the hospital on 3/5/26 and refused to allow them to return, and the family never received written discharge notices as required.Review of the clinical record revealed R902 was initially admitted into the facility on 2/19/26 and was discharged to hospital on 3/5/26 and had not returned. Diagnoses included: chronic kidney disease stage 3A, anxiety disorder, personal history of traumatic brain injury, vascular dementia severe with other behavioral disturbance, dementia in other diseases classified elsewhere, severe, with other behavioral disturbance, mild cognitive impairment of uncertain or unknown etiology, and age-related cognitive decline. The clinical record further identified that R902's wife was their responsible party, emergency contact #1, and power of attorney for care and financial decisions.According to the admission Minimum Data Set (MDS) assessment dated [DATE], R902 had severe cognitive impairment, had physical behavioral symptoms directed towards others and other behavioral symptoms not directed towards others, which occurred 1 to 3 days that significantly interfered with the resident's care and significantly interfered with the resident's participation in activities or social interactions, put others at significant risk of physical injury, significantly disrupted care or living environment, and had wandering behavior that placed the resident at significant risk of getting to a potentially dangerous place or significantly intruded on the privacy or activities of others, was independent with mobility, required supervision or touching assistance with walking at least 10-150, and was frequently incontinent of bowel and bladder.Progress notes included an entry on 3/6/26 at 1:36 AM by Nurse ?H' that read: Ems (Emergency Medical Services) attempted return of resident at this time staff nurses made Ems aware that we could not provide care for resident d/t (due to) his behavior [name redacted] from [name of local hospital resident was sent to] called to inquire why resident was refused writer explained that order were given for a do not return r/t (related to) facility unable to maintain his needs r/t aggressive and combative behavior and that resident has again attacked a staff member, he was given Admin (Administrator) and [NAME] (Director of Nursing) information and stated he would reach out to facility in the am (morning).Review of the transfer/discharge documentation available for R902 included:A form titled, Emergent Transfer Requirement dated 3/5/26 by Nurse ?H' and Medical Records Staff ?B' on 3/6/2. This form instructed staff to:Print the following items for the Transfer Packet, and initial once completed.There was a check mark next to face sheet, MAR/TAR (Medication Administration Record/Treatment Administration Record), Applicable Progress Notes, Applicable HCP (Health Care Provider) notes, Applicable Labs, Preferred Treatment Option, ADL (Activities of Daily Living) Care Plan, Complete the eINTERACT Transfer Form - Transfer Out to Hospital. There were two areas that were not checked off (left blank) for: Below are regulatory forms inside of this packet that need to be completed with the resident or responsible party. This can be done verbally with two nurse witnesses. Prepared transfer notice form; signed or witnessed acknowledgement AT TIME OF TRANSFER and bed hold policy. (MCL 333.21702 483.15 Admission, Transfer, Discharge Rights) and FIT-100 Form - All Informational Boxes Addressed with postage prepared envelope for appeal request. (Facility Initiated Transfer).Further review of the form titled MCL 333.21702 483.15 Admission, Transfer, Discharge Rights revealed there were two check marks placed next to Reason for Transfer (Check all that apply) The Welfare and needs of the resident cannot be met in the facility and An emergency exists in which the safety of individuals in the home is endangered. The bottom portion of the form was signed by one nurse (Nurse ?H') on 3/5/26. The section for Witnessing Licensed Nurse was left blank.This (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	form also identified the Local Ombudsman as [name of former local ombudsman] (not updated with accurate information).Review of a form titled, FACILITY-INITIATED TRANSFER FOR NURSING HOMES dated 3/5/26 was noted as Reason(s) for facility-initiated transfer.Behavioral needs cannot be met in the nursing home.Explanation for the reasons identified above: combative with STAFF hitting, kicking, spitting, had her shirt collar and pulling her shirt up around her neck.On 3/9/26 at 10:06 AM, an interview was conducted with the facility's social services staff (SS ?C'). When asked about the process for discharge notifications, especially involuntary discharges, SS ?C' deferred to their Director of Nursing (DON).On 3/9/26 at 10:30 AM, an interview was conducted with the DON. When asked to explain the facility's process for discharge and requirements, the DON reported if someone was to be discharged acutely the nurse does e-interact form and vitals and the paperwork. The DON reported the paperwork included face sheet, diagnoses, immunizations, orders, order summary, pertinent progress, dr notes, labs and reported that assessment was completed for R902.When asked about the section of the discharge papers for the bed hold notification, the DON reported the bed hold notification and another form that goes with the bed hold notification, including the representative is called, the physician is called, then the Administrator and I am called. The DON further reported the Nurse calls a report to EMS and hospital transfer - sometimes EMS asks for paperwork but sometimes they don't.When asked if they were involved in R902's transfer to the hospital, the DON reported they were not but did report they received a call after 10:00 PM that he was sent out after assaulting staff.When asked if they had spoken to anyone about not allowing R902 to return, the DON reported (name of hospital) called and asked if we would take them back and we said no. We also called the ombudsman and spoke with Ombudsman ?J' and let her know we were not accepting R902 back. The DON reported Ombudsman ?J' reported they would have to advocate for R902.When asked about the facility's discharge paperwork that included the bed hold notification as well as the involuntary discharge documentation, and lack of completion per the instructions on the form, the DON reported that was done by their financial staff and the checklist for completion had to be signed off by Staff ?E'. The DON reported Staff ?E' was not in the facility today.The DON reported they did send the bed hold policy and notice of transfer packet with the resident with EMS. When asked if the family was present at the time of discharge, the DON reported they were not sure.On 3/9/26 at 11:50 AM, Ombudsman ?J' was attempted to be contacted by phone, and a message was left to return the call. There was no return call by the end of the survey.On 3/9/26 at 12:45 PM, a phone interview was conducted with Nurse ?F'. When asked to recall the events from the night R902 was sent out, Nurse ?F? reported the same events as their documented progress note. Nurse ?F' was asked about the documentation of the transfer packet, and they reported they sent all of the packet with R902. When asked about the section of the discharge documentation that included a second nurse witness signature, Nurse ?F' reported their understanding was that was something the business office follows-up. Nurse ?F' was asked if family was present at the time of discharge and they reported there was no family around at that time.When asked if they had spoken to anyone that night about not allowing R902 to return, Nurse ?F' reported they had spoken to R902's wife that night and verbally told her we will not be accepting him back because the abuse that night was very dangerous and was not sure what she didn't understand. Nurse ?F' further reported they spoke to the wife on the phone and gave her a call back because she said she was unfamiliar with the area, so they called her back and gave address and phone number to where R902 was discharged .Nurse ?F' further reported the family questioned about the facility not taking R902 back and they said that was for management to explain and their orders from the DON and Administrator were R902 to be sent out with a no return.On 3/9/26 at 12:36 PM, the facility was requested by email to provide policies for Facility Initiated Discharges, Bed Hold, Hospital and Therapeutic Leave, Re-Admission, and Notice of Transfer or Discharge.On 3/9/26 at 12:59 PM, Admissions/Financial Staff 'E' was attempted to be contacted by phone, and a message was left to return the call.Review of the documentation provided by the Administrator included:A policy titled, Bed Hold Hospital and Therapeutic Leave re-admission (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	dated 8/2017 documented, in part: .When a resident has a temporary absence from the facility for emergency medical treatment, the facility will hold a bed open for ten (10) days for that resident's absence .The facility will re-admit a discharged resident who has an expectation of returning to the facility unless .The discharge was necessary of the resident's welfare and the needs of the resident cannot be met in the facility .The safety of the individuals in the facility is endangered due to the clinical or behavioral status of the resident . It should be noted that this policy included references of specific federal regulations that were obsolete and had not been updated with current regulatory references.A policy titled, Notice of Transfer or discharge date d July 2023 documented, in part: .Facility Initiated transfer or discharge: A transfer or discharge to which the resident objects, did not originate through a resident's verbal or written request, and / or is not in alignment with the residents stated goals for care and preferences .Facility - Initiated Transfer (FIT) .The FIT-100 form and process will be used when there is a transfer of a resident from the federally certified nursing home to another facility, such as acute care hospital, with the expectation that the resident will return to the federally certified nursing home .Prepare .FIT-100 .Provide the FIT-100 form to the resident and / or authorized representative along with an envelope and postage for an appeal request .A copy of this notice will be placed in the resident's medical record .Involuntary Transfer or Discharge (IDT) and Facility-Initiated Discharge .Prepare the ITD-100 form - Have an initial discussion with he <sic> resident and / or authorized representative to assist in identification of transfer or discharge location .If the destination changes and this change was initiated by the facility, and updated notice with the new destination will be issued. The change restarts the 30-day timeline for transfer or discharge .Provide the completed ITD-100 form to the resident and / or authorized representative at least 30-days prior to an involuntary transfer or discharge along with an envelope and postage for appeal request .A copy of the ITD-100 form must be submitted to Licensing and Regulatory Affairs ([NAME]) .A copy of the ITD-100 form must be included in the resident's medical record .The resident shall not be transferred or discharged from the facility .Before the 34th day following receipt of the notice or the 10th day following appeal hearing decision, whichever is later, and .Without [NAME] approval of the proposed transfer or discharge plan .[NAME] will provide written approval of acceptance of the proposed transfer or discharge plan .The approval of the proposed transfer or discharge plan shall be placed in the residents' medical record .On 3/9/26 at approximately 1:30 PM, an exit conference was conducted with the Administrator and DON. When informed of the concerns for R902's discharge and the facility's decision not to allow R902 to return, the Administrator reported the facility could not meet R902's needs. The Administrator was asked to review the documentation included with the transfer packet which was left incomplete and confirmed the same missing documentation. When asked if they had notified the ombudsman in writing of R902's transfer and decision not to readmit, the Administrator reported they had a phone conversation, but notification did not include the written notification. The Administrator was further informed of the concern that the documentation of the specific local ombudsman had not been updated to reflect the current ombudsman, as well as their policy provided referenced outdated regulations and had not been updated since 8/2017.On 3/9/26 at 2:13 PM, a phone interview was conducted with the Admissions/Financial Staff ?E'. When asked what they could recall regarding the details of R902 not being allowed to return to the facility, Staff ?E' reported they've been out of the facility since Friday (3/6/26) and wasn't there for a majority of it. When asked if they were involved in the involuntary discharge process, Staff ?E' reported they were not, unless it was due to a financial reason.When asked if they were involved in the bed hold process, Staff ?E' reported they would call to discuss bed hold details, but they had not done that for R902 since they've been out since last Friday. When asked if there was back-up person for their role in the event they were out, Staff ?E' reported their back-up was Medical Records ?B' and the Administrator.