STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345168	A. Building B. Wing	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, NC 27834

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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 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 [DATE] 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 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 (continued on next page)

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NAME OF PROVIDER OR SUPPLIER MacGregor Downs Health Center by Harborview		STREET ADDRESS, CITY, STATE, ZIP CODE 2910 MacGregor Downs Road Greenville, NC 27834	

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F 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #6's room should have been identified and cleaned. When trying to scrape up the hardened brown liquid, it 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 [AGE] 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.

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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** 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 [DATE]. His active diagnoses included Parkinson's disease, bilateral sensorineural hearing loss (a permanent type of hearing loss caused by inner ear 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 [DATE] 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 [DATE], 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 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 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 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 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 (continued on next page)

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F 0627 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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 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.