	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _		Б	
		HAL008042	B. WING		R 04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
		WINDSOR,	NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES (MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
{D 000}	Initial Comments		{D 000}			
	County Department of	sure Section and the Bertie f Social Services conducted ril 4, 2023 to April 5, 2023.				
{D 273}	10A NCAC 13F .0902	(b) Health Care	{D 273}			
	` '	Health Care assure referral and follow-up ad acute health care needs				
	This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 2 of 3 sampled residents (#1, #3) related to failing to ensure scheduling of a podiatry appointment (#1) and failing to inform a primary care provider (PCP) of a change in condition (#3)					
	The findings are:					
	02/16/23 revealed: -Diagnoses included of	at #1's current FL-2 dated diabetes, lower left leg n, and peripheral vascular nstantly disoriented.				
		1's care plan dated 11/09/22 extensive assistance with eting, and grooming.				
	03/15/23 revealed the	enail dystrophy (toenail				

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE (X6) DATE

STATEMENT	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
				B. WING	
		HAL008042	B. WING		04/05/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE	
WINSTON	GARDENS		ST WATSON STR	EET	
	OLIMAN DV OT		R, NC 27983	DROWNERIO PLANTOS CORRECTION	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	e 1	{D 273}		
	Review of Resident #1's record revealed there was no documentation Resident #1 was seen by a podiatrist. Telephone interview with the facility's contracted podiatrist on 04/05/23 at 9:39am revealed: -Resident #1 was last seen by the podiatrist in October 2021The resident did not have any upcoming appointments scheduled.				
	Observation of Resident #1 on 04/05/23 at				
	3:04pm revealed:	ing in his wheelchair on the			
	and the Administrator -Some of his toenails -The right big toenail	(PCA) removed his sock, observed his right foot. were overgrown. was 3/4 inch long extended ail had jagged edges, was			
	-The second toenail of long extended from h -The fourth toenail on long extended from h	on his right foot was ½ inch is toe with jagged edges. his right foot was ¾ inch is toe, the toenail pressed of his third toe, and the			
	_	is right foot was ¾ inch long			
	Interview with Reside revealed: -He had not had his to	nt #1 on 04/05/23 at 3:06pm penails cut in several			
	asked anyone to cut l				
		m three times a week. on 04/05/23 at 3:10pm			

Division of Health Service Regulation

revealed:

STATE FORM 6899 W1WC12 If continuation sheet 2 of 40

NAME OF PROVIDER OR SUPPLIER SIMMARY STATEMENT OF DEFICIENCIES 205 WEST WATSON STREET WINDSOR, NC 27983 PREPIX	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER **STREET ADDRESS*** **SUMMARY STATEMENT OF DEFICIENCIES BY PAUL (PREPTX INC. TON) SPROUNDERS FLAN OF CORRECTION (PREPTX INC. TON) SPROUNDERS FLAN OF COR				7 t. BOILBING.			,
WINSTON GARDENS MAINTON GARDENS CANADARY STATEMENT OF DEFICIENCIES CANADARY STATEMENT OF DEFICIENCIES CANADARY STATEMENT OF DEFICIENCIES CANADARY CALL DEFICIENCY MUST BE PRECEDED BY FULL TAG CROSS-REFIERENCED TO THE APPROPRIATE COMMETTE TAG CROSS-REFIERENCED TO THE APPROPRIATE CANADARY CALL DEFICIENCY CANADARY CALL DEFIC			HAL008042	B. WING			
WINDSOR, NC 27983 (X4) ID (X4	NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION PROPRIATE COMMETTE CO	WINSTON	GARDENS			EET		
-Resident #1 was bathed three times a weekShe had not informed the medication aide (MA) or Resident Care Coordinator (RCC) that the resident's toenalis were longShe should have reported that his toenalis were too long to the MA or RCC. Telephone interview with a practice support specialist at the facility's contracted primary care provider (PCP) agency on 04/05/23 at 11:17am revealed: -When a PCP wrote a visit note on a resident it was reviewed by a practice support specialist at the agencyIf the PCP visit note had orders for a referral to a specialty provider, the orders would be sent to the outside referral department at the agencyThe outside referral department would contact a local specialty provider and initiate the referral for the residentThe local specialty provider would then contact the facility to schedule an appointment for the residentShe was not sure if there was a time-frame in which the facility should contact the contracted agency if they had not heard from a specialty provider or a resident. Telephone interview with the RCC on 04/05/23 at 4:08pm revealed: -She was no longer employed at the facility as of 04/04/23She had not noticed that the PCP had requested Resident #1 be seen by a podiatristResident #1 be seen by a podiatrist.	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	BE	COMPLETE
-She was not aware that the resident's toenails were long, jagged, and yellowThe company the facility's PCP worked with	{D 273}	-Resident #1 was bat -She had not informed or Resident Care Cooresident's toenails we -She should have reptoo long to the MA or Telephone interview vispecialist at the facility provider (PCP) agency revealed: -When a PCP wrote a was reviewed by a provider the PCP visit note specialty provider, the outside referral departing the facility provider the residentThe local specialty provider the facility to schedule residentShe was not sure if the which the facility should agency if they had no provider for a residentShe was no longer e 04/04/23She had not noticed Resident #1 be seen -Resident #1 had dial should have been trints.	hed three times a week. d the medication aide (MA) ordinator (RCC) that the are long. orted that his toenails were RCC. with a practice support y's contracted primary care by on 04/05/23 at 11:17am a visit note on a resident it actice support specialist at thad orders for a referral to a be orders would be sent to the attent at the agency. department would contact a ter and initiate the referral for arovider would then contact the an appointment for the there was a time-frame in all contact the contracted the heard from a specialty t. with the RCC on 04/05/23 at the pCP had requested by a podiatrist. the podiatrist. the petes and his toenails and the resident's toenails and yellow.	{D 273}			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 3 of 40

Division of	of Health Service Regu	lation				
	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SU COMPLE	
					R	
		HAL008042	B. WING		04/05	/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STAT	TE, ZIP CODE		
MINISTON	CARRENC	205 WES	ST WATSON STRE	EET		
WINSTON	GARDENS	WINDSO	R, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page	÷ 3	{D 273}			
		d up with the facility's ral department to ensure a podiatrist appointment for				
	4:40pm revealed: -Her first day at the fa	ministrator on 04/05/23 at acility was 03/27/23.				
	facility's contracted P ensure Resident #1's scheduled.	CP referral department to podiatry referral had been				
	-The facility was responsible for ensuring the resident's podiatry appointment was made; whether through the facility's contracted PCP referral department or the RCC following up to ensure the podiatry appointment had been					
	scheduledResident #1 was dial a podiatrist for footcal complications from hi					
	care provider (PCP) or revealed:	with Resident #1's primary on 04/05/23 at 12:05pm betes and should be seen by				
	a podiatrist to ensure	proper care of his foot. ave contacted her to let her ntracted PCP referral				
		amputation above the left ant that the resident receive suse his right foot had				
	decreased sensitivity increased risk of wou	which placed him at an nds.				
	2. Review of Residen 2/10/23 revealed:	t #3's current FL-2 dated				

Division of Health Service Regulation

-Diagnosis included chronic kidney disease Stage

STATE FORM 6899 W1WC12 If continuation sheet 4 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 t. Boilebiito.		R	
		HAL008042	B. WING		04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON GARDENS 205 WES			WATSON STR	EET		
	WINDSOF					
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page	e 4	{D 273}			
	3, chronic atrial fibrilla and hypertensionThe resident was conducted to the resident was conducted to the resident was sittle entrance doorResident #3 was stated and resident #3 did not resident #3 did not resident with person 04/04/23 at 8:45am resident with person 04/04/23 at 8:45am resident with person 104/04/23	ention (irregular heartbeat), enstantly disoriented. ent #3 on 03/21/23 at eng at the table by the front ering out the window. respond when spoken to. eal care aide (PCA) on revealed: ent #3 did not go to his room kfast. went to his room to lie down				
	-On 03/21/23 Resident #3 sat at the table after breakfast staring out the windowResident #3 did not respond when asked a questionResident #3 did not interact with his family member at breakfastThe PCA reported Resident #3's current behaviors to the Resident Care Coordinator (RCC) on the morning of 03/21/23. Review of the Emergency Medical Services (EMS) incident report dated 03/21/23 revealed: -There was a call received on 03/21/23 at 9:21pm from a local assisted living facilityEMS arrived at the facility at 9:50pmResident #3, who was sitting in the wheel chair, stated, "I do not feel right."					
	-A staff reported to EI a new medication and -EMS assisted Reside	MS that Resident #3 started				

Division of Health Service Regulation

-EMS checked Resident #3's vitals.

STATE FORM 6899 W1WC12 If continuation sheet 5 of 40

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING: _		
		HAL008042	B. WING		R 04/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE	
WINSTON	GARDENS		T WATSON STR	EET	
		WINDSOI	R, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIOI (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE
{D 273}	Continued From page	e 5	{D 273}		
	-Resident #3 was mo transported to a near	ved to the EMS unit and by hospital.			
	03/23/23 revealed the	3's hospital record dated e resident was admitted to			
	the hospital with diagnoses of atrial fibrillation (abnormal heart rhythm) with bradycardia (low heart rate) and heart failure. Review of Resident #3's record on 04/04/23 revealed the resident remained in the hospital.				
	Interview with the Administrator on 04/05/23 at 4:46pm revealed she expected the facility's staff to contact the facility's primary care provider (PCP) immediately when a change was noticed in				
	a resident's current behaviors or symptoms. Interview with Resident #3's PCP on 03/05/23 at 12:06pm revealed: -She expected the facility to contact her or the on-call provider immediately when staff noticed a change in a resident's routine or behaviorShe decided on the follow-up treatment that the facility would arrange for the residentsIf she had been contacted about Resident #3's change in behavior the morning of 03/21/23 she might have arranged to do a telehealth visit to assess the resident and send the resident to the hospital for further evaluation if needed. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable.				
	2/10/23 revealed:	t #3's current FL-2 dated			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 6 of 40

Division of Health Service Regulation					
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED
			· ·		
			D. MING		R
		HAL008042	B. WING		04/05/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE ZIP CODE	
TO THE OT THE	NOVIDER OR GOLF EIER				
WINSTON	GARDENS		T WATSON STR	EEI	
		WINDSO	R, NC 27983		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IAIE DAIE
{D 273}	Continued From page	e 6	{D 273}		
, ,	. •		' '		
		ation (irregular heartbeat),			
	and hypertension.				
	-The resident was con	nstantly disoriented.			
	Observation of Reside	ent #3 on 03/21/23 at			
	09:00am revealed:				
	-Resident #3 was sitti	ing at the table by the front			
	entrance door.				
	-Resident #3 was sta	ring out the window.			
		responding when spoken			
	to.	respending mish spending			
	10.				
	Interview with nerson	al care aide (PCA) on			
	04/04/23 at 8:45am r	` ,			
		ent #3 did not go to his room			
	to lie down after brea				
		went to his room to lie down			
	after breakfast.				
		nt #3 sat at the table after			
	breakfast staring out				
		respond when asked a			
	question.				
	-Resident #3 did not i	nteract with his wife at			
	breakfast.				
	-The PCA reported R				
	behaviors to the Resi	dent Care Coordinator			
	(RCC) on the morning	g of 03/21/23.			
		ency Medical Services			
	(EMS) incident report	dated 03/21/23 revealed:			
		eived on 03/21/23 at 9:21pm			
	from a local assisted	living facility.			
	-EMS arrived at the fa	- ·			
		as sitting in the wheel chair,			
	stated, "I do not feel r				
		MS that Resident #3 started			
	a new medication and				
		ent #3 to the stretcher.			
		apped and secured to the			
	-i resideiii #3 was Slia	apped and secured to the	- 1		

Division of Health Service Regulation

stretcher.

STATE FORM 6899 W1WC12 If continuation sheet 7 of 40

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE A. BUILDING: _	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BOILDING			
		HAL008042	B. WING		04/05	5/2023
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
	WINDSO					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 273}	Continued From page	÷ 7	{D 273}			
	-EMS checked Resident #3's vitalsResident #3 was moved to the EMS unit and transported to a nearby hospital.					
	03/23/23 revealed the the hospital with diagr	3's hospital record dated a resident was admitted to noses of atrial fib with t rate) and heart failure.				
		3's record on 04/04/23 remained in the hospital.				
	4:46pm revealed she to contact the facility's (PCP) immediately wi	ninistrator on 04/05/23 at expected the facility's staff sprimary care provider nen a change was noticed in ehaviors or symptoms.				
	12:06pm revealed: -She expected the factorial provider immer change in a resident's -She decided on the facility would arrange -If she had been contachange in behavior the might have arranged assess the resident a hospital for further events.	ollow-up treatment that the for the residents. acted about Resident #3's e morning of 03/21/23 she to do a telehealth visit to nd send the resident to the				
D 276	10A NCAC 13F .0902	r(c)(3-4) Health Care	D 276			
	10A NCAC 13F .0902 (c) The facility shall as	Health Care ssure documentation of the				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 8 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE	(X3) DATE SURVEY COMPLETED		
			A. BUILDING: _		
		HAL008042	B. WING		R 04/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STAT	TE, ZIP CODE	
WINSTON	GARDENS		T WATSON STRI R, NC 27983	EET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	ILD BE COMPLETE
D 276	a physician or other li and (4) implementation of orders specified in Sur Rule. This Rule is not met a Based on interviews a facility failed to ensure for 3 of 3 sampled rest to dressing changes (checks (#1, #2, #3). The findings are: 1. Review of Resider 02/16/23 revealed: -Diagnoses included amputee, hypertension diseaseThe resident was con Review of Resident # 02/16/23 revealed the blood pressure (BP) of Review of Resident # medication administrative revealed there was not revealed the revealed the revealed there was not revealed the revealed the revealed there was not revealed the revealed there was not revealed the revealed there was not revealed the revealed the revealed there was not revealed the revealed t	ent's record: s, treatments or orders from censed health professional; procedures, treatments or abparagraph (c)(3) of this as evidenced by: and record reviews, the eximplementation of orders sidents (#1, #2, #3) related (#2), and blood pressure at #1's current FL-2 dated diabetes, lower left leg on, and peripheral vascular enstantly disoriented. 1's current FL-2 dated ere was an order for monthly checks. 1's February 2023 electronic	D 276	DEFICIENCY)	
	Interview with Reside	o entry for BP checks. nt #1 on 04/05/23 at 3:04pm			
	i revealed a medication	n aide (MA) checked his BP			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 9 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:			
		HAL008042	B. WING		04	R I/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
WINSTON	I GARDENS		ST WATSON STREE	ĒΤ		
			OR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 9	D 276			
	but he did not know h	now often.				
	Refer to interview wit 04/05/23 at 2:10pm.	th medication aide (MA) on				
		terview with the Resident CC) on 04/05/23 at 4:08pm.				
	Refer to interview wit 04/05/23 at 4:40pm.	h the Administrator on				
	Refer to telephone interview with the facility's contract primary care provider (PCP) on 04/05/23 at 12:05pm.					
	02/16/23 revealed:	nt #2's current FL-2 dated				
	depression. -The resident was co	diabetes, psychosis, and nstantly disoriented.				
	note dated 02/10/23 being seen at a wour to his right foot and a left 4th toe (Wounds stage II pressure wou with a pink wound be	nt #2's history and physical revealed the resident was and clinic for a stage II wound in unstageable wound to his are staged from I to IV. A und is a shallow open ulcered. A wound is unstageable cannot be visualized due to the wound).				
	03/09/23 revealed the	#2's physician visit note dated ere was an order for dry toe after cleaning with soap ub soaks.				
	medication administra	#2's March 2023 electronic ation record (eMAR) o entry for dry dressings to				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 10 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CO			E SURVEY PLETED	
			A. BOILDING.			Б
		HAL008042	B. WING		04	R I/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AF	DDRESS, CITY, STATE	ZIP CODE	•	
			T WATSON STREE	•		
WINSTON	GARDENS		R, NC 27983	-		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE THE APPROPRIATE	(X5) COMPLETE DATE
D 276	Continued From page	e 10	D 276			
		#2's physician visit note dated e resident was released from				
	provider on 04/05/23	with Resident #2's specialty at 9:30am revealed the t's toe was healed at his visit				
	Interview with a medication aide (MA) on 04/05/23 at 2:10pm revealed: -MAs knew to perform dressing changes on residents because it would be on the eMARDressing changes for residents were documented on the eMARShe did not recall ever performing a dry dressing change on Resident #2's toe.					
	Coordinator (RCC) or revealed: -She was no longer of 04/04/23Medication aides known residents because it substituted by the orders of acility's contracted power would put the orders of the phase of	ders were faxed to the harmacy and the pharmacy on the eMAR. he Administrator could send armacy. ing seen at a wound clinic for				
	Interview with the Add 4:40pm revealed: -Her first day at the fa	ministrator on 04/05/23 at acility was 03/27/23.				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 11 of 40

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	
		HAL008042	B. WING		04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		T WATSON STR	EET		
	WINDSOF					
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPI	LETE
D 276	Continued From page	e 11	D 276			
	from 03/09/23 in a tra 04/04/23. -All physician visit she transportation folder a outside provider apportation folder a outside provider apportation folder a chart. -Resident #2's physician been faxed to the pharmacy could put the changes on the eMAF. Telephone interview we care provider (PCP) or revealed Resident #2 important that dressinhis feet as ordered be worsen and cause coinfection.	eets were placed in the after residents had been to bintments. In #2's physician order sheet used since it was still in the and not in the resident's stian order sheet should have armacy by the RCC so the the order for the dressing R. With Resident #2's primary on 04/05/23 at 12:05pm and diabetes and it was not could to because the wounds could				
		nined that Resident #2 was				
	dated 02/10/23 revea	t #2's history and physical led there was an order for re (BP) once monthly.				
	Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed there was no entry for monthly BP checks.					
		2's March 2023 eMAR o entry for monthly BP				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 12 of 40

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		HAL008042	B. WING		R 04/05/2023
NAME OF PI	ROVIDER OR SUPPLIER		RESS, CITY, STA	TE, ZIP CODE	04/05/2023
WINSTON	WINSTON GARDENS 205 WEST WINDSOF			EET	
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE
D 276	Continued From page	: 12	D 276		
	Review of Resident # revealed there was no checks.	2's April 2023 eMAR o entry for monthly BP			
		2's record revealed there n of monthly BP checks.			
	Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable.				
	Refer to interview with medication aide (MA) on 04/05/23 at 2:10pm.				
		erview with the Resident C) on 04/05/23 at 4:08pm.			
	Refer to interview with 04/05/23 at 4:40pm.	n the Administrator on			
	•	erview with the facility's provider (PCP) on 04/05/23			
	 3. Review of Resident #3's current FL-2 dated 2/10/23 revealed: -Diagnosis included chronic kidney disease Stage 3, chronic atrial fibrillation (irregular heartbeat), 				
	and hypertensionThe resident was cor	, ,			
	Review of Resident #3's February 2023 electronic medication administration record (eMAR) revealed there was no entry for BP checks.				
		f3's March 2023 eMAR o entry for BP checks .			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 13 of 40

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			, DOILDING		R	
		HAL008042	B. WING		04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
	WINDSO			DDOWDEDIS DI ANI OF CODDECTION		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLE	
D 276	Continued From page	e 13	D 276			
	Review of Resident #3's record on 04/04/23 revealed the resident was sent to the Emergency Department (ED) on 03/21/23 and the resident remained in the hospital.					
	Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:09pm revealed: -The medication aides (MA) were responsible for					
	checking the resident accuracy.	's eMAR to ensure				
	•	nsible for informing the				
		e contacted the pharmacy to dent #3's monthly BP checks				
		ns, interviews, and record nined that Resident #3 was				
	Refer to interview with 04/05/23 at 2:10pm.	n medication aide (MA) on				
	•	terview with the Resident CC) on 04/05/23 at 4:08pm.				
	Refer to interview with 04/05/23 at 4:40pm.	n the Administrator on				
	Refer to telephone interview with the facility's contract primary care provider (PCP) on 04/05/23 at 12:05pm.					
		evealed:				

BP.
Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 14 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			_		 	<u>t</u>
		HAL008042	B. WING		ı	5/2023
NAME OF PE	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON GARDENS		205 WEST WINDSOR,	WATSON STR	EET		
(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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
D 276	Continued From page	: 14	D 276			
	-Resident's BPs were	recorded on the eMAR.				
	Coordinator (RCC) or revealed: -She no longer worke 04/04/23Resident's BP orders -Orders were faxed to pharmacy by a MA, the and the pharmacy plate eMARA MA would know to when they saw it come. BP results were documented by the eman of the pharmacy plate eman of the pharmacy eman of the pharma	d for the facility as of should be on their eMAR. The facility's contracted the RCC, or the Administrator faced the orders on the check the resident's BP e up on the eMAR. Immented on the resident's ministrator on 04/05/23 at the up on the eMAR. Formed by MAs and the ent's eMAR. With the facility's contracted (PCP) on 04/05/23 at was important to check by as ordered to monitor the				
{D 283}	10A NCAC 13F .0904 Service	(a)(2) Nutrition and Food	{D 283}			
	(a) Food Procurement Homes:					

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 15 of 40

	FOF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ' '	CONSTRUCTION	(X3) DATE S	
VIAN LEWIN	SI CONNECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		CONIPLI	-1-0
		HAL008042	B. WING		R 04/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR R, NC 27983	EET		
	CLIMMADY CT		·	DDOV/DEDIC DLAN OF CODDECTIO	NA I	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETE DATE
{D 283}	Continued From page	e 15	{D 283}			
	This Rule is not met a TYPE B VIOLATION Based on observation failed to ensure all forwere protected from a expired food that was of food items in the fraworking properly. The findings are: Observation of a loca establishment inspect pantry and freezer on revealed: -The facility received -There were no hand the kitchen at the timeThe hand sink in the chair and a fanRaw beef was stored and ready to eat items door. -Pasta noodles, greer refrigerator were store (F) to 45 degrees F; a at 41 degrees F. Observation of the free on 04/04/23 at 8:55ar	as evidenced by: as and interviews, the facility od items stored by the facility contamination related to molded, improper storage eezer, and the freezer not I health department food tion report of the kitchen, 04/05/23 at 9:45am a score of 93.5. towels at the hand sink in e of inspection. kitchen was blocked by a diabove a container of juice inside of a refrigerator in beans, and collards in the ed at 44 degrees Fahrenheit all cold food should be kept eezer in the kitchen pantry in revealed: s of water on the floor in	(U 200)			
	-The freezer was not layer of water on the l	mometer in the freezer. cold and there was a thin bottom shelf of the freezer. reezer had a 32 ounce				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 16 of 40

DIVISION	or riealth Service Negu	iation				
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SUF	
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _		COMPLET	ED
					R	
		HAL008042	B. WING		04/05/	/2023
		111/1200012			1 0-1/00/	72020
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DRESS, CITY, STA	TE, ZIP CODE		
WINCTON	CADDENC	205 WES	T WATSON STR	EET		
WINSTON	GARDENS	WINDSOI	R, NC 27983			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	RIATE	DATE
				DETICIENST)		
{D 283}	Continued From page	e 16	{D 283}			
	stvrofoam cup withou	t a lid with ¼ inch of liquid in				
	the cup.					
	•	ardboard box of bacon in a				
		ppened and the bacon was				
	not frozen.	pened and the bassin was				
		package of hamburger				
		and not frozen on the shelf				
	to the right of the box					
		e of french fries in a clear				
		ot tied at the top sitting on top				
		e of hamburger patties.				
	, ,	the freezer had a 10 pound				
		nat was soft and not frozen.				
		of ground beef was stamped				
	-	date of 04/05/23; keep				
		28 degrees Fahrenheit (F)				
	to 34 degrees F and i					
	_	astic bag that was not				
		8 fried chicken patties				
	beside the tube of gro	•				
		ard box of waffles in a plastic				
	bag that was opened	on the shelf beside the tube				
	of ground beef.					
	-The third shelf of the	freezer had 3 sealed				
	packages of hashbro	wns and 6 unopened				
	packages of vegetabl	es.				
		chen pantry on 04/04/23 at				
	9:10am revealed:					
	-	ound cases of oranges.				
		sour smell coming from the				
	two cases of oranges					
	-The two cases of oranges were stacked on top of each other with one case on the floor and a					
	· ·	against the wall under a				
	window.	Lammarina ataly, circlet 40				
		l approximately eight 48				
	ounce plastic bags of					
		of the oranges in the 48				
	∣ ounce plastic bags ha	ad a thick dark green mold.				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 17 of 40

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER.	A. BUILDING: _		COMPLETED
			D. MINO		R
		HAL008042	B. WING		04/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE	
WINSTON	GARDENS		T WATSON STR	EET	
		WINDSOF	R, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIV (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE COMPLETE
{D 283}	Continued From page	e 17	{D 283}		
	-There were six 24.5 flour tortillas on the pastamped with an expi-There was one 12 or bacon soup that had a 01/04/22 on the top o stamp on the can with Observation of a sign across from the freez-There was a form had idetary staff to docum dailyThe form had dates I temperature was chere 12/25/22; but there working the company of t	ounce packages of 6 inch antry shelf that were ration date of 02/27/23. Unce can of beans with a handwritten date of f the can but there was a in a best by date of 01/19/20. hanging on the pantry shelf for item freezer temperatures isted that the freezer cked from 12/01/22 to ere no temperatures listed. erase board on the hen on 04/04/23 at 9:21am handwritten note that all ind after food was two days			
	revealed: -He had worked at the weeksThe freezer had bee were approximately the weeks that he noticed correctly; the tempera-The freezer had bee during the past two well-he had not reported working to the Reside or the AdministratorHe had not noticed to	ature was not always cold. In working "on and off" eeks. Ithat the freezer was not ent Care Coordinator (RCC) Inat there was not a Id in the freezer to accurately inperatures.			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 18 of 40

STATEMENT	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			A. BUILDING: _			
HAL008042 B. WING			R 04/05/2023			
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS	205 WEST	WATSON STR	EET		
WINDSOR,		NC 27983				
(X4) ID PREFIX TAG	(EACH DEFICIENCY	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{D 283}	Continued From page	e 18	{D 283}			
	Administrator that the the freezer.	re was not a thermometer in				
	-He had not documen since he became emp	ited freezer temperatures bloyed as the DM.				
	Interview with a media	, ,				
	-He worked as a cook	orocaled.				
	ago.					
		reezer not cooling as well report it to anyone because				
	it started working prop	· ·				
		any temperature checks of				
	-He forgot to report the properly to the Admini					
	Observation of the die preparing lunch on 04 revealed:					
	-There were 3 packag	ges of the 24.5 ounce our tortillas on the kitchen				
	-The 3 packages of 6	inch flour tortillas were ration date of 02/27/23.				
	Second interview with 12:01pm revealed:	the DM on 04/04/23 at				
	-He planned to serve residents for lunch.	the 6 inch flour tortillas to				
	-He had not noticed the expiration date on the packages of flour tortillas.					
	-He had not checked	the expiration date on the				
	package of flour tortill not have mold on the	as because the tortillas did				
		rpired packages of expired				

Division of Health Service Regulation

Interview with the Administrator on 04/04/23 at

STATE FORM 6899 W1WC12 If continuation sheet 19 of 40

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
					R	2
		HAL008042	B. WING		1	5/2023
NAME OF F	PROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON GARDENS 205 WEST WINDSOR,		WATSON STR NC 27983	EET			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 283}	9:30am revealed: -Her first day at the fa- She completed a tou but was not aware wh were located at the fa- The DM had not noti the facility was not wound is posing of expired fa- She was not aware the working properly and to log the temperatureShe expected the DM with food storage to he Coordinator (RCC)She was going to the up ground beef for the ground beef for the ground beef in the free the freezer today. Interview with the pring od/05/23 at 12:05pmShe expected staff to expired or molded food and expected the free- Foods should have be facility to prevent gas residents. The facility failed to eef food items were dispositely and food was improper food storage gastrointestinal illness detrimental to the heat the residents and control. The facility provided as the facility provided as the facility provided as the residents and control.	acility was 03/27/23. In of the kitchen on 03/27/23 In of the pantry and freezer In old her that the freezer at orking properly. In old her that the freezer at orking properly. In old her that the freezer at orking properly. In old her that the freezer was not did not have a thermometer eas. In or of the Resident Care In or of the Resident Care In or of the Resident (PCP) In or of the provider (PCP) In or of the provider (PCP) In or of the provider or or of the trointestinal distress for In or of the freezer worked or of the prevent residents from the provider of the prevent residents from the prev	{D 283}			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 20 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					F	t l
		HAL008042	B. WING		04/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	WINSTON GARDENS 205 WES			EET		
			R, NC 27983	DDOWNERIO DI ANI OF CORRECTION		
(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 CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 283}	Continued From page	2 20	{D 283}			
		DATE FOR THE TYPE B IOT EXCEED MAY 20,				
{D 358}	3 10A NCAC 13F .1004(a) Medication Administration		{D 358}			
	10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures.					
	This Rule is not met a FOLLOW-UP TO TYPE	-				
		• • •				
	Based on these findings, the previous Type B Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 2 of 4 residents (#4, #5) observed during the medication pass including errors with medications used to treat diabetes (#4) and a medication used to treat seasonal allergies (#5) and for 3 of 3 residents sampled for record review (#1, #2, #3) including medications used to treat high blood sugar (#1, #2) and a medication used to treat irregular heartbeat (#3).					
	The findings are:					

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 21 of 40

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	CONSTRUCTION	(X3) DATE SU COMPLE	
			A. BUILDING		_	
		HAL008042	B. WING		R 04/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	WINSTON GARDENS 205 WEST WINDSOR			EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	opportunities, during to pass on 04/04/23. a. Review of Residen 11/09/22 revealed: -Diagnoses included to the end of the treat high blood sugartwo times a day with the control of the 8:00/04/23 revealed: -The medication aide to Resident #4 at 8:36The MA administered ER 500mg to Resident Chand on 04/04/23 at 3There was a medicate HCL ER 500mg take daily with foodOne hundred twenty HCL ER 500mg were seach bubble on the resident of Metformin House the treatment of the seach bubble on the resident of Metformin House the seach bubble of Metformin House the seach bubble of Metfor	or rate was 7% as ervation of 3 errors out of 38 the 8:00 a.m. medication It #4's current FL-2 dated type 2 diabetes. for Metformin HCL ER (used gars) 500mg take 2 tablets food. Onam medication pass on (MA) administered 12 pills foam. If 1 tablet of Metformin HCL If #4 instead of 2 tablets. If we medications on If the instead of 2 tablets If the instead of 3/17/23. If the instead of 3/1	{D 358}			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 22 of 40

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C		, ,	SURVEY PLETED
			A. BUILDING:			_
		HAL008042	B. WING		04	R 4 /05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	ODRESS, CITY, STATE	, ZIP CODE		
WINSTON	GARDENS	205 WES	T WATSON STREE	ET .		
WINSTON	GARDENS	WINDSO	R, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	e 22	{D 358}			
	8:00am on 04/01/23 t on 04/01/23 to 04/04/	o 04/05/23 and at 5:00pm 23.				
	Interview with the MA on 04/04/23 at 3:21pm revealed he knew Resident #4 was supposed to receive 2 tablets of Metformin HCL ER 500mg but he was trying to go too fast and accidentally administered 1 tablet of Metformin HCL ER 500mg instead.					
	Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26pm revealed the MA should have administered 2 tablets of Metformin HCL ER to Resident #4 because she had diabetes, and it was important that she receive her medications as ordered.					
	3:42pm revealed the instructions on the eN	ministrator on 04/04/23 at MA should have read the MAR and administered 2 HCL ER to Resident #4 as				
	care provider (PCP) of revealed: -Resident #4 not recent Metformin HCL ER concert imeIf Resident #4 was not do age of Metformin blood sugar the PCP medications when the	with Resident #4's primary on 04/05/23 at 12:05pm living the correct dosage of ould affect her blood sugars of receiving the correct HCL ER and it affected her might adjust her expected resident may not need are receiving the correct				
	11/09/22 revealed: -Diagnoses included	t #4's current FL-2 dated Type 2 diabetes. for Lantus (used to treat				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 23 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			7. BOILDING.		R	
		HAL008042	B. WING		04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS	205 WEST WINDSOR,	WATSON STR NC 27983	EET		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) COMPLETE DATE
{D 358}	diabetes (Lantus man to perform a safety che by turning the dosage to 2 units, placing the pen and removing the injection button all the out of the tip of the ne priming. When injectin button should be presslowly count to 10 beto needle). Observation of the 8:004/04/23 revealed: -The medication aide to 26 units and placed penThe MA administered Resident #4 at 8:38ar -The MA immediately without holding it in placed without holding it in placed button until insulin call administering Lantus Review of Resident # medication administration administration at 8:00 alministration at 8:00 alministered at 8:00 almin	ect 26 units every day for aufacturer's instructions read neck before each injection e selector on the Lantus pen pen needle on the Lantus e cap, then pressing the e way in until insulin comes eedle, a process known as an Lantus, the injection esed all the way in and fore withdrawing the Doam medication pass on (MA) dialed the Lantus pen d the needle on the insulin d Lantus 26 units to m. withdrew the insulin pen lace for 10 seconds. The pressing the injection me out of the needle prior to to Resident #4. 4's April 2023 electronic ation record (eMAR) For Lantus inject 26 units is scheduled for lam.	{D 358}			
	Lantus pen with 2 uni					

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 24 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE (A. BUILDING:		· ,	SURVEY PLETED	
			A. Boilebino.			В
		HAL008042	B. WING	· · · · · · · · · · · · · · · · · · ·	04	R / 05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AL	DDRESS, CITY, STATI	E, ZIP CODE		
MINIOTON	LOADDENO	205 WES	T WATSON STRE	ET		
WINSTON	GARDENS	WINDSO	R, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENC	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETE DATE
{D 358}	Continued From page	24	{D 358}			
	soHe should have held	Resident but he forgot to do Resident #4's Lantus pen in econds after injecting the				
	(RCC) on 04/04/23 at -Prior to administering MA should have diale to make sure there was -The MA should have back to zeroAfter dialing the Lant should have then dial administered the 26 uarrow place for 4 to 5 secon medication to make sethe whole doseShe was not aware to	g Lantus to Resident #4 the d the Lantus pen to 26 units as enough insulin in the pen. then dialed the Lantus pen tus pen back to zero the MA ed it to 26 units and				
	3:42pm revealed: -A Lantus insulin pen units of insulin prior to the air out of the need	uld have been held in place fter administering the				
	care provider (PCP) of revealed: -The Lantus pen should units prior to administ Resident #4 in order to	with Resident #4's primary on 04/05/23 at 12:05pm all have been primed with 2 dering the medication to to get the air out and make a correct dosage of insulin.				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 25 of 40

	OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL008042	B. WING		R 04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
		WINDSOR,	NC 27983		1	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLE	
{D 358}	Continued From page	25	{D 358}			
	-The Lantus pen should for at least 10 second Resident #4 to ensure the medicationNot receiving all of the cause Resident #4 to c. Review of Resident 02/16/23 revealed: -Diagnoses included and vitamin deficiencyThe resident was constructed and vitamin deficiencyThe resident was constructed and vitamin deficiencyThere was an order of 50mcg (used to treat into each nostril daily). Observation of the 8:004/04/23 revealed: -The medication aide Resident #5 at 8:12ar -Fluticasone propional Resident #5. Observation of Resident #5. Observation of Resident #5 medication administrative aled: -There was an entry of 50mcg use 1 spray in scheduled for administrative and the second sec	alld have been held in place is after administering it to be the resident received all the dosage of Lantus could have higher blood sugars. It #5's current FL-2 dated is schizophrenia, paranoia, by the seasonal allergies in t				
	Interview with the MA	on 04/04/23 at 3:21pm				

Division of Health Service Regulation

-He did not administer fluticasone propionate to

STATE FORM 6899 W1WC12 If continuation sheet 26 of 40

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 WEST WATSON STREET WINSTON GARDENS C(A) ID PREFIX (EACH DEPICIENCY MIST'SE PRECEDED BY PULL TAG) (EACH DEPICIENCY MIST'SE PRECEDED BY PULL TAG) (EACH DEPICIENCY MIST'SE PRECEDED BY PULL TAG) (EACH OFFICIENCY MIST'SE PRECEDED BY PULL TAG) (EACH OFFICIENCY MIST'SE PRECEDED BY PULL TAG) (EACH OFFICIENCY) (EACH OFFICIENCY (EACH OFFICIENCY) (EACH OFFICIENCY (EACH OFFICIANCY (EACH OFFICIANCY (EACH OFFICIANCY (EACH OFFICIANCY (EACH OFFICIANCY	STATEMEN	FOR DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
MAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 WEST WATSON STREET WINDSOR, NC 27983 [(A4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC IDENTIFYING INFORMATION) (D 358) Continued From page 26 Resident #5 with his other morning medications because he missed seeing it on the eMAR. -After he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident #55 fluticasone propionate when he administered this other morning medications. -The MA should have offered to administer Resident #55 fluticasone propionate when he administered this other morning medications. -If Resident #5 refused the fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3.42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications. -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications.							
WINSTON GARDENS 205 WEST WATSON STREET WINDSOR, NC 27983 CAUTURE SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG PROVIDER'S PLAN OF CORRECTION PREFIX TAG PREFIX TA			HAL008042	B. WING		1	/2023
WINDSOR, NC 27983 WINDSOR, NC 27983 WINDSOR, NC 27983 SUMMARY STATEMENT OF DEFICIENCIS LIDER OF CORRECTION SHOULD BE CEACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX TAG CONTINUED FROM THE APPROPRIATE DEFICIENCY (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (Date of the Appropriate	NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) (D 358) Continued From page 26 Resident #5 with his other morning medications because he missed seeing it on the eMARAfter he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26am revealed: -Resident #5's fluticasone propionate when he administered his other morning medicationsIf Resident #5's fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications.	WINSTON	GARDENS	205 WEST	WATSON STR	EET		
(EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) {D 358} Continued From page 26 Resident #5 with his other morning medications because he missed seeing it on the eMAR. -After he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26am revealed: -Resident #5 did not usually refuse medications. -The MA should have offered to administer Resident #5 fluticasone propionate when he administered his other morning medications. -If Resident #5 refused the fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications.	WINDSOR		R, NC 27983				
Resident #5 with his other morning medications because he missed seeing it on the eMAR. -After he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26am revealed: -Resident #5 did not usually refuse medicationsThe MA should have offered to administer Resident #5's fluticasone propionate when he administered his other morning medicationsIf Resident #5 refused the fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications.	PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR	BE	COMPLETE
because he missed seeing it on the eMAR. -After he administered medications to some other residents, he went back to Resident #5 and asked if he wanted his fluticasone propionate and the resident stated he did not want to take it. Interview with the Resident Care Coordinator (RCC) on 04/04/23 at 3:26am revealed: -Resident #5 did not usually refuse medications. -The MA should have offered to administer Resident #5's fluticasone propionate when he administered his other morning medications. -If Resident #5 refused the fluticasone propionate at that time the MA should have gone back 30 minutes later and offered it to the resident again. Interview with the Administrator on 04/04/23 at 3:42pm revealed: -Fluticasone propionate should have been administered to Resident #5 with the rest of his morning medications.	{D 358}	Continued From page	26	{D 358}			
-The MA should not have missed administering fluticasone propionate to Resident #5 because it was on the eMAR to be administered at 8:00am with his other medications. Telephone interview with Resident #5's primary care provider (PCP) on 04/05/23 at 12:05pm revealed: -Fluticasone propionate was used for allergy symptom reliefResident #5 not receiving fluticasone propionate as ordered could cause him to have congestion or a runny nose. Based on observations, interviews, and record reviews it was determined that Resident #5 was		Resident #5 with his obecause he missed s -After he administered residents, he went bate asked if he wanted his the resident stated he linterview with the Resident #5 did not usure. The MA should have Resident #5 fluticas administered his otherlif Resident #5 refuse at that time the MA should have at that time the MA should have resident #5 refuse at that time the MA should not he linterview with the Administered to Resident #5 refuse at that time the MA should not he fluticasone propional administered to Resident morning medications. The MA should not he fluticasone propionate was on the eMAR to living the with his other medical. Telephone interview with the care provider (PCP) of revealed: -Fluticasone propional symptom reliefResident #5 not recease ordered could cause or a runny nose. Based on observation	other morning medications eeing it on the eMAR. d medications to some other ck to Resident #5 and s fluticasone propionate and d did not want to take it. sident Care Coordinator 3:26am revealed: usually refuse medications. offered to administer one propionate when he or morning medications. d the fluticasone propionate hould have gone back 30 ered it to the resident again. ministrator on 04/04/23 at the should have been dent #5 with the rest of his eave missed administering to to Resident #5 because it to eadministered at 8:00am tions. with Resident #5's primary on 04/05/23 at 12:05pm ate was used for allergy eiving fluticasone propionate se him to have congestion as, interviews, and record				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 27 of 40

	T OF DEFICIENCIES OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
			7 50.25 10		R	
		HAL008042	B. WING			5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS	205 WEST	WATSON STR	EET		
WINDSOF		, NC 27983				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETE DATE
{D 358}	Continued From page	27	{D 358}			
[D 500]	2. Review of Residen 02/16/23 revealed: -Diagnoses included depressionThe resident was coracter (used to treat high blofingerstick blood sugainject 12 units everyd hold if FSBS below 10 a. Review of Residen revealed there was an insulin inject 12 units evening meals, hold of Review of Resident # medication administrate revealed: -There was an entry for check FSBS prior to gunits before breakfast dose if FSBS is below administration at 8:00 administration at 8:00 administered at 8:00 administered at 5:00 pulling 102/10/23, and 02/12/2-On 02/02/23 at 5:00 pulling 120On 02/02/23 at 5:00 pulling 120 administered at 3:00 pulling 120On 02/02/23 at 5:00 pulling 120 at 5:00 pu	diabetes, psychosis, and instantly disoriented. for Humulin 70/30 insulin bod sugars) check for (FSBS) prior to giving, ay at breakfast and evening, for Humulin 70/30 before for Humulin 70/30 before breakfast and fose if FSBS below 100. 2's February 2023 electronic for Humulin 70/30 insulin for Humulin 5:00pm. for Hum	[0.000]			

as 116.

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 28 of 40

DIVISION	n nealth Service Negu	lation				
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
		HAL008042 B. WING		R	10000	
		HAL008042			04/05	5/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
	205 WEST			EET		
WINSTON	GARDENS		NC 27983			
	CLIMMA DV CT		<u> </u>	DDOV/DEDIC DLANLOE CODDECTION		
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETE
TAG		LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPR		DATE
				DEFICIENCY)		
(5, 050)	0 11 1 -		(D. 050)			
{D 358}	Continued From page	e 28	{D 358}			
	-On 02/11/23 at 5:00p	om Humulin 70/30 was not				
		nistered with a note stating,				
		5, 12 units too much for				
	blood sugar of 116".	, 12 dilita too maan loi				
		ted as 316 on 02/12/23 at				
	8:00am.	led as 310 off 02/12/23 at				
	o.00am.					
	lasta mai avvo voitla tla a maa	diantian side (NAA) an				
	Interview with the me					
	04/05/23 at 2:10pm re					
		om Resident #2 did not want				
		mulin 70/30 because he				
	said it was too much i					
		e wanted to take 6 units of				
		d of 12 units and that is why				
	she administered 6 ur					
	instead of the 12 units					
	-She did not write the	note correctly on the eMAR				
	on 02/02/23.					
	-She should not have	administered 6 units of				
	Humulin 70/30 to Res	sident #2 on 02/02/23 but				
	should have documer	nted it as refused on the				
	eMAR or she should I	have contacted Resident				
	#2's primary care pro	vider (PCP) to see how				
	much insulin to admir	nister.				
	-On 02/11/23 at 5:00p	om Resident #2 refused				
	Humulin 70/30.					
	-She did not write the	note correctly on Resident				
	#2's eMAR on 02/11/2	-				
	-She should have dod	cumented Resident #2's				
	Humulin 70/30 as refu					
		riting a note stating 12 units				
		s too much for a FSBS of				
	116.					
	110.					
	Telephone interview v	vith the Resident Care				
	Coordinator (RCC) or					
	revealed:	. 0 .,00,20 at 4.00pm				
		ave administered a different				
		0 to Resident #2 without				

Division of Health Service Regulation

checking with his PCP first.

STATE FORM 6899 W1WC12 If continuation sheet 29 of 40

	OF DEFICIENCIES DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
			A. BOILDING.	A. BOILDING.		
		HAL008042	B. WING		R 04/05/2 0)23
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON GARDENS		205 WEST WINDSOR,	WATSON STR NC 27983	EET		
(X4) ID PREFIX TAG	REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE C	(X5) OMPLETE DATE
{D 358}	refusedShe had never know of his medications. Interview with the Adr 4:40pm revealed: -If Resident #2 stated Humulin 70/30 instead have documented Hu -The MA should not h Humulin 70/30 to Resident #2 refuse 02/11/23 the MA should stating 12 units of Hubut should have documented Hubut should have ordered Hubut should have ordered Hubut should cause his sugarsHigh blood sugars contained Hubut should could cause his sugarsHigh blood sugars contained Hubut should his formal hubut should have being for a wound on his formal hubut should have being for a wound on his formal hubut should have delayed wour Review of Resident #2	d Humulin 70/30 on we been documented as an Resident #2 to refuse any ministrator on 04/05/23 at the wanted to take 6 units of d of 12 units the MA should mulin 70/30 as refused. ave administered 6 units of sident #2 without receiving 2. ad Humulin 70/30 on ald not have written a note mulin 70/30 was too much mented it as refused. With Resident #2's PCP on revealed: of follow orders for ident #2's Humulin 70/30. ave decided to administer a umulin 70/30 to Resident #2 ad. siving Humulin 70/30 when g a lower dosage than he im to have high blood buld cause damage to concreas, or liver. In g seen by a wound clinic of in February 2023 and not dosage of insulin could have	{D 358}			
		c for a stage II wound to his				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 30 of 40

HAL008042 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINSTON GARDENS 205 WEST WATSON STREET WINDSOR, NC 27983 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE C		(X3) DATE SURVE COMPLETED	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 205 WEST WATSON STREET WINDSOR, NC 27983			HAL008042	B. WING	B. WING		23
WINSTON GARDENS 205 WEST WATSON STREET WINDSOR, NC 27983	NAME OF F	PROVIDER OR SUPPLIER		DRESS, CITY, STATE	E, ZIP CODE		
WINDSOR, NC 27983							
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (X5)	WINSTOR	N GARDENS	WINDSOR	, NC 27983			
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPI		EFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL			(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO	LD BE CO	(X5) DMPLETE DATE
(D 358) Continued From page 30 right foot and an unstageable wound to his left 4th toe (Wounds are staged from I to IV. A stage II pressure wound is a shallow open ulcer with a pink wound bed. A wound is unstageable when the wound bed cannot be visualized due to a layer of other tissue over the wound). Review of Resident #2's physician visit note dated 03/30/23 revealed the resident was released from the wound clinic. Telephone interview with Resident #2's specialty provider on 04/05/23 at 9.30am revealed the wounds to both of his feet were healed at his visit on 03/30/23. Based on observations, interviews, and record reviews it was determined that Resident #2 was not interviewable. b. Review of Resident #2's February 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Humulin 70/30 insulin check FSBS prior to giving insulin and inject 12 units before breakfast and evening meals, hold dose if FSBS is below 100 scheduled for administration at 8.00am and 5.00pmFSBS was documented as 89 on 02/28/23 at 8.00amHumulin 70/30 12 units was documented as administered on 02/28/22 at 8.00am when it should have been held. Review of Resident #3's March 2023 eMAR revealed: -There was an entry for Humulin 70/30 insulin check FSBS prior to giving insulin and inject 12 units before breakfast and evening meals, hold	{D 358}	right foot and an unstath toe (Wounds are signature) Il pressure wound is a pink wound bed. A wo the wound bed cannot layer of other tissue on Review of Resident # 03/30/23 revealed the the wound clinic. Telephone interview victory provider on 04/05/23 wounds to both of his on 03/30/23. Based on observation reviews it was determined interviewable. b. Review of Resident electronic medication (eMAR) revealed: -There was an entry for check FSBS prior to gunits before breakfast dose if FSBS is below administration at 8:00 administration at 8:00 are should have been helected: -There was an entry for check FSBS prior to gunits before breakfast dose if FSBS was document 8:00amHumulin 70/30 12 un administered on 02/26 should have been helected: -There was an entry for check FSBS prior to get a pink to get	ageable wound to his left staged from I to IV. A stage a shallow open ulcer with a bund is unstageable when of be visualized due to a over the wound). 2's physician visit note dated a resident was released from with Resident #2's specialty at 9:30am revealed the feet were healed at his visit as, interviews, and record ained that Resident #2 was administration record for Humulin 70/30 insuling giving insulin and inject 12 than and 5:00pm. The das 89 on 02/28/23 at aits was documented as 8/22 at 8:00am when it d. 3's March 2023 eMAR for Humulin 70/30 insuling giving insulin and inject 12 than and 5:00pm.	{D 358}			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 31 of 40

DIVISION	n nealth Service Regu	ialion			
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION	
AND PLAN C	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING:	A. BUILDING:	
			B. WING		R
		HAL008042	D. WING		04/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET AI	DDRESS, CITY, STA	TE, ZIP CODE	
		205 WES	T WATSON STR	FFT	
WINSTON	WINSTON GARDENS				
			R, NC 27983	I	
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTIO	()
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP	
IAG			IAG	DEFICIENCY)	
{D 358}	Continued From page	e 31	{D 358}		
	administration at 0:00	lam and E:00nm			
	administration at 8:00	•			
		ted as 99 on 03/20/23 at			
	8:00am.				
		nits was documented as			
		0/23 at 8:00am when it			
	should have been hel				
		ted as 88 on 03/25/23 at			
	8:00am.				
	-Humulin 70/30 12 units was documented as				
	administered on 03/25/23 at 8:00am when it				
	should have been hel	d.			
	-FSBS was document	ted as 84 on 03/26/23 at			
	8:00am.				
	-Humulin 70/30 12 un	its was documented as			
	administered on 03/20	6/23 at 8:00am when it			
	should have been hel	ld.			
	-FSBS was document	ted as 99 on 03/30/23 at			
	8:00am.				
		its was documented as			
		0/23 at 8:00am when it			
	should have been hel				
		ted as 99 on 03/31/23 at			
	8:00am.	ted as 55 on 66/6 1/20 at			
		its was documented as			
		1/23 at 8:00am when it			
	should have been hel				
		o. 00 to 448 at 5:00pm on			
	•	•			
	03/25/23 to 03/31/23.				
	Tolonhone interview	with Pagidant Care			
	Telephone interview v				
	Coordinator (RCC) or	1 U4/U5/23 at 4:U8pm			
	revealed:	15050 1 1			
	-She usually performe				
	Resident #2 around 7				
	-	did not eat breakfast until			
		0am and that was when she			
	administered his Hum	nulin 70/30.			
	-She usually rechecke	ed Resident #2's FSBS			
		Humulin 70/30 between			

Division of Health Service Regulation

8:30am to 9:00am.

STATE FORM 6899 W1WC12 If continuation sheet 32 of 40

	or riealth Service Regu		1		1		
	F OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	CONSTRUCTION	(X3) DATE S		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _	A. BUILDING:		COMPLETED	
					R		
		HAL008042	B. WING		1	5/2023	
					1 0-1/0		
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STA	TE, ZIP CODE			
WINGTON	GARDENS	205 WES	T WATSON STR	EET			
WINSTON	GANDLING	WINDSO	R, NC 27983				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	N	(X5)	
PREFIX	`	Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROP DEFICIENCY)	KIAIE	DATE	
				BEHOLINOTY			
{D 358}	Continued From page 32		{D 358}				
	\\/\langle						
		ted that she administered					
		sident #2 on 02/28/23,					
		3/26/23, and 03/31/23					
	1	must have been above 100					
	when she rechecked						
	· ·	and Humulin 70/30 were in					
	•	e eMAR so they were					
	documented at the sa						
	-She did not know wh	ny she would document					
	Resident #2's FSBS f	from earlier in the day					
	instead of the current FSBS on the eMAR. Interview with the Administrator on 04/05/23 at						
	4:40pm revealed:	111113trator 011 0 1 703/23 at					
	'	uld have held Resident #2's					
		lered if his FSBS was less					
	than 100.						
		on the eMAR for his FSBS					
		in 70/30 administration were					
	in the same place so	the FSBS and Humulin					
	70/30 would be docur	mented at the same time.					
	-The FSBS that was	documented for Resident					
	#2's eMAR at 8:00am	should be what his FSBS					
	was at that time and I	his Humulin 70/30					
	administration should	match with the FSBS that					
	was documented on t	the eMAR.					
	Tolonbone interviewe	with Docidant #91					
		with Resident #2's primary					
		on 04/05/23 at 12:05pm					
	revealed administerin	-					
		FSBS was below 100 could					
		nich could result in Resident					
	#2 going into a coma.	•					
	Based on observation	ns, interviews, and record					
		nined that Resident #2 was					
		iiileu tiiat kesident #2 was					
	not interviewable.						
	3. Review of Resider	nt #1's current FL-2 dated					
	02/16/23 revealed:						

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 33 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` '	CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
7.1.2.2.1.1		.52.11.10/11/01/11/01/02	A. BUILDING: _				
			5 14/110		I	R	
		HAL008042	B. WING		04/	05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
	0.155510	205 WES	WATSON STR	EET			
WINSTON	GARDENS	WINDSOF	R, NC 27983				
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE	(X5) COMPLETE DATE	
{D 358}	Continued From page	33	{D 358}				
	amputee, hypertensic diseaseThe resident was corolline was an order of short-acting insulin us sugars) check fingers times a day before mescale insulin (SSI) FS units of insulin, FSBS of insulin, FSBS 351-400	diabetes, lower left leg on, and peripheral vascular enstantly disoriented. For Humalog insulin (a sed to treat high blood tick blood sugar (FSBS) 4 leals and at bedtime; sliding liss 201-250 administer 2 leading liss 201-300 administer 4 units 350 administer 6 units of 0 administer 8 units of lier 400 administer 10 unit of					
Review of Resident #1's March 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog check FSBS 4 times a day before meals and at bedtime; sliding scale insulin FSBS 201-250 administer 2 units of insulin, FSBS 251-300 administer 4 units of insulin, FSBS 301-350 administer 6 units of insulin, FSBS 351-400 administer 8 units of insulin, and FSBS over 400 administer 10 unit of insulin. -A FSBS of 222 was documented at 12:00pm on 03/02/23; Humalog was not documented as administered, when Humalog 2 units should have been administered. -A FSBS of 262 was documented at 8:00am on 03/05/23; Humalog was not documented as administered, when Humalog 4 units should have been administered. -A FSBS of 227 was documented at 8:00am on 03/19/23; Humalog was not documented as administered when, Humalog 2 units should have been administered when, Humalog 2 units should have been administered. -Humalog 6 units was documented as							

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 34 of 40

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
				R		
		HAL008042	B. WING		04/05/2023	
NAME OF PI	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
	CLIMMADY CT		R, NC 27983	DDOVIDEDIC DI AN OF CORDECTIO	N	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	e 34	{D 358}			
	03/14/23 when Humal been administeredHumalog 4 units was administered for a FS 03/16/23 when Humal been administeredFSBS ranged from 1 03/31/23. Telephone interview was Coordinator (RCC) or revealed: -The resident had not taken, she and MAs was FSBS as ordered by the (PCP)She and the MAs had Resident #1's FSBS the did not realize the incorrect dose of orders to the resident -She and MAs were exparameters for SSI for the PCP of any change Interview with the Administration.	log 10 units should have s documented as BS of 420 at 8:00pm on log 10 units should have 77 to 578 from 03/01/23 to with the Resident Care n 04/05/23 at 4:08pm refused to have his FSBS's were expected to check his the primary care provider d parameters to follow for to help control his diabetes. That she had not administered Humalog per the PCP expected to follow the PCP's tr Resident #1 and to notify				
	4:40pm revealed: -She expected the MAs and RCC to follow PCP ordersMAs and the RCC should have followed the PCP SSI parameters as orderedThe RCC was responsible for ensuring that residents received their medication as ordered to prevent complications from diabetes. Telephone interview with Resident #2's primary care provider (PCP) on 04/05/23 at 12:05pm revealed: -She expected MAs to follow SSI orders for administration of Resident #1's Humalog per the					

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 35 of 40

	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED	
			B. WING		R	
		HAL008042	B. WING		04/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS		WATSON STR	EET		
		WINDSOR,	NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page	35	{D 358}			
	the correct dosage of blood sugars for Resi-High blood sugars correct Resident #1's heart a 4. Review of Resident 2/10/23 revealed: -Diagnosis included correct and hypertensionThe resident was correct Review of Resident # prescription dated 03/electronic order for Diagnosis take one tablet by mo arrhythmia, hold if apia a stethoscope by lister	buld cause damage to and pancreas. t #3's current FL-2 dated abronic kidney disease Stage ation (irregular heartbeat), anstantly disoriented.				
	irregular heartbeat.) Review of Resident #3's March 2023 electronic medication administration record(eMAR) on revealed: -There was an entry for Digoxin 125mcg, take one tablet by mouth every other day for arrhythmia, hold if apical pulse is less than 60. -On 03/21/23 Resident #3's apical pulse was 57 and Digoxin was documented as administered. -On 03/22/23 Resident #3 was of the facility and in a nearby hospital. -On 0326/23 Resident #3 was out of the facility and in a nearby hospital. -On 3/28/23 Resident #3 was out of the facility and in a nearby hospital. -On 03/30/23 Resident #3 was out of the facility and in a nearby hospital.					

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 36 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		
		HAL008042	B. WING		R 04/05/2023
NAME OF P	ROVIDER OR SUPPLIER	STREET A	DDRESS, CITY, STATE	E, ZIP CODE	-
		205 WES	ST WATSON STRE	ET	
WINSTON	I GARDENS	WINDSC	OR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC' (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE COMPLE
{D 358}	Continued From page 36		{D 358}		
	Continued From page 36 Telephone interview with the Resident Care Coordinator (RCC) on 04/05/23 at 4:09pm revealed: -Digoxin was to be held if Resident #3's apical pulse was less than 60She checked Resident #3's apical pulse twice on 03/21/23 and did not enter the apical pulse over 60 on the eMAR. Interview with the Administrator on 04/05/23 at 4:46pm revealed medication aides (MAs) were expected to withhold medication as prescribed by a physician. Telephone interview with Resident #3's primary care provider (PCP) on 04/05/23 at 12:30pm revealed: -She expected MAs to withhold Digoxin as ordered by the providerDigoxin could lower heart rate and if Resident #3's apical pulse was lower than 60 and Digoxin was administered it could cause an increase in low heart rate, dizziness, and an increase in falls.				
		ns, interviews, and record nined that Resident #3 was			
	administered an arbitic resident and held instant the primary care provided blood sugar which corresident's heart, pand delayed wound healin (#1) and administered sliding scale insulin or resulted in high blood 578 (#2). The facility's	ollow medication orders and rary dose of insulin to a ulin without an order from ider which caused a high uld cause damage to the reas, and liver as well as any to a wound on his foot of the incorrect dose of a tleast 5 occasions which sugars ranging from 177 to be failure was detrimental to discontinuation.			

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 37 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					R	
HAL008042		B. WING		04/05/2023		
NAME OF PI	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS	205 WEST WINDSOR,	WATSON STR	EET		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF CORRECTION	N (X5)	
PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE COMPLETE	
{D 358}	Continued From page 37		{D 358}			
	and constitutes a Typ	e B Violation.				
	this violation. THE CORRECTION I	plan of protection in 131D-34 on 04/05/23 for DATE FOR THE TYPE B IOT EXCEED MAY 20,				
{D 367}	10A NCAC 13F .1004 Administration	l(j) Medication	{D 367}			
	5,					
	This Rule is not met	as evidenced by:				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 38 of 40

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION IDENTIFIC		IDENTIFICATION NOMBER.	A. BUILDING: _		GOWN LETED	
		HAL008042	B. WING		R 04/05/2023	
NAME OF P	ROVIDER OR SUPPLIER	STREET ADI	DRESS, CITY, STA	TE, ZIP CODE		
WINSTON	GARDENS	205 WEST	WATSON STR	EET		
WINSTON	GARDENS	WINDSOR	, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE	
{D 367}	Continued From page 38		{D 367}			
	Based on observations, interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#5) including inaccurate documentation of a medication used to treat seasonal allergies. The findings are:					
	02/16/23 revealed: -Diagnoses included and vitamin deficiency -The resident was corThere was an order of 50mcg (used to treat into each nostril daily). Observation of the 8:004/04/23 revealed: -The medication aide Resident #5 at 8:12ar	nstantly disoriented. for fluticasone propionate seasonal allergies) 1 spray				
	medication administrative revealed: -There was an entry for 50mcg use 1 spray in scheduled for administrative administered at 8:00 Interview with the MA revealed: -He did not administered Resident #5 with his control because he missed services.	or fluticasone propionate to each nostril daily stration at 8:00am. tte 50mcg was documented				

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 39 of 40

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		HAL008042	B. WING		R 04/05/2023
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE					
WINSTON GARDENS 205 WEST WA' WINDSOR, NC				EET	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULE CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETE
{D 367}	residents, he went ba asked if he wanted his the resident stated he -He should have docu fluticasone propionate documenting it was as Interview with the Resident #5 refused f MA should have docu eMAR. Interview with the Adr 3:42pm revealed: -Resident #5's fluticas have been documented.	ck to Resident #5 and s fluticasone propionate and d did not want to take it. Immented Resident #5's as refused instead of dministered. sident Care Coordinator 3:26pm revealed if luticasone propionate the mented it as refused on the ministrator on 04/04/23 at sone propionate should not ed as administered. sone propionate should have	{D 367}		

Division of Health Service Regulation

STATE FORM 6899 W1WC12 If continuation sheet 40 of 40