STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345380	A. Building B. Wing	02/20/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Village Green Health and Rehabilitation	1601 Purdue Drive Fayetteville, NC 28304

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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 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews with residents, staff, Physician, and Psychiatric Nurse Practitioner, the facility failed to develop and implement individualized person-centered care plan approaches for a resident (Resident # 8) diagnosed with dementia who had a known pattern of verbal behaviors, to include yelling slurs and foul language, specifically targeting Resident # 9. Staff reported that they attempted redirection of Resident #8, but the behaviors had continued and no additional care plan interventions had been developed or implemented that focused on instructing staff on how to manage these verbal behaviors. This deficient practice was for 1 of 1 resident (Resident # 8) sampled for dementia care.The findings included:Resident # 8 was admitted to the facility on [DATE] with diagnoses which included early onset Alzheimer's Disease, dementia, major depressive disorder, and a history of stroke. Resident # 8's annual Minimum Data Set (MDS) assessment, dated 10/15/25 revealed Resident # 8 was moderately cognitively impaired, had no behaviors during the assessment period of the MDS, and used a wheelchair to self-propel himself with supervision. He received antidepressant and anticonvulsant medication.Resident # 8's care plan was updated on 10/30/25 with a new problem area of frequent conflicts with peers and staff, apparently related to mood distress, poor coping skills, and intolerance of others. These conflicts often took the form of complaints about his roommate, cursing/yelling at his roommate, complaints and concerns about other residents/staff, and unprovoked expressions of anger towards staff/ residents. The care plan approaches included staff intervening when inappropriate behaviors were observed and to communicate assertively that the resident must exercise control over his impulses and behaviors; staff to remind the resident to communicate his anger and frustration without offending, being mean, or being verbally aggressive towards others; and staff to refer the resident to the consulting psychiatrist. On 11/18/25 a Mental Health Counselor documented the following notations after seeing Resident # 8 for talk therapy. The staff had noted that Resident # 8 was becoming increasingly agitated and argumentative and she (the Mental Health Counselor) probed the resident to discuss triggering situations. The Mental Health Counselor documented that Resident #8 stated, 'I am not agitated. I am tired of being here. The resident indicated that he wanted to go somewhere like a movie or retail store. The resident stated that he wanted to do different things sometimes as he always played games and watched TV. He went on to explain that he wished they had more ice cream socials and that he liked when the preacher/pastor came from the church to have bible study and prayer. The resident reported that he liked his roommate, but the roommate didn't talk; and that he wished he could talk with his family more, but they are living their own lives. Resident #8 verbalized that deep breathing didn't work for him and meditation was ok but sometimes he couldn't focus.On 12/30/25 the Mental Health Counselor documented she saw Resident # 8 who reported he was alright, a new year was coming, and he was hoping that good things would come to him and everyone else. The resident also reported he did not expect much from his family because they had their (continued on next page)

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 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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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	own lives.On 1/8/26 the Psychiatric Nurse Practitioner (NP) noted she was seeing Resident # 1 for Alzheimer's disease, neurocognitive disorder due to the Alzheimer's disease, and depressive disorder. The resident's dementia was classified as moderate. The Psychiatric NP noted the resident's behavioral disturbances were at his baseline and there had been no reports of inappropriate behaviors from the staff. Resident # 8 was currently receiving the mood stabilizing medication Depakote (an anticonvulsant medication that acts as a mood stabilizer) 250 mg (milligrams) twice per day for mood support and Zoloft 100 mg for depressive disorder. On 2/6/26 at 8:52 AM Nurse # 1 entered a nursing progress note into Resident # 8's record that indicated a Nurse Aide reported she could overhear Resident # 8 cursing and yelling at a resident in another room (Resident # 9) and that Resident # 8 was redirected to move away from Resident # 9's doorway. Resident # 9, who was being cursed at from his doorway, reported the incident was unprovoked and Resident # 8 had a history of this type of behavior towards him. Resident # 9 reported Resident # 8 just started yelling faggot bitch into his room that morning.Resident #9's quarterly MDS assessment dated [DATE] indicated his cognition was intact and he had no behaviors. Review of Resident # 8's nursing and social service progress notes for January and February 2026 revealed no other documentation of any additional behaviors by Resident # 8 towards Resident # 9.Nurse # 1 was interviewed on 2/20/26 at 2:00 PM and reported the following information. Nurse Aide # 1 had reported on 2/6/26 that she heard Resident #8 calling Resident # 9 a faggot and a bitch. On 2/6/26 she (Nurse #1) had talked to Resident # 9 who reported Resident # 8 had not come into his room but had yelled the remarks into the room while sitting in the middle of the hallway outside his door. Resident # 9 reported he did not respond to Resident # 8 on that day or other times. She (Nurse # 1) had worked on Resident # 8's unit during orientation for only about a week. After a week of orientation, she moved to another unit and therefore was not aware of any ongoing behaviors exhibited by Resident # 8. On the day the incident of derogatory name calling had occurred (2/6/26), she had talked to Resident # 8 also who appeared pleasant to her and not confused.Nurse Aide # 1 was interviewed on 2/20/26 at 3:00 PM and reported the following information. Resident # 8's room was in close proximity to Resident # 9's room. Resident # 8 was outside of Resident # 9's room calling him a faggot and telling him to do a particular sexual act on 2/6/26. She stated that it appeared to her that Resident # 9 had been upset about the incident. She did not explain what made her think Resident # 9 was upset. This was the only time she had witnessed the behavior from Resident # 8. When Nurse Aide # 1 was asked whether Resident # 9 had provoked Resident # 8 in any way to say the things he did she responded that Resident # 9 had not done so. Nurse Aide # 1 reported that was not even in [Resident #9's] character at all. Nurse Aide # 1 was interviewed regarding what she did about the behavior and reported that she had redirected Resident # 8 to the dayroom and away from Resident # 9's door. Resident # 9 was interviewed on 2/20/26 at 9:00 AM and reported the following information. When he (Resident # 9) first arrived at the facility (2/24/25), he thought Resident # 8 was cool. Then for no reason, Resident # 8 started calling him derogatory names and every time Resident # 8 now saw Resident # 9 he would call him derogatory names. He did not indicate when this behavior first took place. This happened in the dining/activity room with other residents around. Resident # 8 would also come to his door where he resided, stare in, and call him names. Resident # 8 did not enter the room but yelled from the hallway. He would say things such as You ole faggot. You ole bitch. You need to suck my . I am going to f. you. Resident # 8's behaviors toward him were happening almost on a daily basis while he was outside of his room. The current week, Resident # 8 had said such derogatory things to him Monday, Tuesday, and Wednesday while they were both outside of their rooms. The incidents where Resident # 8 would come to the doorway and yell in his room derogatory remarks (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	occurred about two to three times a month. He wanted it to stop, and he had talked to the Social Worker and the Director of Nursing about the problem. It was his understanding that the staff were supposed to move Resident # 8 out of the dining/activity room when he (Resident #9) was in the dining/ activity room. He did not specify who informed him that staff were supposed to move Resident # 8 out of the dining/activity room when he (Resident # 9) was present. Resident # 9 reported he liked his room and he did not want to move. He wanted to be able to sit in public spaces without being called names. Resident #9 reported, I don't want to hurt him. During the interview, it was observed that Resident # 8's room was across the hallway from Resident # 9's room.Resident # 8 was interviewed on 2/20/26 at 2:30 PM regarding whether he had called another resident derogatory terms. Resident # 8 appeared frustrated by repeating that he just wanted to leave the facility and said he was tired of people saying he did things. He further reported the following information. He had called Resident # 9 a faggot because Resident #9 had called him one. Staff would blame him (Resident # 8) and take him out of the dining room/activity room, and he did not think this was fair. He had told staff this when they had talked to him. Resident # 8 did not report exact dates that name calling had occurred or dates staff had talked to him. He reported he just wanted to leave and not be at the facility. Resident # 1, who was coded as cognitively intact on a 12/11/25 quarterly MDS assessment, was interviewed on 2/19/26 at 1:19 PM. He reported that he (Resident # 1) sat in the dining/activity room at times and witnessed Resident # 8 calling Resident # 9 a faggot for no reason. Resident # 9 never did anything to provoke this type of behavior.Nurse Aide # 2 was interviewed on 2/20/26 at 9:30 AM and reported the following information. She was caring for Resident # 9 that day (2/20/26) and was also familiar with Resident # 8. Resident # 8 was difficult to deal with. She explained that he would call staff derogatory names and was not easily redirected. Resident # 8 would stare at Resident # 9 and Resident # 8 would call Resident # 9 a faggot and tell him he was going to beat his [a**]. Anytime the residents were in the dining/activity room together this tended to happen which according to Nurse Aide # 2 was often. It was hard to redirect Resident # 8 because he would get mad if he was redirected. Resident # 8 used to call another resident a derogatory name, but he no longer did so and was instead directing the derogatory remarks to Resident #9.Nurse # 2 was interviewed on 2/20/26 at 9:46 AM and reported the following information. She had heard Resident # 8 and Resident # 9 have smart remarks between the two of them. Resident # 8 would start it by calling Resident # 9 a faggot and a bitch. It happened sporadically and occurred multiple times per week. When it occurred, Resident # 9 would let staff know. They (the staff) tried to monitor the dining room/activity room, but they had multiple residents and duties and therefore they could not be there all the time to redirect Resident # 8. For a while, Resident # 8 was on one-on-one supervision a couple months ago, but that stopped and she was not sure why he had been on one on one or why the monitoring stopped. She knew that the derogatory remarks upset Resident # 9. She explained that Resident # 9 would made remarks such as if Resident # 8 kept making the derogatory remarks to him then he was going to do something about it. She indicated she just thought that was Resident # 9 talking and that Resident # 9 would not really hurt Resident # 8.Resident # 8's active care plan revealed that the most recent care plan conference was on 2/9/26. There was no information on Resident # 8's active care plan related to the known pattern of targeted derogatory name calling and foul language directed towards Resident # 9. The care plan interventions related to the problem area of conflicts with peers continued to include interventions developed on 10/30/25 that were ineffective with managing Resident # 8's verbal behaviors directed toward Resident # 9. No new interventions had been developed that instructed staff on how to manage these known verbal behaviors.The Social Worker and the Care Plan Nurse were interviewed on (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	2/20/26 at 1:17 PM. The Social Worker reported the following information. Resident # 9 had reported to her that Resident # 8 would stare at him and say negative things to him. Resident # 9 reported he did not know why it was happening and he had not provoked the behavior. She recalled Resident # 9 mentioning that Resident # 8 was making sexual remarks but did not recall if he had mentioned specifically being called a faggot. She followed up weekly and thought there had been small incidents and lately that things had been okay. She thought Resident # 9 had come to her at the end of 2025 or sometime in January 2026 about the issue. She had not made a note about it to reference the date. She had talked to Resident # 8 who denied the whole situation. The Nurse Aides were supposed to be redirecting Resident # 8 and keeping the residents separated. She thought Resident # 8 was easy to redirect. The Social Worker was interviewed about Nurse Aide # 2's comments about Resident # 8 being difficult to redirect. The Social Worker reported that it was how you did the redirection that mattered as well as the approach to the situation. The Care Plan Nurse reported the following information. When she revised the care plan, she reviewed the documentation in the record. She explained that if she saw nursing notes, then she would incorporate any documented behaviors in the care plan. She indicated the care plan for Resident # 8 had been reviewed related to behaviors, but they (the facility) had not included a plan specifically to deal with Resident # 8 targeting Resident # 9 in public and in his room with derogatory comments.The Director of Nursing was interviewed on 2/20/26 at 1:10 PM and reported the following information. He had been the acting DON since the former DON left in October 2025. He saw Resident # 9 sitting in a corridor area almost every day and the resident had not brought up specifically the concern with Resident # 8. It was his understanding that Resident # 8 and Resident # 9 sometimes got along and other times they did not like each other, but he was not aware of specific details of why. He indicated he knew that the Psychiatric NP spoke to the facility Social Worker about any type of behavioral problems residents were displaying so that the behaviors could be addressed. The Psychiatric NP was interviewed on 2/20/26 at 3:38 PM and reported the following information. She saw Resident # 8 again on 2/9/26 following her 1/8/26 visit. She saw only one incident noted in the record since her January notation about Resident # 8 having behaviors and that was the note on 2/6/26 (related to Resident # 8 cursing and yelling at Resident # 9). It had not been made clear to her that Resident # 8 was using derogatory language more frequently than what was charted. She was familiar with Resident # 9 and had evaluated Resident # 9 when he was initially admitted in order to conduct depression screening, but Resident # 9 had no mental illness, no behavioral problems, and there was no further need to provide services to him after she conducted her screening process. Resident # 8's dementia did contribute to confusion and like any resident with dementia, he would wax and wane regarding his confusion. When she talked to him, he would say he just wanted to go home. She knew he had had arguments in the dining room/activity room but did not know they involved any specific resident. When she asked him (Resident # 8) if he had any arguments, he would always say no. The Psychiatric NP indicated that the Social Worker was usually very good at discussing with her any behavioral issues. She did not recall specifically discussing the incident of Resident # 8 calling Resident # 9 derogatory names on a repetitive basis, but the Social Worker probably did mention it to her. She did not realize it was a big problem for Resident # 8. It was her opinion that any targeted behavior by Resident # 8 of calling Resident # 9 derogatory names was stemming from his dementia diagnosis.The Medical Director was interviewed on 2/20/26 at 11:57 AM and reported the following information. She was not aware of any targeted derogatory remarks by Resident # 8 to another resident. There was a psychiatric provider for the facility, and the staff should be talking to the psychiatric provider about behavioral issues.The Administrator was interviewed on 2/20/26 at 10:35 AM (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and reported the following information. Resident # 8 was cognitively impaired and did not want to be at the facility and wished to reside elsewhere, but he did have behavioral problems which made it difficult to find an alternate facility to accept him when they saw that he had behaviors. During a follow up interview with the Administrator on 2/20/26 at 5:17 PM, the Administrator was interviewed regarding any type of behaviors that Resident # 9 had which might provoke Resident # 8 to target him and whether Resident # 9 also called Resident # 8 a faggot as Resident # 8 alleged. The Administrator reported there had been one documented incident when Resident # 9 had been admitted and was adjusting to residing at the facility and roomed with an older resident. He called his former roommate a creepy old man, and then after an adjustment period Resident # 9 never had any further behavior problems that were documented or of which she was aware. She indicated she talked to her staff (she did not specify which staff) on the date of this interview (2/20/26) and no one had reported that Resident # 9 called Resident # 8 a faggot.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and interviews with staff and Medical Director the facility failed to ensure the medical record was complete regarding documentation of acute medical symptoms and the administration of an as needed medication. This was for 1 (Resident # 1) of 3 residents reviewed for acute medical needs.The findings included:Resident # 1 was admitted to the facility on [DATE].Nurse # 4 was interviewed on 2/18/26 at 3:19 PM and reported the following information. She did not recall the specific date, but a couple days prior to the date of 2/3/26, Resident # 1 had vomited undigested food. She assisted to help him get cleaned up and gave him some ginger ale and soup for supper. She recalled no further complaints or vomiting after one episode of emesis.Review of the record revealed no documentation of the vomiting incident referenced by Nurse # 4 during her interview on 2/18/26 at 3:19 PM.Nurse # 3 was interviewed on 2/19/26 at 8:16 AM and reported the following information. She had cared for Resident # 1 on the shift which began at 11:00 PM on 2/2/26 and ended at 7:00 AM on 2//3/26. Resident # 1 had complained of having gas and stomach pain. She had administered Milk of Magnesia per an as needed standing order to do so at some point during her shift. She did not recall the specific time. Review of Resident # 1's record revealed no documentation of the administration of Milk of Magnesia on Nurse # 3's shift.The facility Medical Director was interviewed on 2/20/26 at 11:57 AM and reported the following information. Staff should have documented any clinical symptoms of medical problems that Resident # 1 was having and any treatment they had rendered. It was important to document clinical symptoms for any resident that might be experiencing an acute issue because when she and other providers came in to review any acute illness, they reviewed a resident's record as well as talking to staff and the resident while making decisions.The Director of Nursing was interviewed on 2/20/26 at 1:10 PM and reported he would have liked to have seen that Nurse # 4 documented Resident # 1's episode of vomiting in the record. The DON reported the administration of an as needed medication should have been documented in the resident's record. The DON validated that the as needed medication administration had not been documented making the record incomplete.