STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation from 02/14/24 to 02/16/24. The complaint investigation was initiated by the Bertie County Department of Social Services initiated on 01/08/24.	D000	Responses to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth. In the statement of deficiencies, the plan of correction is prepared solely as a matter of compliance with State Law.	ddd
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews the facility failed to provide supervision for 1 of 5 sampled residents (#5) in a special care unit as evidenced by a resident with dementia who eloped from the facility without the knowledge of staff and was found sitting in the driver's side of a car in the parking lot. The findings are: Review of the facility's license revealed: -The facility was licensed to operate an adult care home effective date 01/01/24. -The facility was licensed for a capacity of 60 residents with Alzheimer's/Dementia. -The facility was a special care unit (SCU). Review of the facility's Identification and	D 270	**10A NCAC 13F .0901 Personal Care and Supervision** **Area Clinical Director in-serviced all staff on importance of supervision for residents that wander or at risk for elopement.** **Maintenance Manager ensured that chime alarms where in good condition and actively working to alarm staff when someone is exiting on entering the building.** **The Care Manager and Administrator review all FL2's and care plans to ensure that all residents were receiving that proper care and if a significant change occurred there will be a staff meeting held to discuss any changes and interventions that needed to be put into place.** **Any significate changes in the resident(s) condition the care manager will contact the PCP and responsible party to discuss changes along with proper interventions and orders to put into place.** **ACD in-serviced staff on the importance of noticing behavior changes and proper redirection that can cause behavior or exit seeking.** **All staff have daily stand up between shift to report any noticeable changes in behaviors or condition. Also, any events that occurred previously from the prior shift.**	03/06/24 03/06/24 03/16/24 03/16/24 03/06/24 03/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 1 Supervision of Confused/Wandering Resident Policy dated September 2021 revealed: -The facility would identify residents who walk or wheel around unrestricted and are a threat to leave the community unattended due to their confusion. -The facility would inform staff upon admission and as necessary if the potential exists for a resident to wander. -We will practice the following environment Safeguards: -Check door alarms regularly to assure they are working properly. -Notify all staff when alarms fail and assure extra precautions for residents at rick of wandering. -Repair/reactivate alarm system as soon as practicable. -The community will check the operations of the mag lock door security system, window system and gate systems to assure proper working order twice a week. Review of Resident #5's current FL-2 dated 07/26/23 revealed: -Diagnoses included dementia, and insomnia. -The resident was ambulatory. -The resident was constantly disoriented. -The resident's functional limitations was hearing. -The resident's recommended level of care was special care unit. -The resident was a wanderer. Review of Resident #5's Resident Register revealed an admission date of 07/24/23. Review of Resident #5's Care Plan dated 01/03/24 revealed: -The resident was ambulatory. -The resident had wandering and aggressive behaviors.	D 270	**The facility notifies the PCP and the responsible party when an incident take place within 24 hours.** **The Care Manager notify the Adult Home Specialist within 24-48 hours of the incident. The Administrator will follow-up with the Care Manager to ensure the notification.**	**03/06/24** **03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 2 -The resident was seen by a mental health provider. Review of Resident #5's Special Care Profile and Care Plan dated 02/08/24 revealed: -The resident's behavioral patterns included uncooperative and aggression. -The intervention was for staff to monitor the resident. Interview with a personal care aide (PCA) on 02/15/24 at 8:10am revealed Resident #5 had wandering and exit seeking behaviors and needed to be monitored. Interview with a medication aide (MA) on 02/15/24 at 3:40pm revealed Resident #5 had wandering behaviors and stood at the front door of the facility often and pushed against the door trying to get out. Interview with a second MA on 02/15/23 at 10:00am revealed Resident #5 had wandering behaviors and would walk the hall. Interview with the Special Care Coordinator (SCC) on 02/15/24 at 2:25pm revealed Resident #5 roamed the hallway and stood at the front door frequently and should have been monitored. Interview with the Administrator on 02/16/23 at 2:00pm revealed Resident #5 had wandering behaviors and should have been supervised closely. Review of Resident #5's Accident/Incident (A/I) Report revealed: -Resident #5 eloped from the front entrance of the facility on 10/31/23. -Staff witnessed the resident exit front entrance	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 3 door. -The A/I report was completed on 11/07/23 by the Special Care Coordinator (SCC). -The resident's family member and primary care provider (PCP) were notified on 11/07/23. -Increased supervision was initiated for the resident to be monitored at least every hour each shift from 11/07/23 through 11/10/23 and to chart progress notes daily. Review of Resident #5's Psychiatry Progress Note dated 11/20/23 note revealed: -Staff reported concerns about the resident's behavior, which affected his safety as well as the safety of other residents. -Staff reported frequent agitated behaviors. -Staff reported the resident was able to exit the facility's front door and sat in a unlocked vehicle. -Staff who were outside were able to observe this and redirected the resident back inside. Interview with a personal care aide PCA on 02/15/24 at 8:10am revealed: -She was doing residents' laundry when she heard staff running down the hall toward the front door of the facility. -She went down the hall toward the front of the facility to see what was going on and saw Resident #5 sitting in a staff person's car. -She did not know how long he had been out there. -The facility was notified by a staff person who usually came to work early and was sitting outside in her car that Resident #5 was outside of the facility unattended. -She thought the resident was on fifteen minute checks prior to elopement that should be documented in the 24-hour communication log book that was kept in the medication room.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 4 Observation of the medication room on 02/15/24 at 9:00am revealed there was a list of residents' names posted on the wall in the medication room where Resident #5 was listed as a 15-minute check resident. Review of the 24-hour log in the medication room revealed there was no documentation of Resident #5 being on any supervision checks prior to and after the elopement on 10/31/24. Interview with a MA on 02/15/24 at 3:40pm revealed: -She worked on the second shift (3:00pm to 11:00pm). -She usually came to work early and sat in her care outside the facility until about 2:45pm. -She was sitting in the parking lot in the front of the facility on 10/31/23 when she saw Resident #5 walking toward a staff person's car in the parking lot. -She did not know how long he had been out of the facility. -She got out of her car and began running toward the resident and called his name while calling a MA's personal mobile phone who was inside the facilty. -The resident got in the driver's side of a staff person's car and closed the door and was reaching to turn on the ignition as if a key was in the ignition. -She told the MA inside the facility that Resident #5 was outside of the facility by himself. -The MA that she called, the SCC, and the Administrator came outside of the facility and re-directed the resident back into the facility. -The Dietary Manager observed the resident outside of the facility as well because she was leaving from work in her car. -She did not know how he got out of the facility	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 5	D 270		

because the front door was locked and required a staff person to type in the code on a keypad near the door to unlock the door.
-No one in the facility knew he was outside of the facility alone.

Interview with a second MA on 02/15/23 at 10:00am revealed:
-She worked at the facility on the first shift on 10/31/23.
-She was in the breakroom when she received a call from a MA who usually came to work early and was sitting in her car outside of the facility.
-The MA told her that Resident #5 was outside of the facility by himself and was walking toward a staff person's car.
-She immediately got up and ran down the hall and notified other staff and the SCC and the Administrator while running toward the front door to go outside to re-direct the resident back into the facility.
-When she got outside the facility, the resident had gotten into the driver's side of a staff person's car and the car alarm was going off.
-The resident was re-directed back into the facility.

Interview with a third MA on 02/15/24 at 7:50am revealed:
-She worked on first shift on 10/31/23 when Resident #5 eloped from the building.
-A staff person ran down the hall and told her to come and turn off the alarm to her car because Resident #5 had gotten out of the facility and was sitting on the driver's side of her car.
-She had left the driver's side of her car unlocked, but the alarm was on.
-She did not know how long the alarm had been going off.
-When she got to the front door of the facility,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 6	D 270		

staff were bringing the resident back into the facility.
-She did not know if he had eloped before.
-She parked in the same parking space every time she worked.

Observation of the MA's car on 02/16/34 at 2:00pm that Resident #5 eloped and got into the driver's side revealed a sports utility vehicle (SUV) about 50 steps from the front of the facility.

Observation of the facility on 02/16/24 at 2:05pm and the parking lot revealed the facility was in a heavily wooded area with trees down a paved side road with no houses nearby.

Interview the Dietary Manager on 02/15/24 at 4:06pm revealed:
-She was working on 10/31/23 when Resident #5 eloped out of the front door of the facility.
-She was leaving the facility in her car from the back of the facilty where the kitchen was located to the front of the facility when she saw Resident #5 walking from the front porch of the facility toward a car in the parking lot.
-She also saw a staff person who worked on the third shift who usually came to work early getting out of her car and running toward Resident #5 who was getting in the driver's side a car parked in the parking lot in front of the facility.
-She then saw staff running out of the front door of the facility to re-direct Resident #5 back into the facility that included a MA, the SCC, and the Administrator.

Interview with the Maintenance Director on 02/16/24 at 8:45am revealed:
-He was working on the day Resident #5 eloped out of the front door of the facility on 10/31/23.
-He had unlocked the front door by entering in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 7 code on the keypad located to the left side of the door to let a delivery person out who had delivered equipment to the facility that day. -He walked back down the hall after unlocking the front door to let the delivery person out. -He had not waited to ensure the door was locked before going back down the hall. -In about three minutes of walking back down the hall he heard staff yelling that Resident #5 was outside of the facility alone. -Resident #5 must have followed the delivery person outside of the facility. Interview with Resident #5's family member on 02/14/24 at 9:55am revealed: -She was notified on 11/07/23 that Resident #5 had gotten out of the facility without the knowledge of staff on 10/31/23 and that he was okay. -She was concerned that she was not notified that the resident got out of the facility until 7 days later. -She was told Resident #5 must have followed a delivery person out of the front door of the facility. -She was later told during a meeting with the SCC and the Administrator that he did not elope and that staff was with him outside on the front porch of the facility. -It was unclear to her what happened.	D 270		
	Interview with the SCC on 02/15/24 at 2:25pm revealed: -She was in her office in the facility when a staff person came running down the hall and told her a staff person outside of the facility called to let them know Resident #5 was outside sitting in a staff person's car. -She and the staff person ran out the front door and observed Resident #5 sitting in a staff person's car.			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 8 -They redirected the resident back into the facility. -She thought he got out of the facility when a delivery person exited the facility. -She did not remember the frequency of supervision checks the resident was on prior to the elopement. -After the elopement, she instructed staff including the PCAs and MAs to keep an eye on him at all times for the safety of the resident. -If the staff person that saw the resident would not have been in the parking lot, Resident #5 could have wandered into the woods or down the road. -She completed the A/I report on Resident #5's elopement 7 days after the incident because she thought the MA had completed the report. -The Maintenance Director should have made sure the front door was locked before going back down the hall. -She expected staff to know where Resident #5 was at all times. Interview with the Administrator on 02/16/23 at 2:00pm revealed: -She was in the facility on 10/31/23 when Resident #5 left the facility and was found sitting in a staff person's car. -She was not sure the frequency of supervision checks the resident was on prior to the elopement or after. -The SCC was responsible for ensuring supervision checks were implemented by staff for the resident. -Staff had been trained on the elopement policy. Telephone interview with Resident #5's Primary Care Provider (PCP) on 02/15/24 at 2:50pm revealed: -She found out about the Resident #5's elopement a couple of weeks ago through her	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 270	Continued From page 9 medical assistant that was informed by a family member. -The facility did not inform her of the resident's elopement. -She was not aware of any increase in supervision after the elopement. -She expected Resident #5 to be supervised at all times due to wandering behaviors and a dementia diagnosis. Based on observations, record reviews, and interviews, it was determined Resident #5 was not interviewable. The facility failed to provide supervision for Resident #5, who eloped from the facility without the knowledge of staff and was found sitting on the driver's side of a staff person's car in the parking lot in front of the facility that was located in a heavily wooded area with trees and no houses nearby. This failure placed the residents at substantial risk for physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/16/24 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 03/17/24.	D 270		
D 312	10A NCAC 13F .0904(f)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (f) Individual Feeding Assistance in Adult Care Homes: (2) Residents needing help in eating shall be	D 312	**10A NCAC 13F .0904(f)(2) Nutrition and Food Service** **ACD in-service all staff on Residents Rights and Dignity.**	**03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 10 assisted upon receipt of the meal and the assistance shall be unhurried and in a manner that maintains or enhances each resident's dignity and respect. This Rule is not met as evidenced by: Based on record reviews, observations and interviews, the facility failed to ensure staff provided a resident (#6) requiring assistance with their meal in the special care dining room. The findings are: Review of Resident #6's FL2 dated 05/31/23 revealed: -Diagnoses included Alzheimer's Disease, anxiety disorder and insomnia. -Resident #6 had a diet order for puree meals. Review of a physician order dated 05/31/23 revealed Resident #6 required feeding assistance. Review Resident #6's care plan dated 06/21/23 revealed: -Resident #6's assessment was total care. -Resident #6 required staff to feed for all meals and snacks. Observation of lunch meal on 02/14/24 at 12:14pm to 12:34pm revealed: -Resident #6 was seated at a table alone. -Resident #6's meal was pureed. -Resident #6 was served ham, vegetable medley, candied yams, biscuit, tea, and water. -Resident #6 fed herself her meal and beverages. -Resident #6 consumed at least ¾ of her meal and all of the tea, drinking only ½ of the water. -There were 5 personal care aides (PCA) in the dining room.	D 312	**The facility provided the dietary department with an updated diet list and list of feeders. Also, the care manager reviewed all feeders based on their personal care plan with staff during stand up between each shift.** **Any new admissions or changes in resident(s) plan was updated immediately and communicated to the dietary department, medication aide, personal care staff and the Administrator.**	03/06/24 **03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 11 -The PCAs were not monitoring Resident #6 as she ate her meal. -The Dietary Manager encouraged Resident #6 to drink some water. Interview with a PCA on 02/14/24 at 12:32pm revealed: -Resident #6 did not require feeding assistance and she could feed herself without any issues. -She did not know if Resident #6 had an order for feeding assistance. Interview with a second PCA on 02/14/24 at 12:33pm revealed: -Resident #6 did not require feeding assistance. -Resident #6 would stop eating when she was full. -She was not informed of Resident #6 needing feeding assistance. Observation of breakfast meal on 02/15/24 at 8:45am to 9:00am revealed: -Resident #6 was served her breakfast meal in her room. -Resident #6's meal was pureed. -Resident #6 was served oatmeal, scrambled eggs, milk, and water. -There was a PCA providing feeding assistance to Resident #6. -Resident #6 consumed all of the scrambled eggs, ¼ of oatmeal and ½ of milk and water. Interview with the PCA on 02/15/24 at 8:57am revealed: -She always provided feeding assistance to Resident #6. -She had not observed Resident #6 feeding herself. Interview with Resident #6's Primary Care	D 312		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 312	Continued From page 12 Physician (PCP) on 02/14/24 at 2:53pm revealed: -Resident #6 required feeding assistance from staff because she was total care. -Feeding assistance to Resident #6 was expected to in order to monitor her food intake. Interview with the Special Care Coordinator (SCC) on 02/16/24 at 1:24pm revealed: -Resident #6 did require feeding assistance. -She was not aware of staff not providing feeding assistance to Resident #6. -The PCAs were to provide feeding assistance to all residents who needed feeding assistance. -She informed the PCAs of the residents who needed feeding assistance. Interview with the Administrator on 02/16/24 at 2:47pm revealed: -All residents who had been identified as needing feeding assistance were to be fed by the PCAs or medication aides (MA). -The SCC was responsible for updating the dietary list for staff where feeding assistance residents were identified.	D 312		
D 358	10A NCAC 13F .1004(a) Medication Administration 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 as evidenced by:	D 358	**10A NCAC 13F .1004(a) Medication Administration** **Area Clinical Director in-serviced all staff on medication administration.** **The facility utilizes the second verification process of orders to ensure medications are clarified and obtained in the facility.** **Current physician orders are verified and processed with the pharmacy.**	**03/06/24** 03/06/24 03/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 13 TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered 1 of 5 residents (#9) observed during the medication pass including errors with a medication used to treat and prevent constipation, a medication used to treat and prevent low iron levels in the blood and a medication used to treat anxiety and depressions (#9); and for 2 of 5 residents (#2, #5) sampled for record review for a medication used to prevent infection, a medication used to control blood pressure, a medication used to treat anxiety, 2 medications used to aid sleep (#2) and medications used to treat agitation and aide sleep (#5). The findings are: 1. The medication error rate was 12% as evidenced by 3 errors out of 25 opportunities during the 7:00am/8:00am medication pass on 02/15/24. Review of Resident #9's current FL-2 dated 01/30/24 revealed: -Diagnoses included dementia, depression, anxiety and hypertension. -She was intermittently disoriented. -There was a physician's order for citalopram 10mg to be administered once each day. (Citalopram is a medication used to treat depression.) -There was a physician's order for docusate sodium 100mg to be administered once each day. (Docusate Sodium is a medication used to prevent constipation.) -There was a physician's order for Nu-Iron 150mg to be administered once each day. (Nu-Iron is a	D 358	**If a medication is not found to be available the medication aide should call the pharmacy and notify the care manager for follow-up.** **Care Manager and Administrator review medication compliance reports daily to ensure appropriate compliance.** **Care Managers and medication aides are responsible for reviewing medication cart audits.** **Upon admission the admitting resident should have an updated FL2 or medication clarified by the PCP in order to administer any medication or treatments.** **Medication not administered as ordered, will have the medication error reports completed by the CM and notification to the PCP and responsible party. Medication errors will be reviewed during at risk meetings and monthly Quality Assurance and Performance Improvement (QAPI).** **All staff responsible for medication administration will be observed quarterly thereafter. Copies of their medication pass observation will be maintained in their personal file.**	03/06/24 03/06/24 03/06/24 03/06/24 03/06/24 03/13/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 14 polysaccharide iron complex used to treat iron deficiency.) Observation of the 8:00am medication administration pass on 02/15/24 revealed: -Resident #9 was administered 5 pills at 7:43am. -Citalopram 10mg, docusate sodium 100mg and polysaccharide iron complex 150mg was not available for administration to Resident #9. Interview with the medication aide (MA) on 02/15/24 at 8:50am revealed: -Refills for Resident #9's citalopram 10mg, docusate sodium 100mg and polysaccharide iron complex 150mg were requested on 02/14/24. -The citalopram 10mg, docusate sodium 100mg and polysaccharide iron complex 150mg had not been received. Review of Resident #9's electronic medication administration record (eMAR) for February 2024 revealed: -There was a computerized entry for citalopram 10mg to be administered each day at 8:00am. -There was documentation citalopram 10mg was not administered on 02/15/24 with an exception note stating the medication was reordered. -There was a computerized entry for docusate sodium 100mg to be administered each day at 8:00am. -There was documentation docusate sodium 100mg was not administered on 02/15/24 with an exception note stating the medication was reordered. -There was a computerized entry for polysaccharide iron complex 150mg to be administered each day at 8:00am. -There was documentation polysaccharide iron complex 150mg was not administered on 02/15/24 with an exception note stating the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 15 medication was reordered. Telephone interview with Resident #9's pharmacist on 02/14/24 at 10:20am revealed: -Scheduled medications should never be missed because it could decrease the effectiveness of the treatment for which they are prescribed. -Missing some medications, like citalopram which was a selective serotonin reuptake inhibitor (SSRI), could disrupt neurotransmitters in the brain. Telephone interview with Resident #9's primary care provider (PCP) on 02/14/24 at 11:11am revealed: -Citalopram was used to treat depression and should never be abruptly stopped. -Missing a single dose of medication was not ideal for treatment. 2. Review of Resident #2's current FL-2 dated 02/01/24 revealed diagnoses included dementia and hypertension. Review of Resident #2's Resident Register revealed she was admitted to the memory care unit from an assisted living facility on 02/01/24. Observation of Resident #2 on 02/14/24 at 10:20am revealed she was asleep in the common area and her right hand was wrapped in gauze. Second observation of Resident #2 on 02/16/24 at 9:09am revealed: -She was in her bedroom and her right hand was wrapped in gauze. -She was not able to respond to questions. -She was restless and walked around the room scratching at the walls and bed cover. -When she sat on the bed, she scratched at her	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 16 pants or the bed. a. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for Cephalexin 500mg to be administered four times a day for 7 days. (Cephalexin is an antibiotic medication used to treat or prevent infection.) Review of Resident #2's primary care provider note dated 01/29/24 revealed: -Resident #2 was seen for a follow-up to an emergency room visit for a fracture and amputation of the right middle finger. -Resident #2's fingers were accidentally slammed in a door the previous weekend (01/27/24 through 01/28/24). -Resident #2's right middle finger was amputated and the ring finger was likely fractured. -Resident #2 received an order for Keflex (Cephalexin) to prevent infection. Review of Resident #2's electronic medication administration record (eMAR) for February 2024 revealed there was no entry for Cephalexin 500mg to be administered four times each day for 7 days and there was no documentation of administration. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed: -There was a bottle labeled Cephalexin 500mg to be administered four times each day for 7 days. -A quantity of 28 capsules were dispensed on 01/29/24. -There were 16 doses remaining. Interview with Resident #2's primary care provider (PCP) on 02/14/24 at 2:55pm revealed: -Resident #2 had wandering behaviors and would	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 17 scratch at surfaces. -A medical mitt was ordered to prevent infection and further injury in the right middle finger that was amputated when it was slammed in the door at the assisted living facility. Telephone interview with Resident#2's PCP on 02/15/24 at 11:11am revealed not taking all of a prescribed antibiotic increased the risk of infection and could possibly lead to an infection that was resistant to antibiotic treatment. Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed: -Cephalexin came in with Resident #2 when she was admitted to the facility. -The Cephalexin was not on the eMAR and had not been administered. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 10:20am revealed: -Cephalexin was used to treat or prevent infection and not taking a full course of a prescribed antibiotic could increase the risk of infection. -They received an FL-2 dated 03/13/23 on 02/01/24 that did not contain an order for Cephalexin. -They did not receive the FL-2 dated 02/01/24 until 02/15/24. Interview with the Special Care Unit (SCU) Coordinator on 02/16/24 at 2:16pm revealed: -She was responsible for faxing the FL-2 to the pharmacy when resident is admitted to the facility. -She sent the FL-2 dated 03/13/23 to the pharmacy when Resident #2 as admitted to the facility instead of the current FL-2 dated 02/01/24 by mistake.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 18 Interview with the Administrator on 02/16/24 at 2:47pm revealed: -She was not aware Resident #2's current FL-2 was not sent to the pharmacy when she was admitted. -The RCC was responsible for ensuring current medication orders were sent to the pharmacy and the ordered medications were available for administration. -Medications were to be administered as ordered to be effective. b. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for lorazepam 0.5mg to be administered twice daily as needed for anxiety. Review of Resident #2's eMAR for February 2024 revealed there was no entry for lorazepam 0.5mg to be administered twice daily as needed for anxiety and no documentation it was administered. Review of a Leave of Absence form from the previous facility dated 02/01/24 revealed there were 8 tablets o lorazepam 0.5mg sent with Resident #2 upon discharge. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed: -There was a dispensing card labeled lorazepam 0.5mg to be administered twice daily as needed for agitation/anxiety. -A quantity of 30 tablets were dispensed on 01/10/24. -There were 8 tablets remaining. -There was no controlled substance available for the lorazepam 0.5mg for Resident #2.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 19 Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed: -Lorazepam 0.5mg came in with Resident #2 when she was admitted to the facility. -The lorazepam 0.5mg was not on the eMAR and had not been administered. Telephone interview with Resident #2's family member on 02/16/24 at 8:19am revealed: -Resident #2 was falling a lot at the previous facility. -Resident #2 scratches at things constantly, even in her sleep. -She thought the scratching was because she was anxious. -Lorazepam was administered to Resident #2 on the day she was to be transported from the assisted living facility to help her relax and she thought it was helpful. -She brought in lorazepam from the previous facility but she did not know how many there were. Interview with a personal care aide (PCA) on 02/14/24 at 10:20am revealed: -Resident #2 was usually anxious. -Resident #2 tried to hit staff when she became agitated. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 10:20am revealed: -Lorazepam was used to treat anxiety and agitation. -They received an FL-2 dated 03/13/23 on 02/01/24 that did not contain an order for Lorazepam 0.5mg. -They did not receive the FL-2 dated 02/01/24 until 02/15/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 20 Interview with Resident #2's home health nurse on 02/16/24 at 9:28am revealed: -She saw Resident #2 for wound care. -Two facility staff were needed to assist her for a dressing change on 02/12/24; Resident #2 was kicking and hitting so she was unable to fully assess or measure the wound due to the combativeness. -Resident #2 irritated the wound by continually scratching at surfaces. -Lorazepam could be helpful with the scratching and the aggression. Interview with Resident #2's primary care provider (PCP) on 02/14/24 at 2:55pm revealed: -Resident #2 was restless and anxious most of the time. -Resident #2 had a history of becoming aggressive with staff when they attempt to assist her or redirect her. -Resident #2 had wandering behaviors and would scratch at surfaces. -A medical mitt was ordered to prevent infection and further injury in the right middle finger that was amputated when it was slammed in the door at the assisted living facility. Telephone interview with Resident #2's PCP on 02/16/24 at 11:11am revealed Lorazepam was used to treat agitation and aggression for Resident #2 and should always be available for administration. Interview with the Special Care Unit (SCU) Coordinator on 02/16/24 at 2:16pm revealed: -She was responsible for faxing the FL-2 to the pharmacy when resident is admitted to the facility. -She sent the FL-2 dated 03/13/23 to the pharmacy when Resident #2 as admitted to the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 21 facility instead of the current FL-2 dated 02/01/24 by mistake. Interview with the Administrator on 02/16/24 at 2:47pm revealed: -She was not aware Resident #2's current FL-2 was not sent to the pharmacy when she was admitted. -The RCC was responsible for ensuring current medication orders were sent to the pharmacy and the ordered medications were available for administration. -Medications were to be administered as ordered to be effective. c. Review of Resident #2's FL2 dated 03/13/24 revealed there was an order for lisinopril 10mg to be administered each day. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for lisinopril 20mg to be administered each day. Review of Resident #2's eMAR for February 2024 revealed: -There was a computerized entry for lisinopril 10mg to be administered each day. -There was documentation lisinopril 10mg was administered each day from 02/06/24 to 02/14/24 at 8:00am. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed there was a multidose pack with a dispense date of 02/06/24 that was labeled to contain lisinopril 10mg to be administered each day. Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed Resident #2 was administered lisinopril 10mg each morning from	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 22 the multidose pack. Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/16/24 at 9:57am revealed: -Lisinopril 10 mg was dispensed in a multidose pack on 02/06/24 according to the FL-2 on 02/01/24 that was dated 03/13/23. -Lisinopril 20mg was dispensed on 02/15/24 after receiving a new FL-2 dated 02/01/04. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 10:20am revealed: -They received an FL-2 dated 03/13/23 on 02/01/24 with an order for lisinopril 10mg to be administered each morning . -They did not receive the FL-2 dated 02/01/24 until 02/15/24. -Lisinopril was used to control blood pressure and not getting the prescribed dose could cause her blood pressure to not be well controlled. Telephone interview with Resident #2's primary care provider (PCP) on 02/16/24 at 11:11am revealed: -Resident #2 should be receiving lisinopril 20mg and the dose was increased to better control her blood pressure. -The reason for prescribing the medication was to prevent a stroke or heart attack. -Resident #2 could experience a headache or a major medical event from not receiving the medication as ordered. Interview with the Special Care Unit (SCU) Coordinator on 02/16/24 at 2:16pm revealed: -She was responsible for faxing the FL-2 to the pharmacy when resident is admitted to the facility.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 23 -She sent the FL-2 dated 03/13/23 to the pharmacy when Resident #2 as admitted to the facility instead of the current FL-2 dated 02/01/24 by mistake. Interview with the Administrator on 02/16/24 at 2:47pm revealed: -She was not aware Resident #2's current FL-2 was not sent to the pharmacy when she was admitted. -The RCC was responsible for ensuring current medication orders were sent to the pharmacy and the ordered medications were available for administration. -Medications were to be administered as ordered to be effective. d. Review of Resident #2's FL2 dated 03/13/24 revealed there was an order for trazodone 100mg to be administered each night at bedtime. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for trazodone 150mg tab, one half tablet (75mg) to be administered each night at bedtime. Review of Resident #2's eMAR for February 2024 revealed: -There was a computerized entry for trazodone 100mg to be administered each night at bedtime. -There was documentation trazodone 100mg was administered each day from 02/05/24 to 02/13/24 at 8:00pm. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed there was a multidose pack with a dispense date of 02/06/24 that was labeled to contain Trazodone 100mg to be administered each night at bedtime.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 24 Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/16/24 at 9:57am revealed: -Trazodone 100mg was dispensed in a multidose pack on 02/06/24. -Trazodone 100mg was dispensed on 02/15/24 after receiving a new FL-2 dated 02/01/04. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 10:20am revealed: -Trazodone could be used to treat insomnia, agitation and depression. -They received an FL-2 dated 03/13/23 on 02/01/24 with an order for Trazodone 100mg to be administered each night at bedtime. -They did not receive the FL-2 dated 02/01/24 until 02/15/24. Telephone interview with Resident #2's primary care provider (PCP) on 02/16/24 at 11:11am revealed: -Trazodone could increase the risk of falls and may have been decreased to reduce the risk. -Resident #2 had a history of falls but no fall had been reported since being admitted to the facility. -There had been no report of Resident #2 having difficulty sleeping. Interview with the Special Care Unit (SCU) Coordinator on 02/16/24 at 2:16pm revealed: -She was responsible for faxing the FL-2 to the pharmacy when resident is admitted to the facility. -She sent the FL-2 dated 03/13/23 to the pharmacy when Resident #2 as admitted to the facility instead of the current FL-2 dated 02/01/24 by mistake. Interview with the Administrator on 02/16/24 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 25 2:47pm revealed: -She was not aware Resident #2's current FL-2 was not sent to the pharmacy when she was admitted. -The RCC was responsible for ensuring current medication orders were sent to the pharmacy and the ordered medications were available for administration. -Medications were to be administered as ordered to be effective. e. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for melatonin 5mg to be administered each night at bedtime. Review of Resident #2's eMAR for February 2024 revealed there was no entry for melatonin 5mg to be administered each night at bedtime and no documentation it was administered. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed there was no melatonin available for administration. Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed: -There was no melatonin available for administration for Resident #2. -Melatonin was not on the eMAR for Resident #2 and had not been administered. Telephone interview with Resident #2's primary care provider (PCP) on 02/16/24 at 11:11am revealed she was not aware of any sleep disturbances for Resident #2. Telephone interview with the pharmacy technician for the facility's contracted pharmacy on 02/16/24 at 9:57am revealed they received an order for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 26 melatonin 5mg to be administered each night at bedtime on 02/15/24. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 10:20am revealed: -They received an FL-2 dated 03/13/23 on 02/01/24 that did not have an order for melatonin 5mg to be administered. -They did not receive the FL-2 dated 02/01/24 until 02/15/24. -Melatonin was a natural sleep aide and Resident #2 could have difficulty falling asleep if she did not get the medication as ordered. Interview with the Special Care Unit (SCU) Coordinator on 02/16/24 at 2:16pm revealed: -She was responsible for faxing the FL-2 to the pharmacy when resident is admitted to the facility. -She sent the FL-2 dated 03/13/23 to the pharmacy when Resident #2 as admitted to the facility instead of the current FL-2 dated 02/01/24 by mistake. Interview with the Administrator on 02/16/24 at 2:47pm revealed: -She was not aware Resident #2's current FL-2 was not sent to the pharmacy when she was admitted. -The RCC was responsible for ensuring current medication orders were sent to the pharmacy and the ordered medications were available for administration. -Medications were to be administered as ordered to be effective. Based on observations, record reviews, and interviews it was determined Resident #2 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 27 3. Review of Resident #5's current FL-2 dated 07/26/23 revealed diagnoses included dementia, hyperlipidemia, and insomnia. a. Review of Resident #5's physician order dated 11/06/23 revealed there was an order for Risperdal 1mg, 1 tablet two times a day. (Risperdal is a medication used to treat schizophrenia, bipolar disorder and irritability.) Review of Resident #5's physician order dated 12/22/23 revealed an order for Risperidone 0.5mg, 1 tablet two times a day Review of Resident t#5's physician order dated 12/29/23 revealed: -There was an order to discontinue Risperidone 0.5mg, 1 tablet two times a day. -There was an order to start Risperidone 0.5mg, 1 tablet at bedtime. Review of Resident #5's physician amended order dated 01/03/24 revealed there was an order to discontinue Risperidone 0.5mg. 1 tablet two times day and to start Risperidone 0.5mg, 1 tablet at bedtime. Review of a physician order dated 01/12/24 revealed there was an order to discontinue Risperdal 0.5mg, 1 tablet at bedtime. Review of Resident #5's December 2023 electronic medication administration record (eMAR) revealed: -There was an entry for Risperidone 1mg, 1 tablet two times a day to be administered at 8:00am and 8:00pm. -There was documentation Risperidone 1mg, 1 tablet was not administered on 12/16/23 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 28 8:00pm, 12/17/23 at 8:00am and 8:00pm and 12/22/23 at 8:00pm due to being discontinued. -There was an entry for Risperidone 0.5mg, 1 tablet two times a day. -There was documentation Risperidone 0.5mg, 1 tablet was not administered on 12/26/23 and 12/29/23 at 8:00pm, 12/30/23 at 8:00am and 8:00pm due to being discontinued or on hold. Review of Resident #5's January 2024 eMAR revealed Risperidone 0.5mg, 1 tablet at bedtime was not on the eMAR. Review of Resident #5's Mental Health (MH) Provider note dated 12/29/23 revealed: -The family expressed a desire to reduce and eventually discontinue the resident's Risperidone. -There was an order on 12/29/23 to discontinue the Risperidone 0.5mg two times a day and to start Risperidone 0.5mg at bedtime. -The plan was to continue to taper the Risperidone to 0.5mg one time a day at bedtime. -This reduction would be done gradually to avoid any rebound symptoms. b. Review of a physician order dated 11/06/23 revealed there was an order for Trazodone 100mg, 1 1/2 tablet (150mg) at bedtime. (Trazodone is a medication used to treat depression and help with sleep.) Review of a physician order dated 12/22/23 revealed an order for Trazodone 100mg, 1 tablet every evening. Review of physician order dated 01/12/24 revealed there was an order to discontinue Trazodone 100mg, 1 tablet every evening. Review of Resident #5's December 2023	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 29 electronic medication administration record (eMAR) revealed: -There was an entry for Trazodone 100mg, 1 1/2 (150mg) every evening at 8:00pm. -There was documentation Trazodone 100mg, 1 1/2 (150mg) was not administered on 12/16/23, 12/17/23, and 12/22/23 due to being discontinued or on hold. -There was an entry for Trazodone 100mg, 1 tablet every evening at 8:00pm. -There was documentation Trazodone 100mg, 1 tablet was not administered on 12/26/23, 12/29/23, 12/30/23, and 12/31/23 due to being discontinued or on hold. -There was no documentation Trazodone 100mg, 1 tablet was administered on 12/24/23 and 12/25/23 at 8:00pm where it was left blank. Review of Resident #5's January 2024 eMAR revealed: -There was an entry for Trazodone 100mg, 1 tablet every evening at 8:00pm -There was documentation Trazodone 100mg, 1 tablet was not administered on 01/01/24. 01/02/24, 01/03/24, 01/05/24, 01/06/24, 01/07/24, 01/10/24, and 01/11/24 due to being discontinued or on hold per family request. Review of Resident #5's MH Provider Progress Note dated 12/22/23 revealed; -Per facility, the family was requesting to discontinue the resident's Risperidone and Trazodone. -The MH provider would discuss with family today to decrease doses of both medications and a plan to slowly reduce medications in order to prevent rebounding behavioral problems. Telephone interview with Resident #5's MH Provider on 02/14/24 at 1:00pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 30 -She last saw Resident #5 via Telehealth on 02/14/24. -The resident's Risperidone was increased in November 2023 due to the facility reporting the resident was aggressive and concerns with patient safety and the safety of other resident because he was trying to get out of the window and pushing other residents down the hall in their wheelchairs. -Resident #5 was prescribed Risperidone 0.5mg, 1 tablet two times a day on 12/01/23 and it was decreased on 12/29/23 to Risperidone 0.5mg, 1 tablet at bedtime. -The resident's Risperdal 0.5mg, 1 tablet at bedtime and the Trazodone 100mg in the evening was discontinued on 01/12/24 at the request of his family. Interview with Resident #5's family member on 02/14/24 at 9:55am revealed: -She did not know the resident's Trazodone and Risperidone were increased in November 2023. -She spoke to the facility and the Mental Health (MH) provider in December 2023 regarding discontinuing Resident #5's medications because it could have caused the false positive Fentanyl urine screen and him being sent to the local hospital emergency (ER) on 12/28/23 due to lethargy. Interview with a medication aide (MA) on on 02/16/24 at 11:00pm revealed: -The MAs could notify the prescriber for a verbal order to hold or discontinue Resident #5's Trazodone and Risperidone. -She was not aware she needed a physician order to hold the medications. -She held Resident #5's Trazodone and Risperidone because the family wanted the medications to be discontinued due to a positive	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 31 fentanyl urine screen and sedation. -She understood now that the medications should not have been held or discontinued without an order from the prescriber. Interview with the Special Care Coordinator (SCC)on 02/16/24 at 11:00am revealed: -The family of Resident #5 requested in December 2023 that the Trazodone and Risperidone be discontinued due to the medications causing a false positive Fentanyl urine screen and the resident being lethargic. -She thought the MA contacted the prescriber to request a hold or discontinue order for the resident's medications. -She was aware a physician order was needed to hold a medication. Interview with the Administrator on 02/16/24 at 2:45pm revealed: -The MA or the SCC should have requested an order from the prescriber to hold or discontinue Resident #5's Trazodone and Risperdal. -The medications should have been administered until a hold or discontinued order was received. Telephone interview with Resident #5's Primary Care Provider (PCP) on 02/16/24 at 11:45am revealed: -Resident #5's MH provider prescribed the Trazodone and the Risperidone. -The facility should have contacted the MH provider to request an order to hold or discontinue Resident #5's Trazodone and Risperidone. -Resident #5 had to be weaned off the medications slowly to prevent a rebound affect of the medications such as increased depression , numbness, tingling. and ringing in the ears.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 32 Based on observations, record reviews, and interviews it was determined Resident #5 was not interviewable. The facility failed to administer medications as ordered for 2 of 5 sampled residents, one of which sustained a traumatic amputation of a finger (#2), which included an order for a medication used to prevent infection of a wound and a medication used to treat anxiety and agitation related to wound care and assessment, neither of the medications were on the eMAR to prompt staff to administer. This resulted in 12 missed doses of the antibiotic and the resident being resistant and combative with wound care and assessment (#2). The facility failed to administer medications as ordered for Resident #5 with dementia and wandering and aggressive behaviors for medications used to treat depression and mood disorder that were being slowly tapered to prevent a rebound occurrence of symptoms. This failure was detrimental to the health and safety of the residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 02/15/24 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED April 01, 2024.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the	D 367	**10A NCAC 13F .1004(j) Medication Administration** **Area Clinical Director in-serviced all staff on the 6 Rights of Medication Administration.**	**03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 33 following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) Instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to accurately document medication administration for 1 of 5 sampled residents (#2) including a medication used to treat high blood pressure. The findings are: Review of Resident #2's current FL-2 dated 02/01/24 revealed: -Diagnoses included dementia and hypertension. -She was constantly disoriented. Review of Resident #2's Resident Register revealed she was admitted to the memory care unit from an assisted living facility on 02/01/24. Review of Resident #2's current FL-2 dated 02/01/24 revealed there was an order for Atenolol	D 367	Care Manager and staff responsible for medication administration or treatment will ensure the following: (a)Right Resident (b)Right Medication (c)Right Dose (d)Right Route (e) Right Time (f) Right documentation Documentation should be recorded each time a medication or treatment is administered. Also, it should be documented when residents refused, unavailable or if a medication or treatment is on hold. Staff reviewing medication will ensure that all 6 rights are included on each individual order or treatment plan. If there is any element missing staff should not administer until they receive clarification from the prescribing provider. Once clarification is received documentation and eMAR (Electronic Medication Administration Record) should reflect each other to ensure that the medication or treatment matches the order. If the facility can not enter orders on eMAR a paper MAR (Medication Administration Record should be provided) for documentation with (MA) initials and recording of medication given. During stand-up Care Manager should bring all new orders to be reviewed over. CM and the Administrator will check accuracy on MAR.	03/06/24 03/06/24 03/06/24 03/06/24 03/06/24 03/16/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 34 50mg to be administered once daily. (Atenolol is a medication used to treat high blood pressure.) Review of a Leave of Absence form from the previous facility dated 02/01/24 revealed there were 15 tablets of Atenolol 50mg sent with Resident #2 upon discharge. Review of Resident #2's electronic medication administration record (eMAR) for February 204 revealed: -There was a computerized entry for Atenolol 50mg to be administered once daily and scheduled for 8:00am. -There was documentation Atenolol 50mg was administered each day at 8:00am on 02/06/24 through 02/09/24 and on 02/12/24 through 02/14/24. -There was no documentation of administration on 02/01/24 through 02/05/24 or on 02/10/24 through 02/11/24. Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed: -Atenolol 50mg was administered to Resident #2 every day since admission. -Residents were administered the medications they bring into the facility even if they were not entered into the system. -MAs read the label of each medication and administered the medication according to the instructions until the medication could be entered by the pharmacy. -Medications that were not entered into the system could not be documented in the computer and were not documented anywhere. Telephone interview with the pharmacist for the facility's contracted pharmacy on 02/16/24 at 1:58pm revealed:	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 367	Continued From page 35 -Newly admitted residents have to be made active in the facility's computer documenting system for staff to be able to document and it sometimes took a couple of days for this to occur. -Resident #2's orders were faxed to the pharmacy late on 02/01/24 and were added to the system on 02/02/24 and medications were dispensed on 02/03/24. Telephone interview with Resident #2's primary care provider (PCP) on 02/16/24 at 11:11am revealed she relied on the eMAR to be accurate so she could change or modify treatment appropriately. Interview with the Special Care Unit (SCU) Coordinator (RCC) on 02/16/24 at 2:16pm revealed: -The MAs administered medications that were brought in on admission based on the instructions on the label but there was no where for them to document the medication was administered until it was entered into the system. -Residents' PCP reviewed eMARs in order to make changes so it was important for the eMAR to be accurate. Interview with th Administrator on 02/16/24 at 2:47pm revealed: -Staff should have made a paper MAR to document the administration of medications until the medications could be documented in the computer system. -Physicians could make changes based on eMAR documentation so it should always be accurate.	D 367		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances	D 392	**10A NCAC 13F.1008 (a) Controlled Substances**	**03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 36 (a) An adult care home shall secure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 5 resident (#2) sampled with orders for a controlled substance used to treat moderate to severe pain. The findings are: Review of Resident #2's current FL-2 dated 02/01/24 revealed there was a physician's order for lorazepam 0.5mg to be administered twice daily as needed for anxiety. (Lorazepam is a controlled substance medication used to decrease anxiety and agitation.) Review of Resident #2's electronic medication Administration Record (eMAR) for February 2024 revealed there was no entry for lorazepam 0.5mg to be administered twice daily as needed for anxiety and no documentation it was administered. Observation of medications on hand for Resident #2 on 02/15/24 at 9:20am revealed: -There was a dispensing card labeled lorazepam 0.5mg to be administered twice daily as needed for agitation/anxiety. -A quantity of 30 tablets were dispensed on 01/10/24.	D 392	The facility care manager is responsible for entering controlled medication onto the controlled log received from the pharmacy, other facility or from home. CM along with the Medication aide verifies the count together and it is documented in the control log for administration. MA should document when a control is given so that matrix can calculate the remaining balance of controls left for the resident. At the end of each shift the MA are responsible for the narcotic count on the medication cart and should not switch or accept keys unless the count is correct. If a medication is not showing up in the control log the Care Manager or Administrator should be notified immediately for reconciliation of the controlled log. During the narcotic log count if there are any discrepancies the MA should notify the CM to verify the count is correct and document into matrix that is verified.	03/06/24 03/06/24 03/06/24 03/06/24 03/06/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 37 -There were 8 tablets remaining. Review of a Leave of Absence form from the previous facility dated 02/01/24 revealed there were 8 tablets of lorazepam 0.5mg sent with Resident #2 upon discharge. Interview with the medication aide (MA) on 02/15/24 at 9:20am revealed: -The lorazepam 0.5mg was not on the eMAR and had not been administered. -Lorazepam 0.5mg came in with Resident #2 when she was admitted to the facility. -She did not know how many lorazepam 0.5mg tablets were brought in with her and they were not documented. -The lorazepam 0.5mg was placed on the medication cart and locked with the other controlled substances. -There was no controlled substance log for Resident #2's lorazepam 0.5mg tablets. -MAs counted the controlled substances on hand at the change of shift but since there was no log, there was no way to compare and know if any lorazepam was missing. Telephone interview with Resident #2's family member on 02/16/24 at 8:19am revealed: -Lorazepam was administered to Resident #2 on the day she was to be transported from the assisted living facility to help her relax and she thought it was helpful. -Lorazepam and other medications were brought into the facility for Resident #2 when she was admitted but she did not know how many lorazepam 0.5mg tablets were there. Telephone interview with the pharmacist with the facility's contracted pharmacy on 02/16/24 at 1:58pm revealed lorazepam was a controlled	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 38 substance and should always be accounted for due to high risk for abuse. Interview with the Resident Care Coordinator (RCC) on 02/15/24 at 9:45am revealed: -She did not know how many lorazepam tablets were brought into the facility for Resident #2. -She did not know if the same number remained available. -The medications were brought in by Resident #2's family and she did not sign that she received them. Second interview with the RCC on 02/16/24 at 2:16pm revealed: -She reviewed Resident #2's medications that came in with her on admission. -She gave the lorazepam to the MA on duty and told her to lock the lorazepam in the medication cart. -There was no controlled substance log for the lorazepam because it was never entered into the system. -Controlled substances should be counted at the change of each shift but no instructions were given to the MAs on how to account for Resident #2's lorazepam. -She forgot about the lorazepam and MAs should have reminded her. Interview with the Administrator on 02/16/24 at 2:47pm revealed: -She was not aware lorazepam was on the medication cart and had not been entered into the system for reconciliation. -Controlled substances should be entered into be system and counted at the change of each shift. -She would be afraid of someone taking the medication and no one would know. -The RCC was responsible for ensuring there	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 39 was an accurate record of the lorazepam for Resident #2.	D 392		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to initiate the Health Care Personnel Registry 24-Hour Report and 5-Day Report for 1 of 5 sampled residents (#5) whose family member reported a bruise of unknown origin above the resident 's right eye that was also documented on the local hospital emergency room (ER) report. The finding are: Review of Resident #5's current FL-2 dated 07/26/23 revealed diagnoses included dementia, hyperlipidemia, and insomnia. Interview with Resident #5's family member on 02/14/24 at 9:55am revealed: -She visited Resident #5 on 12/28/23 and noticed he was wearing a baseball cap, which was unusual. -She removed the baseball cap and found a bruise over the resident's right eye that was not there when she last visited two days ago. -She notified a personal care aide (PCA) regarding the bruise.	D 438	**10A NCAC 13F.1205 Health Care Personnel Registry** **The facility Administrator will initiate a 24-hour 5-day report within 24 hours of acknowledgement of a reported bruise, injury or speculations of any kind.** **The initial report will be sent to the Division of Health Service Regulation within 24 hours of the allegation.** **The Administrator will gather information from the person or people making the allegation. Gather statements from the staff that has worked with the resident(s) around the time the incident(s) has occurred.** **The Care Manager and Administrator will review all reports including any skin assessments, hospital discharge notes, physician observations, special reports including labs, X-rays etc. All statements from the staff provided to investigate the issue within the 5-days.** **On the 5th day of the investigation the facility Administrator will decide to unsubstantiated or substantiated the investigation.** **The result will be sent into the Division of Health Service Regulations on the 5th day for there final review.**	**03/06/24** 03/06/24 03/06/24 **03/06/24** **03/06/24** **03/06/24**

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 40 -She was told it was not there when they dressed him that morning. Observation of Resident #5's picture on 02/14/23 at 9:55am revealed: -The resident's family member showed the surveyor a picture of the resident's face prior to him being sent to the local hospital emergency (ER) room for lethargy on 12/28/23. -There was a linear 1 and 1/2 inch purplish/reddish color bruise above the right eye. Review of Resident #5's local hospital emergency room (ER) discharge summary report dated 12/28/23 revealed: -Resident #5 was seen on 12/28/23 and returned to the facility the same day. -The physical exam noted a bruise to the right side of the resident's forehead. -The impression was a small scalp hematoma in the right supraorbital (above eyebrow) region. Review of a Resident #5's Accident/Incident Report dated 12/28/23 revealed there was slight discoloration and redness around the right eye and that the resident sleeps with glasses on. Review of the Mental Health (MH) provider Progress Note dated 12/29/23 revealed -The MH provider spoke to facilty regarding the family's report of bruising included in the note. -The facility noted that there had been no reports of bruising in their charting and reported chronic redness around resident's right eye was from how the resident sleeps at night. Review of Resident #5's Admission/Readmission Skin Assessment sheet dated 12/28/23 at 9:37pm revealed: -A skin assessment was completed when	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 41 Resident #5 returned from the local hospital ER on 12/28/23. -There was no documentation of skin issues including redness, discoloration, and abrasions observed. Interview with a PCA on 02/15/23 at 11:25am revealed: -He provided personal care to Resident #5 sometimes. -He was not aware of any skin issues for the resident. -If he were to see any skins issues he would report it to the medication aide (MA). Interview with a MA 02/16/24 at 9:55am revealed: -She was not aware of there being a bruise above Resident #5's right eye. -She had noticed there being some redness sometimes around his right eye due to him sleeping with his glasses on and it causing redness. Interview with a second MA on 02/15/24 at 10:10am revealed sometimes Resident #5 had redness and discoloration around his eye because he sleeps with his hand pressed against his face with his glasses on. Interview with a third MA on 02/15/23 at 7:50am revealed she was not aware of any skin issues for Resident #5. Interview with the Special Care Coordinator (SCC) 02/15/24 at 4:25pm revealed: -Resident #5's family member notified a PCA that the resident had a bruise above his right eye on 12/28/23 and questioned how did he get it. -The PCA notified her regarding the concerns of the family member.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 42 -She immediately went down the hall to the resident's room about thirty minutes before he left for the local hospital emergency room (ER) at the request of the family member due to the resident being lethargic. -She observed there was redness around his right eye, but she did not observe a bruise above his right eye. -The resident often slept with his glasses on and that probably caused the redness around his right eye. -It did not look like the picture the family member took of his face. -She reviewed the local hospital ER discharge summary report dated 12/28/23 for the resident and noted there was a comment that a bruise was observed over the resident's right eye and that it was a hematoma. -She did not take any action after reading the report regarding the bruise because she had not observed a bruise, only redness around the right eyed due to him sleeping with his glasses on and the glasses pressing against his skin. Interview with the Administrator on 02/16/24 at 2:45pm revealed: -She was not aware of the bruise mentioned in the local hospital (ER) report until now. -A skin assessment was usually done when a resident came back from being out of the facility. -The SCC should have initiated an investigation and completed a 24-hour and 5-day report to the Health Care Personnel Registry (HCPR) for the bruise above Resident #5's right eye. Interview with the Primary Care Provider (PCP) on 02/14/24 at 2:50pm revealed: -She was not notified or aware of a bruise above Resident #5's right eye. -The bruise should have been investigated.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	02/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 438	Continued From page 43 Based on observations, record reviews, and interviews, it was determined Resident #5 was not interviewable.	D 438		