

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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, follow-up survey and complaint investigation on 08/05/25 through 08/07/25. The complaint investigation was initiated by the Bertie County Department of Social Services on 06/25/25.	D 000		
D 079	<p>10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings</p> <p>10A NCAC 13F .0306 Housekeeping and Furnishings</p> <p>(a) Adult care homes shall: (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews the facility failed to ensure the Special Care Unit (SCU) was free of hazards in 47 resident rooms including toiletries, four packages of non prescription pain relieving patches, prescription shampoo, fingernail clippers, batteries and other toiletries that were accessible to residents on the SCU.</p> <p>The findings are:</p>	D 079		

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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Division of Health Service Regulation

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D 079	<p>Continued From page 1</p> <p>Review of the facility's license revealed: -The facility was licensed as a Special Care Unit (SCU) effective 01/01/25 for a capacity of 60 residents. -The expiration date of the facility's license was 12/31/25.</p> <p>Review of the facility's census on 08/05/25 revealed the facility's census in the SCU was 47 residents.</p> <p>Review of the facility's Ingestion Management Program policy dated September 2021 revealed: -Personal items that could be ingested were to be maintained by staff (all liquid personal items, aerosols, hearing aids, pins, buttons, clips, etc.) in a secure location until needed for resident use. -Resident and responsible party (RP) were notified of policy at admission. -Resident rooms/care areas were to be inspected regularly for unsafe items that could be accidentally ingested or harmful. (Glass items, pictures with glass covers, vases, etc.) -Staff were to routinely monitor residents for possible hoarding of substances that could be ingested. -All toxic substances were to remain in the original container and were to be secured in a locked area unless being used under direct supervision. -Items used for activities which could be ingested were only to be used while under direct supervision -Staff training included assessing residents for possible ingestion; initiating necessary emergency procedures; calling the Poison Control Center if necessary; monitoring the facility and resident rooms for substances that could be accidentally ingested; notifying the resident's</p>	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 2</p> <p>physician, RP and other required parties as necessary and per policy.</p> <p>Review of the facility's Special Care Unit (SCU) Disclosure Statement revealed:</p> <ul style="list-style-type: none"> -Personal items that could be ingested were to be maintained by staff (all liquid personal items, aerosols, hearing aids, pins, buttons, clips, etc.) in a secure location until needed for resident use. -Resident rooms/care areas were to be inspected regularly for unsafe items that could be accidentally ingested or harmful. (Glass items, pictures with glass covers, vases, etc.) - Staff were to routinely monitor residents for possible hoarding of substances that could be ingested. - All toxic substances were to remain in the original container and were to be secured in a locked area unless being used under direct supervision. -Items used for activities which could be ingested were only to be used while under direct supervision. -Staff training included assessing residents for possible ingestion; initiating necessary emergency procedures; calling the Poison Control Center if necessary; monitoring the facility and resident rooms for substances that could be accidentally ingested; notifying the resident's physician, RP and other required parties as necessary and per policy. <p>Observation of resident room 316 on 08/05/25 at 8:37am revealed:</p> <ul style="list-style-type: none"> -The room had two beds and two residents resided in that room. -There was a bottle of shampoo on a resident's night stand. -There was a bottle of aftershave on the lower shelf of another resident's night stand. 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 3</p> <p>-Based on observations, interviews, and record reviews it was determined that the residents who resided in room 316 were not interviewable.</p> <p>Observation of a lobby in a second and third resident room (room #308 and #310) on 08/05/25 at 8:45am revealed:</p> <p>-There was a lobby with separate door entrances to resident room 308 and room 310.</p> <p>-There was a clear plastic tote bag in a chair to the right of the sink in the lobby.</p> <p>-The bag contained one 7.7 ounce container of disinfectant wipes with a warning that the wipes were hazardous to humans and domestic animals, avoid contact with eyes, may cause eye irritation, wash hands after use, if in eye hold eye open, and rinse slowly and gently with water for 15 to 20 minutes, call poison control center or physician for treatment advice.</p> <p>-The bag contained a 4 ounce bottle Ketoconazole shampoo (Ketoconazole shampoo is used to treat dandruff and fungal infections) with a warning to keep this and all medication out of reach from children, there was not a prescription label on the bottle of shampoo.</p> <p>-The bag also contained two 2 ounce bottles of hand sanitizer with a warning to keep out of reach of children, the item was flammable, do not use in or near the eyes, in case of contact rinse thoroughly with water, if swallowed, get medical help or contact a poison control center right away.</p> <p>-The bag also contained two 8 ounce perfume body spray bottles with a warning, if ingested may cause discomfort if swallowed including stomach pain, nausea, and vomiting.</p> <p>Based on observations, interviews, and record reviews it was determined the resident that resided in room 308 was not interviewable.</p>	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 4</p> <p>Based on observations, interviews, and record reviews it was determined the resident that resided in room 310 was not interviewable.</p> <p>Observation of a fourth resident's room 305 on 08/05/25 at 9:09am revealed:</p> <ul style="list-style-type: none"> -There was a plastic cabinet in the bathroom with three drawers -The top drawer contained two bottles of 2 in 1 shampoo and conditioner, a box of denture adhesive cream, a can of shaving cream, 4 Razor shaving handles, at least 30 razor shaving cartridges. -The middle drawer contained an electric razor and charger, a bottle of roll-on antiperspirant deodorant, a can of shaving cream, a tube of body butter, a box of powdered denture cleanser, a stick of deodorant, a tube of shaving cream, a tube of hydrocortisone cream 1%, a package of over-the-counter (OTC) pain relieving patches, two tubes of toothpaste. -There was a warning for the hydrocortisone cream in the middle drawer: If swallowed, get medical help or contact a Poison Control Center right away. -There was a warning on both tubes of toothpaste in the middle drawer: If more than used for brushing is accidentally swallowed, get medical help or contact a Poison Control Center right away. -There was an expiration date of 08/2019 on one tube of toothpaste in the middle drawer. -There was an expiration date of 08/2020 on another tube of toothpaste in the middle drawer. -There was a warning on one can of shaving cream in the middle drawer that the product was flammable. -The bottom drawer contained a bottle of mouthwash, a bottle of conditioner, a bottle of cologne, two sticks of antiperspirant / deodorant, 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 5</p> <p>a bottle of musk, a glass bottle with no substance identified on the label, a box of denture adhesive cream, and 5 disposable razors.</p> <p>-There was a warning on two sticks of deodorant in the bottom drawer: If swallowed, get medical help or contact a Poison Control Center right away</p> <p>-There was a warning on the bottle of mouthwash in the bottom drawer: If more than used for rinsing is accidentally swallowed, get medical help or contact a Poison Control Center right away.</p> <p>-There was an 8 ounce tube of toothpaste on the sink with a warning to keep out of reach of children, avoid swallowing, if more than used for brushing is accidentally swallowed, seek medical advise or contact a poison control center immediately, and avoid contact with eyes.</p> <p>-There was a twin pack an unopened box of denture adhesive cream containing two 2.4 ounce tubes on the resident's bed with a warning to keep out of reach of children.</p> <p>-There were two unopened boxes of over the counter (OTC) pain patches on the resident's bed.</p> <p>-One box was opened and contained 5 large pain relieving patches and one box was unopened that contained 60 patches, both had a warning to keep out of reach from children, if prone to allergic reaction from aspirin or salicylates consult a physician before use, avoid contact with eyes, mucus membranes or rashes.</p> <p>-There was an unopened 8 ounce bottle of cologne on the residents bed.</p> <p>-There was one aerosol bottle of hairspray in a chair next to the resident's television with a warning that the contents was flammable until hair has fully dried, do not use near heat, flame or while smoking, avoid inhalation, avoid spraying in eyes, contents under pressure, do not puncture</p>	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 6</p> <p>or incinerate, do not use on broken skin, keep out of reach of children, intentional misuse by deliberately concentrating and inhaling the contents can be harmful or fatal.</p> <p>Observation of the resident who resided in Room 305 on 08/05/25 at 2:37pm revealed there were 2 beige pain relieving patches side by side on his right upper arm.</p> <p>Interview with the resident that resided in room 305 on 08/05/25 at 9:18am revealed: -He was accused of smoking in his room last night. -He believed that a can of hairspray was a more effective weapon than mace when sprayed at someone's eyes.</p> <p>Observation of a fifth residents room 306 at 9:11am revealed: -There was an 11.25 ounce bottle of antibacterial hand soap on the sink with a warning to keep out of reach of children, for external use only, avoid contact with eyes, if swallowed get medical help or contact a poison control center right away. -There was a 30 ounce bottle of liquid body wash on the sink with a warning to keep out of reach of children, avoid contact with eyes, if contact occurs rinse thoroughly with water, in case of accidental ingestion call a poison center or physician immediately and advise them that the product contains eucalyptus oil.</p> <p>Based on observations, interviews, and record reviews it was determined that the resident who resided in room 306 was not interviewable.</p> <p>Observation of a sixth resident's room 301 on 08/05/25 at 9:46am revealed: -There was a nail clipper, with the under-nail</p>	D 079		

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D 079	<p>Continued From page 7</p> <p>cleaner opened to approximately 180 degrees, laying on a piece of furniture beside the resident in his chair.</p> <ul style="list-style-type: none"> -The under-nail cleaner had a sharp, pointed tip. -There was no staff member in the patient's room, and no staff member within line-of-sight. <p>Observation of a seventh resident's room 314 on 08/06/25 at 8:44am revealed there was a remote with installed batteries, which did not have a battery cover installed, laying on a table near a chair in the resident's room.</p> <p>Observation of a resident's room 310 on 08/06/25 at 8:48 am revealed a thermostat with installed batteries which did not have a battery cover installed.</p> <p>Interview with a personal care aide (PCA) on 08/05/25 at 11:20am revealed:</p> <ul style="list-style-type: none"> -There were not supposed to be hazards in resident's room in the SCU because they were considered a hazard. -Any items that resident's could eat or drink were a danger to them because they may eat or drink something that could harm them. -Toiletries and other items a resident could drink or eat were supposed to be kept in a storage room across from the medication room, residents had individual plastic containers that had their name on the container. -If she observed toiletries in a resident's room she would remove the items and take it to a medication aide (MA). <p>Interview with a MA on 08/05/25 at 11:30am revealed:</p> <ul style="list-style-type: none"> -Toiletries and other dangerous items were supposed to be stored in the storage room in individual plastic containers with each resident's 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 8</p> <p>name written on the container.</p> <p>-There were several residents on the SCU that wandered and were at risk of drinking or eating items that could be dangerous to them.</p> <p>-MAs and PCAs completed walk throughs each shift to check for any toiletries or hazards in residents room.</p> <p>-When any staff found a hazardous item in a resident's room they were expected to remove the item immediately to ensure the resident and other resident's safety.</p> <p>-If a toiletry or other hazardous item was found in a resident's room the MA would call the resident's family member to inform them and remind them to not bring personal care items to residents.</p> <p>Telephone interview with a second MA on 08/05/25 at 2:43pm revealed:</p> <p>-Residents were not allowed to have personal items that could cause harm in their rooms.</p> <p>-Many residents on the SCU wandered and residents were not cognitively capable of determining whether or not toiletries were dangerous or not.</p> <p>-MAs and PCAs removed items that could cause harm from resident's rooms if they observed any.</p> <p>Interview with a third MA on 08/07/25 2:55pm revealed:</p> <p>-Staff found and removed shaving razors on a previous shift.</p> <p>-Residents should not have shampoos, deodorants, or any hazards in their rooms because some residents may eat those products.</p> <p>-Every once and a while the Special Care Unit Coordinator (SCC) told staff to complete a sweep of the SCU to search for toiletries and hazards when another staff member found a hazard in a residents room, "it was not a daily assignment" for staff.</p>	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 9</p> <p>Interview with a fourth MA on 08/07/25 at 3:15pm revealed</p> <ul style="list-style-type: none"> -Staff checked on residents every 30 minutes, sometimes every 15 minutes if needed. -The resident that resided in room 305 was found in possession of cigarettes multiple times. -The resident that resided in room 305 preferred not to allow staff in his room. <p>Interview with the Special Care Unit Coordinator (SCC) on 08/07/25 at 4:50pm revealed:</p> <ul style="list-style-type: none"> -She received report of possible cigarette smoking in the building on 08/04/25 -She and the Administrator discussed safety concerns with the resident who resided in room 307 and possible discharge. -She had concerns that the building could catch fire. -She had safety concerns about cigarette smoking in the building with patients who were on supplemental oxygen. -She wanted to implement a log to assess that staff were checking on residents and their rooms regularly. -She did not keep a log of staff checking on residents. -On 08/01/25 she asked a family member of the resident that resided in room 305 to leave any cigarettes at the nurse's station. -The family member of the resident that resided in room 305 reported to her that they wouldn't leave cigarettes at the nurse's station, because the family member was worried that staff would steal his cigarettes. -She removed cigarettes from the coat pocket of the resident that resided in room 305 on the evening of 08/05/25 -Staff discovered 3 other loose cigarettes in his clothing and shoes on the evening of 08/05/25 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 10</p> <p>Interview with Regional Vice President of Operations on 08/07/25 at 9:23am revealed staff training on ingestible hazards was completed via online training modules.</p> <p>Interview with the Administrator on 08/05/25 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -Toiletries and other items that could cause harm were not supposed to be in residents rooms. -Staff were expected to look for personal care items or dangerous items each shift and when they entered the resident's rooms to provide medications or personal care. -Staff reported to her yesterday (08/04/25) that the resident who resided in room 305 had items that could cause him harm in his room, and she instructed staff to remove the items. -She called the family member of the resident that lived in room 305 to inform her hazards were found in his room. <p>Interview with the primary care provider (PCP) for the residents of rooms 305 and 307 on 08/05/25 at 4:41pm revealed:</p> <ul style="list-style-type: none"> -She had concerns about the resident in room 305 having access to hazards such as shaving razors. -She was not notified by staff that the resident who resided in room 305 and 307 were suspected of smoking in the facility on the evening of 08/04/25. -She needed to be aware if a resident was a danger to themselves or others, and no resident should have access to smoking materials in a SCU due to safety risks. -Residents on the SCU should not have access to hazards because they could eat or drink products that could cause them harm. 	D 079		

Division of Health Service Regulation

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D 079	<p>Continued From page 11</p> <p>Interview with the facility's PCP on 08/07/25 at 3:30pm revealed:</p> <ul style="list-style-type: none"> -After learning about hazards in the facility on 08/05/25, she helped to facilitate removal of hazards and cigarettes from a resident's room. -The resident that resided in room 305 reported to her that he sold a pack of cigarettes to the resident that resided in room 307. -She educated the residents of rooms 305 and 307 about the risks of hazards in the SCU. -Batteries should be covered in the SCU. -Residents with dementia were at risk of putting batteries in their mouths, choking on batteries, or ingesting the batteries. <p>_____</p> <p>The facility failed to secure hazardous items to protect 47 residents who resided on the SCU with residents who had known wandering behaviors including pain relieving patches with a warning to keep out of reach of children, contact a physician before use if prone to allergic reaction from aspirin or salicylates, a prescription shampoo with a warning to keep out of reach of children, batteries, and toiletries. The failure was detrimental to the health, safety, and welfare of the residents of the SCU and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a Plan of Protection in accordance with G.S. 131D-34 received on 08/05/25 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 21, 2025.</p>	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision	D 270		

Division of Health Service Regulation

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D 270	<p>Continued From page 12</p> <p>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.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to provide supervision for 2 of 6 sampled residents residing on a Special Care Unit whose room smelled like smoke, cigarettes and a lighter were found in his room (#4) and a resident that law enforcement determined had recently extinguished a cigarette (#7).</p> <p>The findings are:</p> <p>Review of the facility's tobacco policy dated September 2021 revealed:</p> <ul style="list-style-type: none"> -No smoking signs were placed in areas throughout the facility to notify staff, residents, and visitors of the no smoking policy. -The no smoking policy is reviewed with residents and the responsible party (RP) at admission. -The resident and RP document that the policy has been reviewed. -Each resident at admission is assessed for ability to smoke safely by means of an interview with the resident and the RP, and through staff observations. -Assessments are repeated at least on 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 13</p> <p>admission, readmission from the hospital, and quarterly or as needed to assure safe practices.</p> <ul style="list-style-type: none"> -Staff are in-serviced to provide ongoing assessment of resident smoking habits and to report to their supervisor any change in ability to smoke safely. -Residents assessed to need supervision will be placed on the smoking schedule and will be supervised while smoking by staff. -Smoking materials will be secured by staff who will supervise materials during use. -Residents who smoke safely, outside the building, may be allowed access to smoking materials during the time they are outside the building. -The facility reserves the right to confiscate smoking materials and tobacco products in the interests of fire safety and sanitation. -Residents who smoke may do so only in designated smoking areas outside the building. -The facility follows all state laws and regulations regarding the prohibition of smoking inside long-term care facilities. -If any resident does not follow the smoking policy, the resident will be counseled and the smoking policy reviewed with the resident and/or RP. -In the event the resident violates the policy after counseling, the facility reserves the right to discharge the resident due to a smoking safety violation and risk. <p>Review of the Resident Agreement Special Care Unit (SCU) Disclosure Statement on 08/06/25 revealed the SCU was equipped with safety features including supervision by trained staff in Alzheimer/dementia care, two-way communication system between staff members, and fire/smoke alarms throughout the building.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 14</p> <p>Review of a police report from the sheriff's department dated 08/04/25 revealed:</p> <ul style="list-style-type: none"> -Dispatch received a call at 9:07pm that there was someone possibly smoking something in one of the bathrooms. -The caller wanted a deputy to speak with the staff to see "what was going on and what we needed to do." -The deputy arrived at the facility on 08/04/25 at 9:16pm. <p>Observation of Resident #4's room on 08/05/25 at 12:27pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 had his own bathroom in his room. -There was a strong odor of cigarette smoke in Resident #4's bathroom. -There was an 8-ounce white foam drinking cup sitting on the toilet tank lid. -The white foam drinking cup had two squared u-shaped notches cut into the cup rim directly across from one another. -The cut notches were wide enough to accommodate a cigarette. -The white foam cup with the cut notches resembled an ashtray. -The was a scant amount of ashes inside the white foam cup. <p>Observation of Resident #7's room on 08/05/25 at 9:36am revealed:</p> <ul style="list-style-type: none"> -Resident #7 shared a bathroom in a suite with another resident. -There was a slight odor of cigarette smoke in his room. <p>1. Review of Resident #4's current FL-2 dated 04-25-25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), renal abdominal aortic aneurism, and peptic ulcer 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 15</p> <p>disease.</p> <ul style="list-style-type: none"> -The resident was ambulatory and intermittently disoriented. -The resident wandered. -The resident's recommended level of care was Special Care Unit (SCU). <p>Review of Resident #4's Resident Register revealed the resident was admitted to the SCU on 04/18/25.</p> <p>Review of Resident #4's current care plan dated 05/15/25 revealed:</p> <ul style="list-style-type: none"> -The resident was oriented. -The resident was forgetful and needed reminders. -The resident required supervision with toileting and ambulation. -The resident required limited assistance with eating and transfers. -The resident required extensive assistance with bathing, dressing, and grooming. <p>Review of Resident #4's SCU resident profile and care plan dated 07/30/25 revealed:</p> <ul style="list-style-type: none"> -Environmental stimuli that could trigger bad behavior was listed as sundowning (Sundowning is when individuals with dementia or other cognitive disorders experience increased confusion, agitation, and other behavioral changes in the late afternoon or evening hours). -The resident fed himself with staff supervision. -The resident required staff assistance and supervision with toileting. -The resident required supervision with bathing, grooming, and transferring. -Special management needs were listed as cigarettes. -The resident's cognitive impairment was a level 2 for severe memory loss. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 16</p> <p>Review of Resident #4's SCU Pre-Admission Checklist dated 04/18/25 revealed the resident was a smoker and required redirecting at times.</p> <p>Review of a police report from the sheriff's department dated 08/04/25 revealed: -The deputy spoke with Resident #4 and the resident reported that he smoked cigarettes, but he had not smoked in his room. -The deputy found empty cigarette boxes in plain view and gave a staff person the cigarette boxes.</p> <p>Interview with Resident #4 on 08/05/25 at 9:18am revealed: -Last night (08/04/25) at approximately 9:00pm a deputy from the sheriff's department came to his room to search his room for cigarettes. -The deputy found 2 empty packs of cigarettes in a snack cake box between his dresser and his bed.</p> <p>Interview with Resident #4 on 08/07/25 at 2:30pm revealed: -He never smoked in his room. -His cigarettes were kept in the medication room, and staff lit his cigarette with him outside. -His family member got him 2 packs of cigarettes on his birthday which was in June. -Staff found those cigarettes the next day and removed them from his room. -He recently went with a family member to a local grocery store and he purchased 2 packs of cigarettes. -He thought he hid them in a plastic container by his bed. -Staff came into his room last week and found cigarettes and a lighter in his room (07/27/25-08/02/25). -He had the lighter laying on his nightstand in</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 17</p> <p>plain sight and was not trying to hide it. -The primary care provider (PCP) and staff found his cigarettes in his plastic container by his bed.</p> <p>Review of the facility's smoking assessment on 08/06/05 revealed: -A score from 0 to 9 meant a resident was a safe smoker. -A score from 10-18 meant a resident was potentially an unsafe smoker. -A score of 19-27 meant a resident was an unsafe smoker.</p> <p>Review of a smoking assessment for Resident #4 dated 04/18/25 revealed: -The observation date for the smoking assessment was 04/18/25. -The completed date and date recorded was 08/06/25. -There was documentation that the resident smoked cigarettes a couple times per day. -The resident did not borrow smoking materials, beg for smoking materials or steal smoking materials from others. -The resident did not smoke in unauthorized areas. -The resident was not careless with smoking materials and did not smoke cigarettes from ash trays. -The resident had no problem with his general awareness and orientation including his ability to understand the facility's smoking policy. -The resident's mobility was a minimal problem but he did not need assistance getting to the designated smoking area. -The resident followed the facility's smoking policy. -The resident was capable of supervised smoking and was not a danger to himself or others. -The score on the smoking risk assessment</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 18</p> <p>ranged from 0 to 9.</p> <ul style="list-style-type: none"> -The resident was scored a 1 on his smoking risk assessment. -There was documentation that the resident's plan of care action at the end of the smoking assessment rated the resident as an unsafe smoker, staff would provide supervision during designated smoking breaks. <p>Review of a smoking assessment for Resident #4 dated 06/24/25 revealed:</p> <ul style="list-style-type: none"> -The observation date for the smoking assessment was 06/24/25. -The completed date and date recorded was 08/06/25. -There was documentation that the resident smoked cigarettes a couple times per day. -The resident did not borrow smoking materials, beg for smoking materials or steal smoking materials from others. -The resident did not smoke in unauthorized areas. -The resident was not careless with smoking materials and did not smoke cigarettes from ash trays. -The resident had no problem with his general awareness and orientation including his ability to understand the facility's smoking policy. -The resident's mobility was not a problem and he did not need assistance getting to the designated smoking area. -The resident followed the facility's smoking policy. -The resident was capable of supervised smoking and was not a danger to himself or others. -The resident scored a zero on his smoking risk assessment. -The resident's plan of care action item at the end of the smoking assessment rated the resident as an unsafe smoker, staff would provide 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 19</p> <p>supervision during designated smoking breaks.</p> <p>Review of a smoking assessment for Resident #4 dated 08/05/25 revealed:</p> <ul style="list-style-type: none"> -The observation date for the smoking assessment was 08/05/25. -The completed date and date recorded was 08/06/25. -There was documentation that the resident smoked cigarettes a couple times per day. -The resident did not borrow smoking materials, beg for smoking materials or steal smoking materials from others. -The resident had a severe problem with smoking in unauthorized areas. -The resident had a minimal problem with smoking materials and did not smoke cigarettes from ash trays. -The resident had a severe problem with his general awareness and orientation including his ability to understand the facility's smoking policy. -The resident's mobility was a minimal problem but he did not need assistance getting to the designated smoking area. -The resident had a severe problem with following the facility's smoking policy. -The resident was not capable of unsupervised smoking and was a danger to himself or others. -The resident was scored 11 on his smoking risk assessment and was scored as a potentially unsafe smoker. -The resident's plan of care action item at the end of the smoking assessment rated the resident as an unsafe smoker, staff would provide supervision during designated smoking breaks. <p>Telephone interview with a medication aide (MA) on 08/06/25 at 2:43pm revealed:</p> <ul style="list-style-type: none"> -She started her medication pass at the end of the 300 hall and smelled a strong odor of 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 20</p> <p>cigarette smoke on 08/04/25.</p> <p>-She called the Special Care Unit Coordinator (SCUC) to report a concern of smoking in the facility and was informed that the sheriff's department had been notified and would arrive at the facility shortly.</p> <p>-The deputy interviewed Resident #4 in his room and asked if he had any smoking materials.</p> <p>-The deputy found three empty cigarette cases in an empty snack cake box by the resident's bed and nightstand.</p> <p>-She never observed a lighter in Resident #4's room.</p> <p>-She was aware that Resident #4 was caught smoking in his room last week (07/27/25-08/02/25) during the day time shift.</p> <p>Interview with a personal care aide (PCA) on 08/07/25 at 2:42pm revealed:</p> <p>-She smelled cigarette smoke at Resident #4's room before but did not see him smoking.</p> <p>-She smelled cigarette smoke from Resident #4's room last week and reported it to the medication aide (MA) that was on duty.</p> <p>Interview with a MA on 08/05/25 at 11:30am revealed:</p> <p>-Resident #4 had a lighter in his room and a few cigarettes in his coat pocket one time the past week (7/27/25 to 08/02/25).</p> <p>-She and other staff searched the residents room for additional cigarettes or lighters.</p> <p>-She, the Administrator, and the SCUC met with the resident's family member to ensure the family member was aware of the resident's behaviors and to discuss that residents were not allowed to have cigarettes or lighters and he was not allowed to smoke in the facility.</p> <p>Interview with a MA on 08/07/25 at 2:55pm</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 21</p> <p>revealed:</p> <ul style="list-style-type: none"> -She had smelled smoke in Resident #4's room a couple of times. -A PCA reported to her last week that she smelled smoke in Resident #4's room. -Last week she went to the resident's room and told him his room smelled like he had been smoking a cigarette. -She notified the SCUC. -She attended a meeting with the resident, the Administrator and the SCUC last week. -The Administrator reviewed the smoking policy at the facility with Resident #4. -The Administrator explained to the resident that he could be discharged for smoking in his room. -Resident #4 denied that he had smoked cigarettes in his room. -During the meeting a PCA and MA went to the resident's room to search for cigarettes and lighters. -The PCA and MA found one packet of cigarettes and a lighter. <p>Interview with a second MA on 08/07/25 at 3:06pm revealed:</p> <ul style="list-style-type: none"> -She never saw Resident #4 smoke cigarettes in his room. -Approximately 2 months ago she smelled cigarette smoke near Resident #4's room. -She met with the resident in his room and asked if he had been smoking. -The resident denied smoking a cigarette in his room. -She asked the resident if he had cigarettes in his jacket pocket, the resident told her yes and gave her his pack of cigarettes. -After the resident was found with cigarettes, she informed the PCAs and other MAs that the resident needed to be checked on every 15 to 30 minutes to ensure he was not smoking. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 22</p> <p>Interview with the SCUC on 08/07/25 at 4:50 PM revealed:</p> <ul style="list-style-type: none"> -She received report of possible cigarette smoking in the building on 08/04/25 -She and the Administrator discussed safety concerns with Resident #4 and possible discharge. -She had concerns that the building could catch fire. -She had safety concerns about cigarette smoking in the building with residents who were on supplemental oxygen. -She wanted to implement a log to assess that staff were checking on residents and their rooms regularly. -She did not keep a log of staff checking on residents. -She removed cigarettes from Resident #4's coat pocket on the evening of 08/05/25 when staff searched his room. -Staff discovered 3 other loose cigarettes in his clothing and shoes on the evening of 08/05/25. -Last week she opened the door to the SCU to Resident #4's family member that took him out shopping. -She asked the family member to leave all cigarettes and lighters with facility staff and explained that residents were not allowed to keep their own cigarettes and lighter on the SCU. -She reported that the resident's family member said she would not leave cigarettes or lighters with staff because the resident had reported to her that staff were stealing his cigarettes. <p>Telephone interview with Resident #4's RP on 08/07/25 at 5:19pm revealed:</p> <ul style="list-style-type: none"> -She was contacted by the Administrator on Monday 08/04/25 by telephone about concerns of Resident #4 having cigarettes in his room. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 23</p> <ul style="list-style-type: none"> -She visited the facility on 08/04/25 and on 08/05/25. -She met with the Administrator and the SCUC on 08/05/25 to discuss the smoking policy and staff concerns about Resident #4 having cigarettes in his room. -Resident #4 had another family member that took him out on occasions and did not supervise him when he bought items from a local grocery store and smoke shop. -She called the family member on 08/04/25 and informed her that she needed to ensure that Resident #4 did not purchase cigarettes. -Resident #4 told his other family member that facility staff had stolen his cigarettes and the family member recently allowed the resident to purchase \$22.00 worth of cigarettes. -She met with Resident #4 and reminded him that he was not allowed to smoke on the SCU and was not allowed to keep his own cigarettes and lighters. -She spoke with the family member who took Resident #4 to the store and reminded her that he was not allowed to have cigarettes in the facility. <p>Interview with the Administrator on 08/05/25 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -A MA smelled smoke on 08/04/25 near Resident #4's room. -A deputy from the Sheriff's Department came to the facility the evening of 08/04/25 at approximately 9:00pm. -The deputy found two empty packs of cigarettes in the residents room. -She spoke with Resident #4 on 08/05/25 about not smoking in the facility. -She spoke with the resident's RP on 08/05/25 about the resident smoking and discussed setting a time to meet to update his care plan. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 24</p> <p>Interview with the Administrator on 08/07/25 at 4:15pm revealed:</p> <ul style="list-style-type: none"> -After cigarettes were found in Resident #4's room, she had a meeting with his RP to discuss the smoking policy and that the resident could not have cigarettes or lighters in his room. -On 08/04/25, staff found 3 empty packs of cigarettes in his room but they were not full, there were a few in each pack. -She directed staff the evening of 08/04/25 and the morning of 08/05/25 to search the residents room for any cigarettes or lighters. -She assumed staff had completed the search and ensured there were no cigarettes or lighters in his room, however when an additional search was completed the evening of 08/05/25 more cigarettes and a lighter were found. -She was not sure why staff had not increased supervision for Resident #4, she expected them to check on him at least every 30 minutes after cigarettes and a lighter were found in his room. -Normally staff checked on residents every two hours, not every 30 minutes unless there was an issue that triggered increased supervision. -She had not notified Resident #4's primary care provider (PCP) or his psychologist that cigarettes and a lighter had been found in his room. -She was not sure why she did not think to notify the resident's PCP or psychologist of his possession of cigarettes and a lighter. <p>Telephone interview with the facility's contract psychologist on 08/07/25 at 3:34pm revealed:</p> <ul style="list-style-type: none"> -She had not been notified that Resident #4 had cigarettes and a lighter in his room. -She was not aware that Resident #4 had smoked in his room. <p>Interview with Resident #4's PCP on 08/05/25 at 4:41pm revealed:</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 270	<p>Continued From page 25</p> <p>-She was not notified by staff that Resident #4 was suspected of smoking in the facility on the evening of 08/04/25, until 08/05/25.</p> <p>-She needed to be aware if a resident was a danger to themselves or others, and no resident should have access to smoking materials in a SCU due to safety risks.</p> <p>Interview with Resident #4's PCP on 08/07/25 at 3:30 PM revealed:</p> <p>-She was informed by staff on 08/05/25 that there was a strong odor of cigarette smoke near Resident #4's room on 08/04/25.</p> <p>-She, the SCUC, the facility registered nurse (RN), and a MA went to the resident's room to search for cigarettes and lighters.</p> <p>-She talked with the resident while staff searched his room the evening of 08/05/25.</p> <p>-Cigarettes were found in a plastic storage bin next to the resident's bed.</p> <p>-She provided education to the resident about the importance of not smoking in the facility.</p> <p>-She reviewed the dangers of smoking in the facility when oxygen was used in the facility, with one resident on the same hall as the resident's room using oxygen.</p> <p>-She explained to the resident that his smoking could cause the building to blow up and burn down putting all resident's at risk.</p> <p>Refer to telephone interview with a medication aide (MA) on 08/05/25 at 2:43pm.</p> <p>Refer to interview with a MA on 08/07/25 at 3:15pm.</p> <p>Refer to telephone interview with the facility's psychologist on 08/07/25 at 3:35pm.</p> <p>2. Review of Resident #7's current FL-2 dated</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 26</p> <p>01/08/25 revealed: -Diagnoses included dementia, hypertension, and post traumatic stress disorder (PTSD). -The resident was ambulatory and intermittently disoriented. -The resident's recommended level of care was Special Care Unit (SCU).</p> <p>Review of Resident #7's Resident Register revealed the resident was admitted to the SCU on 09/03/24.</p> <p>Review of Resident #7's Resident Contract dated 09/03/24 revealed the residents legal guardian acknowledged that resident rights had been explained to him and he received a copy of the facility's smoking policy.</p> <p>Review of Resident #7's current care plan dated 12/11/24 revealed: -The resident was oriented. -The resident was forgetful and needed reminders. -The resident was independent with ambulation and transferring. -The resident required supervision with toileting. -The resident required limited assistance with eating, bathing, dressing, and grooming. -The resident enjoyed smoking.</p> <p>Review of Resident #7's SCU resident profile and care plan dated 07/17/25 revealed: -Environmental stimuli that could trigger bad behavior was listed as waiting. -The resident was independent with feeding, toileting, ambulation, bathing, dressing, grooming, and transferring. -Special management needs was listed as cigarettes. -The intervention listed for cigarettes was staff will</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 27</p> <p>supervise and monitor the residents' smoking. -The resident's cognitive impairment was a level 3 for mild memory loss.</p> <p>Review of Resident #7's SCU Pre-Admission Checklist dated 09/01/24 revealed the resident was a smoker and wandered.</p> <p>A request was made for Resident #7's smoking assessments on 08/07/25 at 2:22pm and they were not provided by survey exit.</p> <p>Review of a police report from the sheriff's department dated 08/04/25 revealed the deputy spoke with Resident #7 and he reported to the deputy that he did smoke cigarettes but had not smoked in his room.</p> <p>Interview with Resident #7 on 08/05/25 at 9:36am revealed: -He was frustrated that he was not able to smoke cigarettes when he wanted to smoke them. -The smoking schedule including supervised smoking with staff three times a day.</p> <p>Interview with Resident #7 on 08/07/25 at 2:22pm revealed: -He had never smoked cigarettes in his room. -He was only allowed to smoke with staff supervision. -A deputy from the Sheriff's Department came one evening earlier this week and asked him if he had been smoking cigarettes in his room. -He reported he had not smoked in his room. -He told the deputy that he did not have a lighter or cigarettes. -He explained to the deputy that his cigarettes and lighter were in the medication room. -He told the deputy that he did not smoke in the facility and that his cigarettes were kept in the</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 28</p> <p>medication room.</p> <p>-He was not allowed to smoke unless a staff person was with him.</p> <p>Telephone interview with a medication aide (MA) on 08/06/25 at 2:43pm revealed:</p> <p>-When she began her medication pass on 08/04/25 she smelled a strong odor of cigarette smoke.</p> <p>-She was in a resident's room that was across the hall from Resident #7's room and smelled smoke at the resident's room.</p> <p>-There was a bathroom suite that Resident #7 shared with another resident, but the residents resided in separate rooms.</p> <p>-She observed a smokey haze in the bathroom in the suite.</p> <p>-She knocked on Resident #7's door and the resident opened the door.</p> <p>-She asked Resident #7 if he had been smoking a cigarette, he denied smoking a cigarette.</p> <p>-She explained to the resident that she smelled smoke coming from his room and saw a smokey haze in the bathroom.</p> <p>-The resident still denied he had smoked a cigarette.</p> <p>-She called the Special Care Unit Coordinator (SCUC) to inform her of the situation, and the SCUC told her she was going to call the Administrator.</p> <p>-The SCUC called her back and informed her she was going to notify the Sheriff of the Sheriff's Department.</p> <p>-The SCUC called her back and informed her a deputy would be at the facility in about 45 minutes.</p> <p>-A deputy arrived at the facility and spoke with Resident #7, asked him if he had been smoking and she observed the deputy inform the resident that he was not allowed to smoke in the building</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 29</p> <p>due to the safety dangers and there were residents in the facility that were on oxygen. -The deputy agreed with her that Resident #7's room had a strong odor of smoke, and it appeared he had recently extinguished a cigarette.</p> <p>Interview with a medication aide (MA) on 08/05/25 at 11:30am revealed she was informed by the MA that worked prior to her shift on 08/05/25 that Resident #7 was caught smoking in his room the evening of 08/04/25.</p> <p>Interview with a MA on 08/07/25 at 3:06pm revealed: -She never saw Resident #7 smoke cigarettes in his room. -She was not aware of increased supervision for Resident #7 smoking in his room. -If a resident was found with cigarettes or a lighter the SCUC would order staff to complete a "sweep" of all resident rooms to ensure there were not cigarettes or lighters in their rooms.</p> <p>Interview with the SCUC on 08/07/25 at 4:50 PM revealed: -She received report of possible cigarette smoking in the building on 08/04/25. -She and the Administrator discussed safety concerns with Resident #7 and possible discharge. -She explained to Resident #7 that the facility could catch on fire and there were residents on oxygen which his smoking could cause the building to explode. -She did not have a system in place to ensure that staff monitored the resident frequently after he was found with a cigarette packet.</p> <p>Telephone interview with the facility's contract</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 30</p> <p>psychologist on 08/07/25 at 3:34pm revealed she had not been notified that Resident #7 had smoked cigarettes in his room.</p> <p>Interview with Resident #7's primary care provider (PCP) on 08/05/25 at 4:41pm revealed: -She was not notified by staff that Resident #7 was suspected of smoking in the facility on the evening of 08/04/25. -She was not notified by staff about the resident possibly smoking in his room on 08/04/25. -She needed to be aware if a resident was a danger to themselves or others, and no resident should have access to smoking materials in a SCU due to safety risks.</p> <p>Interview with Resident #7's PCP on 08/07/25 at 3:30 PM revealed: -She was informed by staff on 08/05/25 that Resident #7's room had a strong odor of cigarette smoke earlier in the day. -She provided education to the resident about the importance of not smoking in the facility. -She reviewed the dangers of the resident smoking in the facility when oxygen was used in the facility. -She explained to the resident that his smoking could cause the building to blow up and burn down putting all resident's at risk.</p> <p>Refer to telephone interview with a medication aide (MA) on 08/05/25 at 2:43pm.</p> <p>Refer to interview with a MA on 08/07/25 at 3:15pm.</p> <p>Refer to telephone interview with the facility's psychologist on 08/07/25 at 3:35pm.</p> <p>_____ Telephone interview with a medication aide (MA)</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 270	<p>Continued From page 31</p> <p>on 08/05/25 at 2:43pm revealed: -Staff kept cigarettes in the medication room and took residents on three smoking breaks a day. -Staff used matches to light resident's cigarettes. -MAs and PCAs checked on residents at least every 30 minutes to an hour.</p> <p>Interview with MA on 08/07/25 at 3:15 PM revealed staff checked on residents every 30 minutes, sometimes every 15 minutes if needed.</p> <p>Interview with a second MA on 08/07/25 at 3:06pm revealed if a resident was found with cigarettes or a lighter the Special Care Unit Coordinator (SCUC) would order staff to complete a "sweep" of all resident rooms to ensure there were not cigarettes or lighters in their rooms.</p> <p>Telephone interview with the facility's contract psychologist on 08/07/25 at 3:34pm revealed: -She would have liked to have been notified of any resident's having smoking materials or smoking in the facility because it would be good information to have. -She assumed that the facility would have implemented some type of increased supervision when a resident was found with cigarettes, a lighter or found to be smoking in the facility to ensure the safety of all the residents.</p> <p>The facility failed to provide supervision for a resident, who had a history of smoking in his room at the facility, with cigarettes found several times in his room and an ashtray made from a foam cup (#4) and for a resident that staff observed the smell of cigarette smoke and a smokey haze in the resident's bathroom (#7) on a Special Care Unit (SCU) with resident's that used oxygen in the facility. This failure placed the</p>	D 270		

Division of Health Service Regulation

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D 270	Continued From page 32 residents at substantial risk for serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/06/25 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2025.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the health care needs for 3 of 6 sampled residents including failing to notify providers of difficulty swallowing during meals (#1), smoking inside the facility (#4) and hypoglycemic and hyperglycemic episodes (#5). The findings are: 1. Review of the facility's Residents Receiving Diabetic Medications/Treatments policy dated September 2021 revealed: -Residents receiving medication/treatments for Diabetic Care will be monitored according to Physicians Orders. -All medications, blood sugar monitoring and	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 273	<p>Continued From page 33</p> <p>insulins will be added to a Diabetic Flowsheet. -The medication aide (MA) will notify the Care Coordinator of any refusals and/or abnormal results. -The Care Coordinator will review any refusals and/or abnormal blood sugar readings and notify the provider.</p> <p>Review of Resident #5's FL2 dated 04/03/25 revealed: -Diagnoses included type 2 diabetes mellitus, mixed Alzheimer's Disease and vascular dementia, acute kidney injury, essential hypertension, and chronic venous insufficiency. -His level of care was special care unit (SCU). -There was an order for fingerstick blood sugars (FSBSs) twice per day. -There was an order for Novolin 70-30 (Novolin 70-30 is a mix of rapid acting insulin and intermediate acting insulin to treat elevated blood glucose) FlexPen U-100, inject 15 units twice daily before meals. -He was intermittently disoriented.</p> <p>Review of Resident #5's signed physician's order sheet dated 04/03/25 revealed: -There was an order for FSBSs twice per day. -There was an order for Novolin 70-30 FlexPen U-100, inject 15 units twice daily before meals.</p> <p>Review of Resident #5's current FL2 dated 06/16/25 revealed: -Diagnoses included diabetes, dementia, hypertension, peripheral vascular disease, hyperlipidemia and neuropathy. -There was an order for insulin aspart (insulin aspart is a rapid acting insulin used to treat elevated blood sugar), sliding scale insulin (SSI) FSBS less than 100 give 0 units, FSBS 100-150 give 5 units, if FSBS greater than 150, give 7</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 273	<p>Continued From page 34</p> <p>units before meals.</p> <p>Review of a signed physician's order sheet dated 06/16/25 revealed there was an order for insulin aspart flex pen, give 5 units before meals, do not administer if FSBS is less than 100, administer 2 additional units for FSBS greater than 150.</p> <p>Review of Resident #5's May 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry to check FSBS twice a day, scheduled at 9:00am and 9:00pm. -There was an entry that the morning FSBS check for Resident #5 was changed to 7:00am and 9:00pm on 05/16/25. -FSBS was documented as 480 at 9:00pm on 05/01/25. -FSBS was documented as 325 at 9:00pm on 05/03/25. -FSBS was documented as 378 at 9:00pm pm 05/06/25. -FSBS was documented as 62 at 7:00am and as 500 at 9:00pm on 05/25/25. -FSBS was documented as 338 at 7:00am and 68 at 9:00pm on 05/29/25. -FSBS was documented as 378 at 9:00pm on 05/30/25. -FSBS was documented as 68 at 7:00am on 05/31/25. <p>Review of Resident #5's electronic progress notes revealed there was no documentation of primary care provider (PCP) or Special Care Unit Coordinator (SCUC) notification of abnormal FSBSs for the month of May 2025.</p> <p>Review of Resident #5's June 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check FSBS twice a day, 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 35</p> <p>scheduled at 7:00am and 9:00pm.</p> <p>-FSBS was documented as 64 at 9:00pm on 06/01/25.</p> <p>-FSBS was documented as 336 at 9:00pm on 06/03/25.</p> <p>-FSBS was documented as 327 at 9:00pm on 06/04/25.</p> <p>-FSBS was documented as 371 at 9:00pm on 06/06/25 and 06/07/25.</p> <p>-FSBS was documented as 518 at 9:00pm on 06/16/25.</p> <p>-FSBS was documented as 302 at 9:00pm on 06/18/25.</p> <p>-FSBS was documented as 339 at 9:00pm on 06/19/25.</p> <p>-FSBS was documented as 350 at 9:00pm on 06/20/25.</p> <p>-FSBS was documented as 341 at 9:00pm on 06/21/25.</p> <p>-FSBS was documented as 549 at 9:00pm on 06/22/25.</p> <p>-FSBS was documented as "High" at 9:00pm on 06/24/25.</p> <p>-FSBS was documented as 453 at 9:00pm on 06/25/25.</p> <p>-FSBS was documented as 367 at 9:00pm on 06/26/25.</p> <p>-FSBS was documented as 362 at 7:00am on 06/29/25.</p> <p>-FSBS was documented as 341 at 9:00pm on 06/30/25.</p> <p>Review of Resident #5's June 2025 progress notes revealed:</p> <p>-There was an entry on 06/12/25 at 7:04am by Resident #5's primary care provider that Resident #5 was sent out to the emergency department on 06/07/25 at 5:11am for seizure like activity, not responding to name, and a FSBS of 52.</p> <p>-There was an entry on 06/14/25 at 9:47pm by a</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 273	<p>Continued From page 36</p> <p>MA, Resident #5's FSBS was 57, he was given a very sweet drink and rechecked FSBS 30 minutes later was 95, there was no documentation that Resident #5's PCP or the SCUC were notified.</p> <p>-There was an entry on 06/23/25 at 10:35am by a MA, Resident #5's FSBS was 76, glucose gel was given and his FSBS was rechecked and was 133, there was no documentation that Resident #5's PCP or the SCUC were notified.</p> <p>-There was an entry on 06/28/25 at 7:15am, Resident #5's FSBS was 48, he was given glucose gel and a very sweet drink, after 45 minutes, his FSBS had increased to 123, there was no documentation that Resident #5's PCP or the SCUC were notified.</p> <p>-There was no other documentation of PCP notification of abnormal FSBSs for the month of June 2025.</p> <p>Review of Resident #5's July 2025 eMAR revealed:</p> <p>-There was an entry to check FSBS twice a day, scheduled at 7:00am and 9:00pm.</p> <p>-There was a second entry to check FSBS three times a day before meals starting 07/07/25 scheduled at 7:00am, 5:00pm and 11:30pm.</p> <p>-There was a third entry to check FSBS at bedtime, scheduled at 8:00pm.</p> <p>-FSBS was documented as 396 at 9:00pm on 07/01/25.</p> <p>-FSBS was documented as 457 at 9:00pm on 07/03/25.</p> <p>-FSBS was documented as 66 at 7:00am on 07/05/25.</p> <p>-FSBS was documented as 420 at 9:00pm on 07/05/25.</p> <p>-FSBS was documented as 64 at 7:00am on 07/06/25.</p> <p>-FSBS was documented as 310 at 11:30pm on</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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 273	<p>Continued From page 37</p> <p>07/08/25. -FSBS was documented as 429 at 5:00pm on 07/09/25. -FSBS was documented as 473 at 8:00pm on 07/11/25. -FSBS was documented as 379 at 11:30pm on 07/11/25. -FSBS was documented as 401 at 5:00pm and 313 at 8:00pm on 07/12/25. -FSBS was documented as 304 at 5:00pm, 389 at 8:00pm and 302 at 11:30pm on 07/13/25. -FSBS was documented as 346 at 5:00pm, and 536 at 8:00pm on 07/14/25. -FSBS was documented as 432 at 5:00pm on 07/15/25. -FSBS was documented as 523 at 5:00pm, 388 at 8:00pm and 398 at 11:30pm on 07/16/25. -FSBS was documented as 332 at 5:00pm on 07/17/25. -FSBS was documented as 580 at 8:00pm and 430 at 11:30pm on 07/18/25. -FSBS was documented as 375 at 5:00pm and 305 at 8:00pm on 07/22/25. -FSBS was documented as 60 at 7:00am on 07/27/25. -FSBS was documented as 319 at 11:30pm on 07/27/25. -FSBS was documented as 347 at 5:00pm on 07/30/25. -FSBS was documented as 321 at 5:00pm on 07/31/25.</p> <p>Review of Resident #5's July 2025 progress notes revealed: -There was an entry dated 07/01/25 at 7:25am by a medication aide (MA), Resident #5 was transported to the hospital on 07/01/25 at 6:25am via emergency medical services (EMS). -The resident was transported for change in condition, hypoglycemia (hypoglycemia is low</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 38</p> <p>blood sugar).</p> <ul style="list-style-type: none"> -Resident #5's primary care provider (PCP) and responsible party (RP) were notified. -There was an entry on 07/06/25 at 7:32am by a MA, Resident #5 was transported to the hospital on 07/06/25 at 6:15am via EMS. -The resident was transported for change in condition, hypoglycemia. -Resident #5's PCP and RP were notified. -There was an entry on 07/29/25 at 7:09am by a MA, Resident #5 was transported to the hospital on 07/29/25 at 5:51am via EMS. -The resident was transported for hypoglycemia. -Resident #5's VA provider and his RP were notified. -An I/A report was completed on 07/29/25 at 7:07am. -There was no other documentation of PCP notification of abnormal blood sugars in July 2025. <p>Review of Resident #5's August 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check FSBS three times a day before meals scheduled at 7:00am, 5:00pm and 11:30pm. -There was a second entry to check FSBS at bedtime, scheduled at 8:00pm. -FSBS was documented as 355 at 8:00pm on 08/02/25. -FSBS was documented as 344 at 7:00am and 343 at 5:00pm on 08/02/25. <p>Review of Resident #5's August 2025 progress notes revealed there was no documentation of PCP notification of abnormal blood sugars in August 2025.</p> <p>Interview with a MA on 08/07/25 at 1:25pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 39</p> <ul style="list-style-type: none"> -If a resident's FSBS was greater than 400 or less than 90, she always notified the PCP. -If the resident's PCP was notified of abnormal FSBS, there should be a progress note made by the MA. -She knew most of the time, Resident #5's FSBS dropped late in night or early in the morning. -Resident #5 saw a Department of Veteran's Affairs (VA) provider and there was no way to contact them after hours about his FSBSs. <p>Interview with a second MA on 08/07/25 at 3:52pm revealed:</p> <ul style="list-style-type: none"> -If a resident did not have parameters ordered with their FSBSs, she notified the PCP of any FSBS greater than 350 or less than 70. -If the FSBS was less than 70, she gave glucose gel and rechecked the FSBS and notified the resident's provider. -A progress note was to be made anytime a provider was contacted about a resident. -Previously, Resident #5 saw a VA provider and had just recently switched to see the facility's in-house provider. -While Resident #5 was under the care of the VA provider, it was very difficult to contact the VA providers during normal business hours and there was no way to contact the VA providers after hours regarding his abnormal FSBS. <p>Interview with the SCUC on 08/07/25 at 3:18pm revealed:</p> <ul style="list-style-type: none"> -She was a medication aide (MA) and the SCUC. -FSBSs should have parameters. -Resident #5 did not have parameters for his FSBS. -She contacted a resident's PCP if their FSBS was less than 100 or greater than 250-300 if there were no parameters. -She would administer glucose gel for any FSBS 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 40</p> <p>below 100 and call the resident's PCP.</p> <p>-Resident #5 was treated by a VA provider and there was no way to get in touch with his VA provider about his blood sugars.</p> <p>-She had tried to get a fax number for Resident #5's VA provider but was unable to do so.</p> <p>-There should always be a progress note documented of contact with the residents' PCP but there was no way to contact Resident#5's VA provider.</p> <p>Second interview with the SCUC on 08/07/25 at 5:12pm revealed:</p> <p>-If a resident had orders for FSBSs but no parameters, she or the MAs reviewed the resident's FSBS history to determine what might be considered high or low for the resident and if the resident's PCP needed to be contacted.</p> <p>-The MAs or she also evaluated the residents to see if they were having any symptoms of high or low blood sugar, such as sweating, shaking or behavior changes, if they were symptomatic, the PCP was contacted, or they were sent out to the ED.</p> <p>-She reviewed the residents' eMARs once a month, looking for high and lows of their FSBSs and provided this information to the residents' PCP.</p> <p>-Any PCP contact on behalf of a resident was documented in the resident's progress notes.</p> <p>-Resident #5 previously was treated by a VA provider and there was no way to contact the VA provider about his abnormal FSBSs.</p> <p>-She knew Resident #5 had high and low FSBSs but there was no way to contact his VA provider.</p> <p>-Resident #5 was now being followed by the facility's in-house PCP as of today, 08/07/25.</p> <p>Interview with the Administrator on 08/07/25 at 05:50pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 41</p> <ul style="list-style-type: none"> -The MAs or the SCUC were responsible to contact the residents' PCP with any abnormal findings. -If the MAs or SCUC had any difficulty contacting a provider, they should notify her so she could assist. -Resident #5's PCP should have been contacted for FSBS parameters. -Resident #5's PCP should have been contacted regarding high and low FSBSs. -The MAs or the SCUC should make a progress note in the resident's progress notes when their PCP was contacted. <p>Interview with the facility's in-house PCP on 08/07/25 at 3:35pm revealed:</p> <ul style="list-style-type: none"> -She saw Resident #5 when he was first admitted to the facility in April 2025. -After the April 2025 visit with her, Resident #5 established care with a VA provider. -Resident #5 was now under her care as of 08/07/25. -There was a visit note for Resident #5 with her name on it for 06/12/25, but she did not think she saw Resident #5 on 06/12/25. -Resident #5 had poorly controlled type 2 diabetes. -She would expect to be contacted if Resident #5's FSBS fell below 100 or if his FSBS was greater than 300 to 350. -The acute effects of elevated blood sugar and low blood sugar could result in increased thirst, sweating, behavioral changes, dizziness, passing out, seizure activity, weakness, combativeness and disorientation -The long-term effects of elevated blood sugar included kidney damage, heart damage, and neuropathy. <p>A telephone request for a return phone call from</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 42</p> <p>Resident #5's VA provider was left with a Registered Nurse with Resident #5's VA provider's Triage Team on 08/07/25 at 2:10pm and the call was not returned prior to exit from the facility.</p> <p>2. Review of Resident #1's current FL-2 dated 07/14/25 revealed: -Diagnoses included severe late onset alzheimer's dementia with mood disturbance, subdural hematoma, osteoarthritis and gastroesophageal reflux disease. -He was constantly disoriented and non-ambulatory. -He required personal care assistance with feeding. -There was an order for a regular diet.</p> <p>Review of Resident #1's Resident Register revealed he was admitted on 07/14/25.</p> <p>Review of Resident #1's resident record revealed: -There was a Special Care Unit (SCU) Disclosure Statement dated 06/01/25 which stated changes in a resident's condition would be immediately reported to the resident's physician, family, and/or other appropriate community resources. -The SCU Disclosure Statement was signed on 07/14/25 by a facility representative and Resident #1's Responsible Person.</p> <p>Review of Resident #1's current care plan dated 08/05/25 revealed: -Resident #1 was admitted to hospice after admission to the facility. -He was totally dependant on staff for all activities of daily living including eating.</p> <p>Observation of Resident #1 during the lunch</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 43</p> <p>service on 08/05/25 from 12:02pm to 12:31pm revealed:</p> <ul style="list-style-type: none"> -Resident #1 was served a regular diet which consisted of collard greens, sweet potatoes, a pork chop, corn bread and fruit cocktail. -Resident #1 was served thin liquids including milk, tea and water. -Staff assisted Resident #1 with feeding and offered liquids through a straw. -Resident #1 coughed after each drink of liquids that was offered to him. <p>Interview with the staff assisting with feeding on 08/05/25 at 12:30pm revealed:</p> <ul style="list-style-type: none"> -That was the first time she fed Resident #1. -Resident #1 coughed with each liquid he attempted to swallow. -She heard he got strangled during meals but was not sure who told her. -She thought the Administrator was aware of Resident #1 coughing during meals but was not sure if the primary care provider (PCP) or hospice nurse had been notified. -She had not notified either the PCP or the hospice nurse. <p>Observation of Resident #1 during the breakfast service on 08/06/25 at 8:26am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was served a regular diet which consisted of scrambled eggs, hashbrown, a banana and watermelon. -Resident #1 was served thin liquids including milk, tea and water. -Staff assisted Resident #1 with feeding and offered liquids through a straw. -Resident #1 coughed after each drink of liquids that was offered to him. <p>Interview with a personal care aide (PCA) on 08/06/25 at 8:31am revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 44</p> <ul style="list-style-type: none"> -Resident #1 coughed during meals when he drank fluids. -PCAs were responsible for notifying the MA on duty of swallowing concerns and the MA was responsible for notifying the resident's PCP or hospice. -She thought a MA had reported to hospice that Resident #1 coughed during meals but she did not know who. -She had not notified a MA that Resident #1 coughed during meals. <p>Interview with a MA on 08/06/25 at 9:20am revealed:</p> <ul style="list-style-type: none"> -She worked part-time at the facility and assisted Resident #1 with feeding during breakfast. -Resident #1 would cough while drinking and eating his eggs. -She notified hospice because she was concerned Resident #1 might choke or aspirate. <p>Telephone interview with Resident #1's Responsible Person on 08/06/25 at 10:58am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was at a sister facility and contracted pneumonia prior to admission to the current facility. -Resident #1 had a traumatic brain injury from a previous fall and had trouble swallowing for a while after that occurred but was on a regular diet at the previous facility. -While in the hospital for pneumonia, Resident #1 was on thickened liquids. <p>Review of Resident #1's hospital discharge summary dated 07/14/25 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was hospitalized on 07/09/25 through 07/14/25 due to pneumonia. -He was discharged on a regular diet. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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 273	<p>Continued From page 45</p> <p>Interview with Resident #1's primary care provider (PCP) on 08/05/25 at 4:24pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #1 was having difficulty swallowing and had not been notified. -She would want to be notified of coughing because coughing during meals put the resident at risk of choking and aspiration which could lead to pneumonia infection. -She would have ordered a different diet for Resident #1 and swallow studies if the resident was not on hospice. <p>Interview with the Resident #1's hospice nurse on 08/06/25 at 9:28am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was admitted to hospice on 07/17/25. -The facility contacted her that morning just before 9:00am to report concerns with Resident #1's swallowing. -There had been no previous report of coughing during meals or while drinking water. -She reached out to the hospice provider to obtain an order to downgrade Resident #1's diet to keep him from choking. -Resident #1 was at risk for aspiration that could lead to pneumonia. <p>Interview with the Special Care Unit Coordinator (SCUC) on 08/06/25 at 9:16am revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #1 coughed while eating and drinking until 08/05/25. -She thought hospice had been notified on 08/05/25. -She thought the hospice nurse went to see Resident #1 on 08/05/25. -The MA called hospice again that morning (08/06/25). <p>Review of Resident #1's physician's order dated 08/06/25 revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 46</p> <p>-Resident #1's diet was to be downgraded from regular diet to pureed diet and thickened liquids. -There was a clarification to specify thickened liquids were to be nectar thick.</p> <p>Observation of Resident #1 during the breakfast service on 08/07/25 at 8:30am revealed: -He was served a pureed diet and nectar thickened liquids. -There was no coughing observed during the meal service.</p> <p>Telephone interview with the Administrator on 08/07/25 at 5:51pm revealed: -It was not reported to her that Resident #1 was coughing during meals until 08/05/25. -It was the responsibility of the MA to report immediately to hospice and to the SCUC or to her when they observed a resident coughing a lot while trying to swallow because the resident was at risk for choking and aspirating.</p> <p>Based on observations, interviews and record reviews, it was determined that Resident #1 was not interviewable.</p> <p>3. Review of Resident #4's current FL-2 dated 04/25/25 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease (COPD), renal abdominal aortic aneurism, and peptic ulcer disease. -The resident was ambulatory and intermittently disoriented. -The resident wandered. -The resident's recommended level of care was Special Care Unit (SCU).</p> <p>Review of Resident #4's Resident Register revealed the resident was admitted to the SCU on</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 47</p> <p>04/18/25.</p> <p>Review of Resident #4's current care plan dated 05/15/25 revealed:</p> <ul style="list-style-type: none"> -The resident was oriented. -The resident was forgetful and needed reminders. -The resident required supervision with toileting and ambulation. -The resident required limited assistance with eating and transfers. -The resident required extensive assistance with bathing, dressing, and grooming. <p>Review of Resident #4's SCU resident profile and care plan dated 07/30/25 revealed:</p> <ul style="list-style-type: none"> -Environmental stimuli that could trigger bad behavior was listed as sundowning (Sundowning is when individuals with dementia or other cognitive disorders experience increased confusion, agitation, and other behavioral changes in the late afternoon or evening hours). -The resident required supervision with bathing, grooming, and transferring. -Special management needs were listed as cigarettes. -The resident's cognitive impairment was a level 2 for severe memory loss. <p>Review of Resident #4's SCU Pre-Admission Checklist dated 04/18/25 revealed the resident was a smoker and required redirecting at times.</p> <p>Review of a police report from the sheriff's department dated 08/04/25 revealed:</p> <ul style="list-style-type: none"> -The deputy spoke with Resident #4 and the resident reported that they he did smoke cigarettes but had not smoked in his room. -The deputy found empty cigarette boxes in plain view and gave a staff person the cigarette boxes. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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 273	<p>Continued From page 48</p> <p>Observation of Resident #4's room on 08/05/25 at 12:27pm revealed:</p> <ul style="list-style-type: none"> -There was a strong odor of cigarette smoke in Resident #4's bathroom. -There was an 8-ounce white foam drinking cup sitting on the toilet tank lid. -The white foam drinking cup had two squared u-shaped notches cut into the cup rim directly across from one another. -The cut notches were wide enough to accommodate a cigarette. -The was a scant amount of tiny black and gray particles inside the white foam cup. <p>Interview with Resident #4 on 08/05/25 at 9:18am revealed:</p> <ul style="list-style-type: none"> -Last night (08/04/25) at approximately 9:00pm a deputy from the sheriff's department came to his room to search his room for cigarettes. -The deputy found 2 empty packs of cigarettes in a snack cake box between his dresser and his bed. <p>Interview with Resident #4 on 08/07/25 at 2:30pm revealed:</p> <ul style="list-style-type: none"> -He never smoked in his room. -His cigarettes were kept in the medication room, and staff lit his cigarette with him outside. -His family member got him 2 packs of cigarettes on his birthday which was in June. -Staff found those cigarettes the next day and removed them from his room. -He recently went with a family member to a local grocery store and he purchased 2 packs of cigarettes. -He thought he hid them in a plastic container by his bed. -Staff came into his room last week and found cigarettes and a lighter in his room 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 49 (07/27/25-08/02/25). -He had the lighter laying on his nightstand in plain sight and was not trying to hide it.</p> <p>Telephone interview with a medication aide (MA) on 08/06/25 at 2:43pm revealed: -She started her medication pass at the end of the 300 hall and smelled a strong odor of cigarette smoke on 08/04/25. -She called the Special Care Unit Coordinator (SCUC) to report a concern of smoking in the facility and was informed that the sheriff's department had been notified and would arrive at the facility shortly. -The deputy interviewed Resident #4 in his room and asked if he had any smoking materials. -The deputy found three empty cigarette cases in an empty snack cake box by the resident's bed and nightstand. -She never observed a lighter in Resident #4's room. -She was aware that Resident #4 was caught smoking in his room last week (07/27/25-08/02/25) during the day time shift.</p> <p>Interview with a personal care aide (PCA) on 08/07/25 at 2:42pm revealed: -She had smelled cigarette smoke at Resident #4's room before but did not see him smoking. -She smelled cigarette smoke from Resident #4's room last week and reported it to the medication aide (MA) that was on duty.</p> <p>Interview with a MA on 08/05/25 at 11:30am revealed: -Resident #4 had a lighter in his room and a few cigarettes in his coat pocket one time the past week (7/27/25 to 08/02/25). -She and other staff searched the resident's room for additional cigarettes or lighters.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 273	<p>Continued From page 50</p> <p>-She, the Administrator, and the SCUC met with the resident's family member to ensure the family member was aware of the resident's behaviors and to discuss that residents were not allowed to have cigarettes or lighters and he was not allowed to smoke in the facility.</p> <p>-She did not notify the resident's primary care provider (PCP) or his psychologist because she did not think about notifying them of Resident #4's behaviors.</p> <p>Interview with a MA on 08/07/25 at 2:55pm revealed:</p> <p>-She had smelled smoke in Resident #4's room a couple of times.</p> <p>-A PCA reported to her last week that she smelled smoke in Resident #4's room.</p> <p>-Last week she went to the resident's room and told him his room smelled like he had been smoking a cigarette.</p> <p>-She notified the SCUC.</p> <p>-Resident #4 denied that he had smoked cigarettes in his room.</p> <p>-A PCA and MA went to the resident's room to search for cigarettes and lighters and found one packet of cigarettes and a lighter.</p> <p>Interview with a second MA on 08/07/25 at 3:06pm revealed:</p> <p>-She never saw Resident #4 smoke cigarettes in his room.</p> <p>-Approximately 2 months ago she smelled cigarette smoke near Resident #4's room.</p> <p>-She met with the resident in his room and asked if he had been smoking.</p> <p>-The resident denied smoking a cigarette in his room.</p> <p>-She asked the resident if he had cigarettes in his jacket pocket, the resident told her yes and gave her his pack of cigarettes.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 51</p> <ul style="list-style-type: none"> -She could not remember if she notified Resident #4's PCP or psychologist. -Usually when a resident had a change in condition or change in behavior she would notify the PCP and the resident's psychologist. <p>Interview with the SCUC on 08/07/25 at 4:50 PM revealed:</p> <ul style="list-style-type: none"> -She received report of possible cigarette smoking in the building on 08/04/25 -She and the Administrator discussed safety concerns with Resident #4 and possible discharge. -She was concerned that the building could catch fire because there were residents in the building who were on oxygen. -She removed cigarettes from Resident #4's coat pocket on the evening of 08/05/25 when staff searched his room. -Staff discovered 3 other loose cigarettes in his clothing and shoes on the evening of 08/05/25. -She did not think that she notified Resident #4's PCP or physiologist about his smoking and hoarding behaviors. -She should have checked with the MAs to see if they had notified the residents PCP or psychologist because they needed to be aware of the resident's behaviors. <p>Telephone interview with Resident #4's RP on 08/07/25 at 5:19pm revealed:</p> <ul style="list-style-type: none"> -She was contacted by the Administrator on Monday 08/04/25 by telephone about concerns of Resident #4 having cigarettes in his room. -She met with the Administrator and the SCUC on 08/05/25 to discuss the smoking policy and staff concerns about Resident #4 having cigarettes in his room. -Resident #4 had another family member that took him out on occasions and did not supervise 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 52</p> <p>him when he bought items from a local grocery store and smoke shop.</p> <p>-She called the family member on 08/04/25 and informed her that she needed to ensure that Resident #4 did not purchase cigarettes.</p> <p>-She met with Resident #4 and reminded him that he was not allowed to smoke on the SCU and was not allowed to keep his own cigarettes and lighters.</p> <p>-She spoke with the family member who took Resident #4 to the store and reminded her that he was not allowed to have cigarettes in the facility.</p> <p>Interview with the Administrator on 08/05/25 at 4:15pm revealed:</p> <p>-A MA smelled smoke on 08/04/25 near Resident #4's room.</p> <p>-A deputy from the Sheriff's Department came to the facility the evening of 08/04/25 at approximately 9:00pm.</p> <p>-The deputy found two empty packs of cigarettes in the resident's room.</p> <p>-She spoke with Resident #4 on 08/05/25 about not smoking in the facility.</p> <p>-She spoke with the resident's RP on 08/05/25 about the resident smoking and discussed setting a time to meet to update his care plan.</p> <p>-She was not sure why staff had not notified Resident #4's PCP or his psychologist.</p> <p>-She expected the MA or SCUC to notify Resident #4's PCP and psychologist when there was a change in behavior.</p> <p>Interview with the Administrator on 08/07/25 at 4:15pm revealed:</p> <p>-On 08/04/25, staff found 3 empty packs of cigarettes in his room, but they were not full, there were a few in each pack.</p> <p>-She directed staff the evening of 08/04/25 and the morning of 08/05/25 to search the resident's</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 273	<p>Continued From page 53</p> <p>room for any cigarettes or lighters.</p> <p>-She assumed staff had completed the search and ensured there were no cigarettes or lighters in his room, however when an additional search was completed the evening of 08/05/25 more cigarettes and a lighter were found.</p> <p>-She had not notified Resident #4's primary care provider (PCP) or his psychologist that cigarettes and a lighter had been found in his room.</p> <p>-She was not sure why she did not notify the resident's PCP or psychologist of his possession of cigarettes and a lighter.</p> <p>Telephone interview with the facility's contract psychologist on 08/07/25 at 3:34pm revealed:</p> <p>-She had not been notified that Resident #4 had cigarettes and a lighter in his room.</p> <p>-She was not aware that Resident #4 had smoked in his room.</p> <p>-She would like to be notified about Resident #4's behaviors when there was a change or staff had a concern.</p> <p>Interview with Resident #4's PCP on 08/05/25 at 4:41pm revealed:</p> <p>-She was not notified by staff that Resident #4 was suspected of smoking in the facility on the evening of 08/04/25, until 08/05/25.</p> <p>-She needed to be aware if a resident was a danger to themselves or others, and no resident should have access to smoking materials in a SCU due to safety risks.</p> <p>_____</p> <p>The facility failed to notify the primary care provider (PCP) regarding high and low blood sugar levels for a resident with poorly controlled diabetes which put him at risk for organ damage and coma and low blood glucose readings that required evaluations by the local hospital emergency department due to altered mental</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 273	<p>Continued From page 54</p> <p>status (#5); The facility failed to notify hospice or the PCP regarding a resident with swallowing difficulty that coughed with each drink of fluids that placed him at risk for choking and aspiration (#1), and failing to notify the PCP of a resident that was found with smoking paraphernalia in his room, admitted to smoking to local law enforcement and was suspected of smoking inside the facility. This failure placed the residents at substantial risk for serious physical harm and constitutes a Type A2 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/06/25 with an amendment on 08/07/25 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 6, 2025.</p>	D 273		
D 358	<p>10A NCAC 13F .1004 (a) Medication Administration</p> <p>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:</p> <p>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and</p> <p>(2) rules in this Section and the facility's policies and procedures.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to administer medications according to provider orders and in</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 55</p> <p>accordance with facility policy and procedures for 1 of 5 sampled residents (#5) including medications used to treat elevated blood sugar, overactive bladder and insomnia.</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 06/16/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included diabetes, dementia, hypertension, peripheral vascular disease, hyperlipidemia and neuropathy. -There was an order for insulin aspart (insulin aspart is a rapid acting insulin used to treat elevated blood sugar), sliding scale insulin (SSI) finger stick blood sugar (FSBS) less than 100 give 0 units, FSBS 100-150 give 5 units, if FSBS greater than 150, give 7 units before meals. -There was an order for tolterodine 4mg, take one at bedtime. -There was an order for trazodone (trazodone is used to treat insomnia, depression and anxiety) 50mg, take one at bedtime. <p>Review of Resident #5's Resident Register revealed he was admitted to the facility on 03/29/25.</p> <p>a. Review of the facility's Residents Receiving Diabetic Medications/Treatments policy dated September 2021 revealed:</p> <ul style="list-style-type: none"> -Residents receiving medication/treatments for Diabetic Care will be monitored according to Physicians Orders. -All medications, blood sugar monitoring and insulins will be added to a Diabetic Flowsheet. -The medication aide (MA) will notify the Care Coordinator of any refusals and/or abnormal results. -The Care Coordinator will review any refusals 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 56</p> <p>and/or abnormal blood sugar readings and notify the provider.</p> <p>Review of a signed physician's order sheet dated 06/16/25 revealed there was an order for insulin aspart flex pen, give 5 units (for a total of 7 units) before meals, do not administer if FSBS is less than 100, administer 2 additional units for FSBS greater than 150.</p> <p>Review of Resident #5's Pharmacist Drug Review dated 07/17/25 revealed:</p> <ul style="list-style-type: none"> -The Pharmacist drug review requested clarification of an insulin aspart order, the resident was readmitted from the hospital with an order for insulin aspart that needed clarification, insulin aspart inject per sliding scale, for FSBS less than 100= 0 units, for FSBS 100-149= 5 units, for FSBS greater than 150= 7 units as needed (prn). -The Pharmacist drug review asked to please clarify the order to read, insulin aspart, inject per sliding scale, for FSBS less than 100= 0 units, for FSBS 10-149= 5 units, for FSBS greater than 150= 7 units three times per day before meals at 7:30am, 11:30am and 5:00pm. -In the section "write any clarification, new orders or changes, the primary care provider (PCP) wrote a new order for insulin aspart, inject per sliding scale, for FSBS less than 100= 0 units, for FSBS 100-149= 7 units, for FSBS greater than 150= 9 units, at 7:30am, 11:30am and 5:00pm with meals. -The Pharmacist Drug Review was signed by Resident #5's PCP on 07/18/25. <p>Observation of Resident #5's medications on hand on 08/07/25 at 1:21pm revealed there was a 3 ml pen of Novolog (insulin aspart) with an opened date of 07/26/25.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 57</p> <p>Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for insulin aspart U-100 insulin pen,100units/ml, (3 ml) inject 5 units before meals, hold/do not administer if FSBS less than 100, give 2 additional units (7 units total) for a FSBS greater than 150, scheduled at 8:00am, 12:00pm and 5:00pm with a start date of 06/17/25. -There was no space on the insulin aspart eMAR entry to record the FSBSs. -There was no space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was no space on the insulin aspart eMAR entry to document the injection site. -Insulin aspart U-100, 100units/ml was documented as administered at 8:00am on 06/19/25 to 06/22/25 with no number of units administered documented. -Insulin aspart U-100, 100units/ml was documented as administered at 8:00am on 06/24/25 through 06/30/25 with no number of units administered documented. -Insulin aspart U-100, 100 units/ml was documented as administered at 12:00pm and 5:00pm on 06/19/25 through 06/30/25 with no number of units administered documented. -There was no documentation of FSBSs at 12:00pm and 5:00pm on 06/17/25 through 06/30/25. -There was no documentation of the number of units of insulin aspart administered at any time for the month of June 2025. <p>Review of Resident #5's July 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for insulin aspart U-100 insulin pen,100units/ml, (3 ml) inject 5 units 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 58</p> <p>before meals, hold/do not administer if glucose less than 100, give 2 additional units (7 units total) for a glucose greater than 150, scheduled at 8:00am, 12:00pm and 5:00pm.</p> <ul style="list-style-type: none"> -There was no space on the insulin aspart eMAR entry to record the FSBSs. -There was no space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was no space on the insulin aspart eMAR entry to record the injection site. -Insulin aspart was documented as not administered at 8:00am on 07/01/25 with the exception documented as resident unavailable. -Insulin aspart U-100, 100units/ml was documented as administered at 8:00am on 07/02/25 to 07/05/25 with no number of units administered documented. -Insulin aspart U-100, 100units/ml was documented as not administered at 8:00am on 07/06/25 with the exception documented as "resident at ER". -Insulin aspart U-100, 100units/ml was documented as administered at 8:00am on 07/07/25 with no number of units administered documented. -Insulin aspart U-100, 100 units/ml was documented as administered at 12:00pm and 5:00pm on 07/01/25 through 07/06/25 with no number of units administered documented. -There was a second entry for insulin aspart U-100 insulin pen, 100units/ml (3ml) inject per sliding scale, for FSBS less than 100= 0 units, for FSBS 100-149= 5 units, if FSBS greater than 150= 7 units PRN (as needed) with a start date of 07/07/25. -There was no space on the insulin aspart eMAR entry to record the FSBSs. -There was no space on the insulin aspart eMAR entry to record the number of insulin units 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 59</p> <p>administered.</p> <p>-There was no space on the insulin aspart eMAR entry to record the injection site.</p> <p>-There was no documentation that insulin aspart was administered from 12:00pm on 07/07/25 through 5:27pm on 07/12/25.</p> <p>-Resident #5's FSBS was checked on 14 occasions from 07/07/25 to 07/12/25 and ranged from 143 to 429.</p> <p>-Insulin apart was documented as administered at 5:27pm on 07/12/25 for a FSBS documented as 401 with no number of units administered documented.</p> <p>-Resident #5's FSBS was checked on 6 occasions on 07/13/25 and 07/14/25 and ranged from 160 to 346.</p> <p>-There was no documentation that insulin aspart was administered on 07/13/25 and 07/14/25.</p> <p>-Insulin aspart was documented as administered at 5:45pm on 07/15/25 and at 5:19pm on 07/16/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as administered at 12:19pm and 5:46pm on 07/17/25 with no number of units administered documented.</p> <p>-There was documentation that Resident #5's FSBS was checked on 4 occasions on 07/18/25 and ranged from 226 to 580.</p> <p>-There was no documentation that insulin aspart was administered on 07/18/25.</p> <p>-There was a third entry for insulin aspart, inject per sliding scale with meals, FSBS less than 100= 0 units, 100-149= 7 units, greater than 150= 9 units with a start date of 07/19/25.</p> <p>-There was no space on the insulin aspart eMAR entry to record the FSBSs.</p> <p>-There was no space on the insulin aspart eMAR entry to record the number of insulin units administered.</p> <p>-There was no space on the insulin aspart eMAR</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 60</p> <p>to document the injection site.</p> <p>-There was documentation that Resident #5 was out of the facility from 7:30am on 07/19/25 through 11:30am on 07/21/25.</p> <p>-Insulin aspart was documented as administered at 7:30am on 07/23/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as not administered at 7:30am on 07/24/25, with the exception documented as FSBS 85.</p> <p>-Insulin aspart was documented as administered at 7:30am on 07/25/25 through 7/28/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as administered at 11:30am on 07/23/25 through 07/28/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as administered at 5:30pm on 07/22/25 through 07/28/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as not administered at 7:30am on 07/29/25 through 11:30am with the exception documented as "resident unavailable".</p> <p>-Insulin aspart was documented as administered at 5:00pm on 07/30/25 with no number of units administered documented.</p> <p>-Insulin aspart was documented as administered at 7:30am, 11:30am and 5:00pm on 07/31/25 with no number of units administered documented.</p> <p>-There was no space on the insulin aspart eMAR entry to record the number of insulin units administered.</p> <p>-There was no space on the insulin aspart eMAR to document the injection site.</p> <p>-There was no documentation of the number of units of insulin aspart administered at any time for the month of July 2025.</p> <p>Review of Resident #5's August 2025 eMAR revealed:</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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	<p>Continued From page 61</p> <ul style="list-style-type: none"> -There was an entry for insulin aspart, inject as directed per sliding scale with meals, for FSBS less than 100= 0 units, for FSBS 100-149= 7 units, for FSBS greater than 150= 9 units scheduled at 7:30am, 11:30am and 5:00pm. -There was no space on the insulin aspart eMAR entry to record the FSBSs. -There was no space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was no space on the insulin aspart eMAR entry to document the injection site. -Insulin aspart was documented as administered at 7:30am, 11:30am and 5:00pm on 08/01/25 through 08/04/25 with no number of units administered documented. -Insulin aspart was documented as administered at 7:30am and 11:30am on 08/05/25 with no number of units administered documented. <p>There was no documentation of the number of units of insulin aspart administered for the month of August 2025 from 7:30am on 08/01/25 through 11:30am on 08/05/25.</p> <p>Review of Resident #5's Incident and Accident (I/A) report dated 06/07/25 revealed:</p> <ul style="list-style-type: none"> -The event date was 06/07/25 at 4:19am. -The description was medical, without injury on 06/07/25 at 4:19am in the resident's room. -The type of incident was documented as medical-seizure like activity, glucose 52, non-responsive to name. -The location of the incident was the resident's room. -The incident was witnessed by a staff member. -The description, the resident was observed having seizure like activity, non-responsive to name being called, and sweating. -The resident did not exhibit or complain of negative outcome related to the incident. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 62</p> <ul style="list-style-type: none"> -First aid was not administered. -Level of Consciousness was documented as unresponsive. -The resident was sent to the emergency department (ED) on 06/0725 at 4:40am via emergency medical services (EMS). -The status of resident after ED discharge was documented as hypoglycemia, hypothermia, decrease Lantus to 15 units at night and follow up with primary care provider (PCP) at next visit. -The resident's PCP and responsible party were notified. -His vital signs were documented as FSBS 52. <p>Review of Resident #5's ED after visit summary dated 06/07/25 revealed:</p> <ul style="list-style-type: none"> -Reason for visit was hypoglycemia, symptomatic. -Diagnoses for the visit were hypoglycemia and hypothermia. -Laboratory testing included glucose testing and glucometers two times. -The FSBSs were not documented. -Vital signs were documented as blood pressure 115/66, pulse 62, respirations 18, temperature 98.3 F. -Glucagon was administered. <p>Review of Resident #5's I/A report dated 07/01/25 revealed:</p> <ul style="list-style-type: none"> -The event date was 07/01/25 at 6:11am. -The description was medical at 6:11am in the resident's room. -The type of incident was described as medical-hypoglycemia. -The location of the incident was the resident's room. -The incident was witnessed by a staff member. -The resident was not alone. -The description was documented as the resident 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 63</p> <p>was lying on the bed not responding to staff's efforts to arouse him.</p> <ul style="list-style-type: none"> -The resident exhibited negative outcome, he was difficult to arouse. -First aid was not administered. -The resident's FSBS was checked and was 71, administered glucose gel while waiting on EMS to arrive. -Level of Consciousness was documented as will arouse when name called. -The resident was transported to the ED via EMS on 07/01/25 at 6:25am. -The status of the resident after ED discharge was hypoglycemia, no new orders, follow-up with PCP at next visit. -The resident's PCP and responsible party (RP) were notified. -His vital signs were documented as FSBS 71. <p>Review of Resident #5's ED after visit summary dated 07/01/25 revealed:</p> <ul style="list-style-type: none"> -The reason for the visit was hypoglycemia. -The diagnoses for the visit were hypoglycemia, acute kidney injury, hypokalemia, anemia, and hypothermia. -Laboratory testing included glucose glucometer times two. -FSBSs were not documented. -The resident was to follow up with his PCP. -The resident was scheduled to see a nephrologist on 07/09/25 at 2:00pm. <p>Review of Resident #5's I/A report dated 07/06/25 revealed:</p> <ul style="list-style-type: none"> -The event date was 07/06/25 at 5:30am. -The description was medical 07/06/25 at 5:30am in the resident's room. -The type of incident was described as medical-hypoglycemia. -The location of the incident was the resident's 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 64</p> <p>room.</p> <ul style="list-style-type: none"> -The incident was witnessed by a staff member. -The description was documented as resident in bed resting, difficult to arouse. -The resident exhibited negative outcome, he was difficult to arouse. -First aid was administered, administered one tube of glucose gel, remained with the resident until EMS arrived, checked blood sugar again and noted that it had dropped again. -Level of Consciousness was documented as will arouse when name called. -The resident was transported to the ED via EMS on 07/06/25 at 6:15am. -The status of the resident after ED discharge was hypoglycemia. -The resident's PCP and RP were notified. -His vital signs were documented as pulse 61, blood pressure 111/56, FSBS 50. <p>Review of Resident #5's ED after visit summary dated 07/06/25 revealed:</p> <ul style="list-style-type: none"> -The reason for the visit was hypoglycemia. -The diagnoses for the visit included hypoglycemia, chronic anemia, renal insufficiency, and hypokalemia. -He was to decrease his nighttime dose of Lantus insulin from 20 units to 10 units, discontinue metformin, do not skip meals and was started on potassium chloride. -He was to follow up with his PCP and keep the nephrology appointment on 07/09/25 at 2:00pm. <p>Review of Resident #5's I/A report dated 07/29/25 revealed:</p> <ul style="list-style-type: none"> -The event date was 07/29/25 at 5:20am. -The description was medical 07/29/25 at 5:20am in the resident's room. -The type of incident was described as hypoglycemia. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 65</p> <ul style="list-style-type: none"> -The location of the incident was the resident's room. -The incident was witnessed by a staff member. -The description documented was resident lying in bed, exhibiting signs of lethargy. -First aid was administered, checked glucose level and administered glucose gel. -Level of Consciousness was cut off on the first page. -The resident was transported to the ED via EMS on 07/29/25 at 5:51am. -The status of the resident after ED discharge was hypoglycemia. -The resident's PCP and RP were notified. -There were no vital signs documented. <p>Review of Resident #5's hospital discharge summary dated 07/30/25 revealed:</p> <ul style="list-style-type: none"> -The chief complaint was hypoglycemia, the facility reported the resident's FSBS was in the 50s and was given 24 grams of oral glucose, EMS gave two more tubes of oral glucose, getting the FSBS up to 67. -The admitting diagnosis was acute kidney injury. -History of present illness, resident with a history of insulin dependent diabetes (on Lantus and Novolog), hypertension, stage 4 chronic kidney disease, and Alzheimer's dementia, it was noted at the facility that his FSBS was in the 50s, EMS gave two tubes of oral glucose, with a subsequent FSBS of 67. -The resident was unable to provide any history due to dementia. -This morning, the resident was unable to contribute to history, per the nursing staff, the resident was well known to staff and severe dementia was at about baseline. -Overnight the resident was agitated and required multiple medications. -This am, he was calmer. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 66</p> <ul style="list-style-type: none"> -Overnight FSBSs were a bit elevated. -His vital signs were stable. -Hospital course, the resident was treated with intravenous fluids, his blood pressure medications and diuretics were held, his FSBS improved, his acute kidney injury and chronic kidney disease improved toward baseline, he was tolerating oral intake and was considered at or close to baseline and discharged. -He underwent a renal ultrasound, and the results were forwarded to his PCP and nephrologist. <p>Interview with a medication aide (MA) on 08/07/25 at 1:36pm revealed:</p> <ul style="list-style-type: none"> -She worked from 7:00am to 7:00pm as a MA. -She knew Resident #5's blood sugar fluctuated, and he had to go out to the ED for low blood sugar in the past. -She never had to send Resident #5 out on her shift for hypoglycemia, she had to send Resident #1 out on one occasion for low blood pressure. -Resident #5's FSBS usually ran high. -She did not record the number of insulin aspart units administered because the eMAR did not prompt her to do so. -It had not occurred to her to record the number of insulin aspart units administered. -She did not record the insulin injection site on Resident #5's eMAR because the system did not prompt her to do so, -She always administered Resident #5's insulin aspart per the guidelines of his sliding scale orders. <p>Interview with a second MA on 08/07/25 at 3:52pm revealed:</p> <ul style="list-style-type: none"> -She administered Resident #5's insulin aspart per the sliding scale order. -Resident #5's FSBSs were always documented -There was no place on the eMAR to document 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 67</p> <p>the number of insulin apart units administered until today. -She had never recorded the number of insulin aspart units administered to Resident #5 on the eMAR.</p> <p>Interview with the Nurse Consultant on 08/07/25 at 1:27pm revealed: -She was not aware there was no space for the MAs to document the number of insulin units administered or the injection site on the eMAR. -She had discussed with an Administrator from another facility and there was a box on the eMAR that could be checked to "customize" the eMAR entry for insulin to allow for the number of units of insulin to be recorded and the injection site to be documented. -Either the pharmacy or the Special Care Unit Coordinator (SCUC) could add the space to the eMAR to allow documentation of insulin units administered. -The number of units of insulin units administered was important to ensure the residents received the accurate dose of insulin ordered.</p> <p>Interview with the SCUC on 08/07/25 at 5:23pm revealed: -She performed audits of the residents eMARS monthly. -The eMAR audits consisted of making sure the residents were receiving their medications as ordered. -She reviewed Resident #5's eMAR for high and low FSBs and provided his PCP with this information -She was not aware there was not a space on the eMARs for the MAs to document the number of insulin units administered until today. -She thought until today that the pharmacy was responsible for building the space to document</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 68</p> <p>the number of insulin units administered on the eMAR.</p> <p>-She performed an eMAR audit last week and had not considered that there was no place on the eMAR for the MAs to document the number of sliding scale insulin units administered to Resident #5.</p> <p>-It was important that Resident #5 receive the correct amount of insulin, as too much insulin could cause his blood sugar to be too low and not enough insulin could cause his blood sugar to be too high.</p> <p>-She knew Resident #5 had several ED visits last month for hypoglycemia and his insulin orders had changed several times.</p> <p>-She was not sure why there were several days in July when Resident #5 did not receive sliding scale insulin at all.</p> <p>-Resident #5 was previously seen by a VA provider and it was almost impossible to contact the VA provider.</p> <p>Interview with the Administrator on 08/07/25 at 5:50pm revealed:</p> <p>-She thought the MAs were to always document the number of insulin units administered.</p> <p>-She was not aware that there was no space on the eMAR to document sliding scale insulin units administered.</p> <p>-It was important to document all insulin units administered to make sure the residents received their insulin dose as ordered.</p> <p>-The SCUC did eMAR audits weekly to make sure the residents received their medications as ordered.</p> <p>-If there were any questions on the eMARs or about a resident's medication orders, the MAs were to notify the SCUC or her.</p> <p>-The SCUC was responsible to make sure the MAs administered medications as ordered.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 69</p> <p>Interview with the facility's contracted primary care provider (PCP) on 08/07/25 at 3:35pm revealed:</p> <ul style="list-style-type: none"> -She treated Resident #5 when he was first admitted to the facility last spring of 2025 and thought it was probably April 2025 since she last saw him. -Resident #5 was being treated by a VA PCP and she was notified last week that his RP wanted him to resume care with her, and she saw him back for the first time today, 08/07/25. -Resident #5 was an insulin dependent diabetic and required monitoring of his blood sugars. -She was aware that Resident #5's FSBSs fluctuated and that he had been on sliding scale insulin as well as long-acting insulin. -She was made aware of Resident #5's recent ED visits for hypoglycemia. -She was working on trying to get Resident #5 off sliding scale insulin. -It was very important that the number of sliding scale insulin units administered to Resident #5 be recorded to make sure he received the appropriate dosage of insulin. -Too much insulin could cause his blood sugar to bottom out leading to hypoglycemia. -Too little insulin could cause poor control of elevated blood sugars. -The acute effects of elevated blood sugar and low blood sugar could result in increased thirst, sweating, behavioral changes, dizziness, passing out, seizure activity, weakness, combativeness and disorientation -The long-term effects of elevated blood sugar included kidney damage, heart damage, and neuropathy. -It was also important to document the insulin injection sites and to rotate the injection sites to prevent tissue damage to the injection site areas. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 70</p> <p>Attempted telephone interview with Resident #5's VA PCP on 08/07/25 at 2:10pm was unsuccessful.</p> <p>[Refer to Tag 367, 10A NCAC 13F .1004(j) Medication Administration]</p> <p>b. Review of Resident #5's Pharmacist Drug Review dated 05/13/25 revealed:</p> <ul style="list-style-type: none"> -Provider: please see the recommendations and respond according to recommendations. -The resident has an order for tolterodine (used to treat over active bladder) XR 4mg, once daily for overactive bladder. -Tolterodine, a BEERS list (the BEERS list is a list of medications that are considered potentially inappropriate for older adults) medication, has strong, sedating anticholinergic properties and should be avoided for use in older adults. -Recommend changing to a beta-3 adrenergic receptor agonist such as mirabegron (Myrbetriq) (also used to treat overactive bladder) 25mg daily (may increase to 50mg daily within 4-6 weeks based on response). -Beta-3 adrenergic receptor agonists do not have anticholinergic properties, making them ideal overactive bladder options for the elderly. -Please consider discontinuing tolterodine and instead start Myrbetriq 25mg, one daily for overactive bladder. -Discontinue tolterodine. -Start Myrbetriq (generic is mirabegron) 25mg, one every day for overactive bladder. -The facility's contracted primary care provider (PCP) documented "accept recommendation" and signed the Pharmacist Drug Review on 05/22/25. <p>Review of Resident #5's prescription order dated</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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(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	<p>Continued From page 71</p> <p>05/27/25 revealed: -There was an order for mirabegron extended release 24 hour, 25mg, take one tablet once daily for overactive bladder. -The prescription order for mirabegron was electronically signed by the facility's contracted PCP on 05/27/25. -The start date was documented as 05/28/25.</p> <p>Review of Resident #5's signed prescription order dated 06/17/25 revealed: -Tolterodine capsule extended release 24 hour, 4mg, take one capsule at bedtime was ordered on 06/17/25. -There was a discontinue date for tolterodine 4mg of 07/17/25 and was electronically signed by Resident #5's VA provider on 07/17/25.</p> <p>Review of Resident #5's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for tolterodine capsule, extended release 24 hour, 4mg, take one capsule at bedtime for overactive bladder scheduled at 8:00pm. -There was documentation that tolterodine 4mg was administered at 8:00pm on 05/01/25 through 05/28/25 with an end date of 05/28/25. -There was an entry for mirabegron extended release 24 hour, 25mg, take one tablet once daily for overactive bladder scheduled at 8:00am with a start date of 05/28/25. -Mirabegron 25mg was documented as administered at 8:00am on 05/29/25 and 05/30/25. -Mirabegron 25mg was documented as not administered at 8:00am on 05/31/25 with the exception documented as "on hold".</p> <p>Review of Resident #5's June 2025 eMAR</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 72</p> <p>revealed:</p> <ul style="list-style-type: none"> -There was an entry for tolterodine capsule, extended release 24 hour, 4mg, take one capsule at bedtime for overactive bladder scheduled at 8:00pm with a start date of 06/10/25. -There was documentation that tolterodine 4mg was administered at 8:00pm on 06/12/25 through 06/16/25. -There was second entry for tolterodine 4mg capsule, extended release 24 hour, 4mg take one capsule at bedtime for overactive bladder scheduled at 8:00pm with a start date of 06/16/25. -There was documentation that tolterodine 4mg was administered at 8:00pm 06/17/25 through 06/30/25. -There was an entry for mirabegron tablet extended release 24 hour, 25mg, take one tablet once daily for overactive bladder scheduled at 8:00am. -Mirabegron 25mg was documented as not administered at 8:00am on 06/01/25 through 06/04/25 with the exception documented as "on hold". -Mirabegron 25mg was documented as administered at 8:00am on 06/05/25 and 06/06/25. -Mirabegron 25mg was documented as not administered at 8:00am on 06/07/25 with the exception documented as "resident unavailable". -Mirabegron 25mg was documented as administered at 8:00am on 06/08/25 through 06/22/25. -Mirabegron 25mg was documented as not administered at 8:00am on 06/23/25 with the exception documented as "on hold". -Mirabegron 25mg was documented as administered at 8:00am on 06/24/25 through 06/26/25. -Mirabegron 25mg was documented as not 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	<p>Continued From page 73</p> <p>administered at 8:00am on 06/27/25 with the exception documented as "on hold".</p> <p>-Mirabegron 25mg was documented as administered at 8:00am on 06/28/25 through 06/30/25.</p> <p>-Tolterodine 4mg and Mirabegron 25mg were both administered to Resident #5 on 17 occasions in June 2025.</p> <p>Review of Resident #5's July 2025 eMAR revealed:</p> <p>-There was an entry for tolterodine capsule, extended release 24 hour,4mg, take one capsule at bedtime for overactive bladder scheduled at 8:00pm with end date of 07/17/25.</p> <p>-Tolterodine 4mg was documented as administered at 8:00pm on 07/01/25 through 07/16/25.</p> <p>-There was an entry for mirabegron tablet extended release 24 hour, 25mg, take one tablet once daily for overactive bladder, scheduled at 8:00am.</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/01/25 with the exception documented as "resident unavailable".</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/02/25 and 07/03/25 with the exception documented as "on hold".</p> <p>-Mirabegron 25mg was documented at administered at 8:00am on 07/04/25 and 07/05/25.</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/06/25 with the exception documented as "resident at ER".</p> <p>-Mirabegron 25mg was documented as administered at 8:00am on 07/07/25 through 07/14/25.</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/15/25 through</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 74</p> <p>07/18/25 with the exception documented as "on hold".</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/19/25 with the exception documented as "resident unable to take meds".</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/20/25 through 07/22/25 due to resident being hospitalized.</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/23/25 through 07/25/25 with the exception documented as "on hold".</p> <p>-Mirabegron 25mg was documented as administered at 8:00am on 07/26/25 through 07/28/25.</p> <p>-Mirabegron 25mg was documented as not administered at 8:00am on 07/29/25 and 07/30/25 with the exception documented as "resident unavailable".</p> <p>-Mirabegron 25mg was documented as administered at 8:00am on 07/31/25.</p> <p>-Tolterodine 4mg and mirabegron 25mg were both administered to Resident #5 on 11 occasions in July 2025.</p> <p>Review of Resident #5's medications on hand on 08/07/25 at 1:21pm revealed a bubble package of mirabegron 25mg extended release 24 hour, take one tablet once daily for overactive bladder with a dispense date of 07/23/25 for 13 tablets with 4 tablets remaining.</p> <p>Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/07/25 at 1:45pm revealed:</p> <p>-An order for Resident #5 for tolterodine capsules, extended release 24 hour, 4mg, take one capsule at bedtime was received on 03/24/25.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 75</p> <ul style="list-style-type: none"> -Tolterodine 4mg capsules were filled for Resident #5 on 04/30/25 for a quantity of 30 for a 30-day supply to take one capsule at bedtime for overactive bladder. -An order to discontinue Resident #5's tolterodine 4mg capsules was received on 05/27/25. -An FL2 form dated 06/16/25 was received for Resident #5 with an order for tolterodine 4mg, take one at bedtime. -Tolterodine extended release 24 hour, 4mg were dispensed for Resident #5 on 06/16/25 for a quantity of 30 for a 30-day supply to take one capsule at bedtime for overactive bladder. -An order was received for Resident #5 for mirabegron extended release 24 hour, 4mg tablets to take one daily for overactive bladder on 05/27/25. -Mirabegron 4mg tablets were dispensed for Resident #5 on 06/02/25 for a quantity of 13 tablets for a 13-day supply and on 07/23/25 for a quantity of 13 tablets for a 13-day supply. <p>Interview with a medication aide (MA) on 08/06/25 at 2:28pm revealed:</p> <ul style="list-style-type: none"> -The Special Care Unit Coordinator (SCUC) processed all the residents' orders. -If a medication was discontinued for a resident, the SCUC notified the MA, and the discontinued medication was pulled from the medication cart. -If a medication was unavailable for resident, it was usually because they were waiting for the medication to arrive from the pharmacy. -When a medication was not available for administration to a resident, it was usually documented on the eMAR as "on hold". -Resident #5's medications were previously ordered through the VA and sent to his RP, and his RP brought the medications to the facility and there were sometimes delays in getting his medication refills. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 76</p> <p>Interview with a second MA on 08/07/25 at 2:35pm revealed:</p> <ul style="list-style-type: none"> -The MAs or the SCUC could request medication refills for the residents. -The MAs did weekly medication cart audits which consisted of comparing the medications to the physician's orders. -Medications sometimes did not arrive from the pharmacy because they were waiting on a new prescription. -If a medication was not available for administration for a resident, "on hold" was documented on the eMAR. <p>Interview with the SCUC on 08/07/25 at 2:56pm revealed:</p> <ul style="list-style-type: none"> -She processed all medication orders for the residents. -She gave the facility's contracted PCP, Resident #5's Pharmacist Drug Review dated 05/13/25 with the pharmacy recommendations to review. -The facility's contracted PCP reviewed and signed Resident #5's Pharmacist Drug Review form dated 05/13/25 and she faxed it to the pharmacy with the order changes to discontinue tolterodine and to start mirabegron. -Resident #5 was previously treated by a provider with the VA until this week. -The 05/13/25 Pharmacist Review Form was not sent to Resident #5's VA provider because it had already been reviewed and signed by the facility's contracted PCP. -Resident #5's VA provider signed a new FL2 for Resident #5 on 06/16/25 with a medication list. -She was not sure why the tolterodine showed back up on the eMAR in June and July after it had been discontinued in May but thought the tolterodine was re-ordered for Resident #5 from his updated FL2 dated 06/16/25. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 77</p> <ul style="list-style-type: none"> -She thought the tolterodine order was a duplicate order. -If a medication expired or needed a refill, the resident's PCP was contacted for refills either by the pharmacy, herself or the MAs. -If a medication was not available for administration to a resident, the MAs documented "on hold" on the eMAR while waiting for the medication to arrive from the pharmacy. -When the residents' medications arrived, the medication pill pack was checked against the eMAR and placed on the medication cart. -Resident #5's medications came through the VA and were sent to his responsible party (RP) and his RP brought his medications to the facility and that was probably why Resident #5's mirabegron was documented as "on hold" on the May, June and July eMAR. -She and the MAs were responsible for making sure medications were available and on the medication cart for the residents. -She performed eMAR audits once a month to make sure medications were available and matched the PCP's orders. <p>Interview with the Administrator on 08/07/25 at 5:50pm revealed:</p> <ul style="list-style-type: none"> -The SCUC was responsible for processing all orders for the residents. -The SCUC was responsible to verify and clarify all PCP orders for the residents including new medication orders and discontinued medication orders. -The SCUC and the MAs were responsible to make sure all medications were on the medication cart and available for administration. -The SCUC was responsible for eMAR audits weekly to make sure medications were administered as ordered and the eMARs were accurate. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 78</p> <ul style="list-style-type: none"> -The MAs were responsible for medication cart audits at least once a week to make sure medications were available for the residents. <p>Interview with the facility's contracted PCP on 08/07/25 at 3:35pm revealed:</p> <ul style="list-style-type: none"> -She had treated Resident #5 when he was first admitted to the facility last spring of 2025 and thought it was probably April 2025 since she last saw him. -Resident #5 was being treated by a VA PCP and she was notified last week that his responsible party (RP) wanted him to resume care with her, and she saw him back for the first time today, 08/07/25. -She signed Resident #5's Pharmacist Drug Review form with the recommendations to discontinue tolterodine 4mg and to start mirabegron 25mg. -Tolterodine and mirabegron were used to treat overactive bladder. -Taking both tolterodine and mirabegron could cause urinary retention or being unable to void. -Symptoms of urinary retention included fullness or feeling of pressure in the bladder, lower abdominal pain and discomfort and could possibly lead to an emergency department visit for in and out catheterization. -Resident #5 should not have received two medications for overactive bladder. <p>Attempted telephone interview with Resident #5's VA PCP on 08/07/25 at 2:10pm was unsuccessful.</p> <p>c. Review of Resident #5's current FL2 dated 06/16/25 revealed an order for trazodone (used to treat insomnia, depression and anxiety) 50mg, take one tablet at bedtime for insomnia associated with depression.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 79</p> <p>Observation of Resident #5's medications on hand on 08/07/25 at 1:21pm revealed there were no trazodone 50mg tablets available for Resident #5.</p> <p>Telephone interview with a pharmacist with the facility's contracted pharmacy on 08/07/25 at 1:45pm revealed: -An order was received for trazodone 50mg for Resident #5 on 06/16/25 to take one tablet at bedtime. -30 tablets of trazodone 50mg were dispensed for Resident #5 on 07/04/25 to take one tablet at bedtime for a 30-day supply. -A refill request had been received today 08/07/25 from the facility for trazodone 50mg for Resident #5 and would be filled for a quantity of 30 for a 30-day supply to take one tablet at bedtime.</p> <p>Review of Resident #5's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for trazodone 50mg, take one tablet at bedtime, scheduled for 8:00pm. -Trazodone 50mg was documented as not administered at 8:00pm on 08/01/25 with the exception documented as "on hold". -Trazodone 50mg was documented as administered at 8:00pm on 08/02/25 through 08/04/05.</p> <p>Interview with the medication aide (MA) on 08/06/25 at 2:28pm revealed medication cart audits were done weekly by the MAs when new medications arrived to compare the medications to the physicians' orders and to make sure all the residents' medications were on the medication cart.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 80</p> <p>Second interview with the MA on 08/07/25 at 1:25pm revealed:</p> <ul style="list-style-type: none"> -The MAs or the Special Care Unit Coordinator (SCUC) requested medication refills for the residents. -The MAs ordered medication refills for the residents when the medication got low, about a week supply remaining. -She usually requested Resident #5's medications 2 weeks in advance because Resident #5's medications were ordered through the VA and sent to his responsible party (RP) and his RP brought his medications to the facility. -She worked from 7:00am to 7:00pm and did not administer trazodone to Resident #5 so she had not noticed his trazodone was out. <p>Interview with the SCUC on 08/07/25 at 2:56pm revealed:</p> <ul style="list-style-type: none"> -She and the MAs could request refills for the residents. -Medications should be ordered in advance so the residents did not run out of their medications. -Resident #5's medications were provided through the VA. -Resident #5 ran out of trazodone 50mg on Tuesday 08/05/25. -She tried to request a 30-day supply of trazodone 50mg for Resident #5 through the facility's contracted pharmacy yesterday but had not received it. -She contacted the facility's back up pharmacy today and Resident #5's trazodone should be delivered to the facility later today. -She and the MAs performed weekly medication cart audits to compare the residents' medications to the eMAR and the physicians orders to make sure medications were available for administration. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 358	<p>Continued From page 81</p> <p>Interview with the Administrator on 08/07/25 at 5:50pm revealed:</p> <ul style="list-style-type: none"> -The SCUC and the MAs were responsible to make sure all medications were on the medication cart and available for administration. -The MAs were responsible for medication cart audits at least once a week to make sure medications were available for the residents. <p>Interview with the facility's contracted PCP on 08/07/25 at 3:35pm revealed:</p> <ul style="list-style-type: none"> -She had treated Resident #5 when he was first admitted to the facility last spring of 2025 and thought it was probably April 2025 since she last saw him. -Resident #5 was being treated by a VA PCP and she was notified last week that his RP wanted him to resume care with her, and she saw him back for the first time today, 08/07/25. -Trazodone was prescribed for Resident #5 for insomnia. -Going consecutive nights without trazodone could cause Resident #5 to experience poor sleep. <p>Attempted telephone interview with Resident #5's VA PCP on 08/07/25 at 2:10pm was unsuccessful.</p> <hr/> <p>The facility's failure to ensure medications were administered as prescribed resulted in inadequate control of blood glucose with occasions when rapid acting insulin was not documented as administered at all and on other occasions, undetermined amounts of rapid acting insulin were administered. Resident #5 had 4 emergency department visits since June 2025 for hypoglycemia with the most recent visit for hypoglycemia resulting in a diagnosis of acute kidney injury. This failure resulted in neglect of</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 358	Continued From page 82 the resident and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131-34 on 08/07/25 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED SEPTEMBER 06, 2025.	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 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:	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 367	<p>Continued From page 83</p> <p>Based on observations, record reviews, and interviews, the facility failed to ensure the accuracy of the medication administration records (MARs) for 1 of 6 sampled residents (#5,#6) related to documentation of medications used to treat elevated blood glucose(#1), vitamin supplements, and an iron supplement (#6).</p> <p>The findings are:</p> <p>Review of the facility's medication administration policy revised November 2018 revealed:</p> <ul style="list-style-type: none"> -Five rights-right resident, right drug, right dose, right route and right time are applied for each medication administered. -A triple check of these five rights is recommended at three steps in the process of preparation of a medication for administration, when the medication is selected, when the dose is removed from the container, and finally just after the dose is prepared and the medication put away. -Check #1, select the medication, label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. -Check #2, prepare the dose, the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. -Check #3, complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. -The MAR is always employed during medication administration. -Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. -Documentation, current medications, except topicals used for treatments are listed on the 	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 367	<p>Continued From page 84</p> <p>MAR.</p> <p>1. Review of Resident #5's current FL2 dated 06/16/25 revealed: -Diagnoses included diabetes, dementia, hypertension, peripheral vascular disease, hyperlipidemia and neuropathy. -There was an order for insulin aspart (insulin aspart is a rapid acting insulin used to treat elevated blood sugar), sliding scale insulin (SSI) FSBS less than 100 give 0 units, FSBS 100-150 give 5 units, if FSBS greater than 150, give 7 units before meals.</p> <p>Review of Resident #5's Resident Register revealed he was admitted to the facility on 03/29/25.</p> <p>Review of Resident #5's June 2025 electronic medication administration record (eMAR) revealed: -There was an entry for insulin aspart U-100 insulin pen, 100units/ml, (3 ml) inject 5 units before meals, hold/do not administer if glucose less than 100, give 2 additional units (7 units total) for a glucose greater than 150, scheduled at 8:00am, 12:00pm and 5:00pm. -Insulin aspart U-100, 100units/ml was documented as administered on 35 occasions from 06/19/25 through 06/30/25. -There was not a space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was not a space on the insulin aspart eMAR entry to document the injection site. -There was no documentation of the number of units of insulin aspart administered at any time for the month of June 2025.</p> <p>Review of Resident #5's July 2025 eMAR</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 85</p> <p>revealed:</p> <ul style="list-style-type: none"> -There was an entry for insulin aspart U-100 insulin pen, 100units/ml, (3 ml) inject 5 units before meals, hold/do not administer if glucose less than 100, give 2 additional units (7 units total) for a glucose greater than 150, scheduled at 8:00am, 12:00pm and 5:00pm. -There was a second entry for insulin aspart U-100 insulin pen, 100units/ml (3ml) inject per sliding scale, for FSBS less than -There was a third entry for insulin aspart, inject per sliding scale with meals, FSBS less than 100= 0 units, 100-149= 7 units, greater than 150= 9 units with a start date of 07/19/25. -Insulin aspart was documented as administered on 44 occasions from 07/01/25 through 07/31/25. -There was not a space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was not a space on the insulin aspart eMAR to document the injection site. -There was no documentation of the number of units of insulin aspart administered at any time for the month of July 2025. <p>Review of Resident #5's August 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for insulin aspart, inject as directed per sliding scale with meals, for FSBS less than 100= 0 units, for FSBS 100-149= 7 units, for FSBS greater than 150= 9 units scheduled at 7:30am, 11:30am and 5:00pm. -Insulin aspart was documented as administered on 14 occasions from 08/01/25 through 11:30am on 08/05/25. -There was not a space on the insulin aspart eMAR entry to record the number of insulin units administered. -There was not a space on the insulin aspart eMAR entry to document the injection site. 	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 86</p> <p>-There was no documentation of the number of units of insulin aspart administered for the month of August 2025 from 7:30am on 08/01/25 through 11:30am on 08/05/25.</p> <p>Interview with a medication aide (MA) on 08/07/25 at 1:36pm revealed:</p> <p>-She did not record the number of insulin aspart units administered because the eMAR did not prompt her to do so.</p> <p>-It had not occurred to her to record the number of insulin aspart units administered.</p> <p>-She did not record the insulin injection site on Resident #5's eMAR because the system did not prompt her to do so,</p> <p>-She always administered Resident #5's insulin aspart per the guidelines of his sliding scale orders.</p> <p>Interview with a second MA on 08/07/25 at 3:52pm revealed:</p> <p>-She administered Resident #5's insulin aspart per the sliding scale order.</p> <p>-Resident #5's FSBSs were always documented</p> <p>-There was no place on the eMAR to document the number of insulin apart units administered until today.</p> <p>-She had never recorded the number of insulin aspart units administered to Resident #5 on the eMAR.</p> <p>Interview with the Nurse Consultant on 08/07/25 at 1:27pm revealed:</p> <p>-She was not aware there was no space for the MAs to document the number of insulin units administered or the injection site on the eMAR.</p> <p>-She had discussed with an Administrator from another facility and there was a box on the eMAR that could be checked to "customize" the eMAR entry for insulin to allow for the number of units of</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 367	<p>Continued From page 87</p> <p>insulin to be recorded and the injection site to be documented.</p> <p>-Either the pharmacy or the Special Care Unit Coordinator (SCUC) could add the space to the eMAR to allow documentation of insulin units administered.</p> <p>-The number of units of insulin administered was important to ensure the residents received the accurate dose of insulin ordered.</p> <p>Interview with the SCUC on 08/07/25 at 5:23pm revealed:</p> <p>-She performed audits of the residents eMARS monthly.</p> <p>-The eMAR audits consisted of making sure the residents were receiving their medications as ordered.</p> <p>-She was not aware there was not a space on the eMARs for the MAs to document the number of insulin units administered until today.</p> <p>-She thought until today that the pharmacy was responsible for building the space to document the number of insulin units administered on the eMAR.</p> <p>-She performed an eMAR audit last week and had not considered that there was no place on the eMAR for the MAs to document the number of sliding scale insulin units administered to Resident #5.</p> <p>Interview with the Administrator on 08/07/25 at 5:50pm revealed:</p> <p>-She thought the MAs were to always document the number of insulin units administered.</p> <p>-She was not aware that there was no space on the eMAR to document sliding scale insulin units administered.</p> <p>-It was important to document all insulin units administered to make sure the residents received their insulin dose as ordered.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 88</p> <p>Interview with the facility's contracted primary care provider (PCP) on 08/07/25 at 3:35pm revealed:</p> <ul style="list-style-type: none"> -She had treated Resident #5 when he was first admitted to the facility last spring of 2025 and thought it was probably April 2025 since she last saw him. -Resident #5 was being treated by a Department of Veteran's Affairs (VA) PCP and she was notified last week that his RP wanted him to resume care with her, and she saw him back for the first time today, 08/07/25. -She was aware that Resident #5's FSBSs fluctuated and that he had been on sliding scale insulin as well as long-acting insulin. -It was very important that the number of sliding scale insulin units administered to Resident #5 be recorded to make sure he received the appropriate dosage of insulin. -Too much insulin could cause his blood sugar to bottom out leading to hypoglycemia. -Too little insulin could cause poor control of elevated blood sugars. -It was also important to document the insulin injection sites and to rotate the injection sites to prevent tissue damage to the injection site areas. <p>Attempted telephone interview with Resident #5's VA PCP on 08/07/25 at 2:10pm was</p> <p>2. Review of Resident #6's current FL2 dated 07/17/25 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included unspecified dementia, Alzheimer's Disease, and essential hypertension. -Her level of care was Special Care Unit. -The was an order for Vitamin B complex (a vitamin B supplement) tablet, take one tablet once daily. -There was an order for biotin (a vitamin B 7 	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 89</p> <p>supplement) 10mg. take one tablet once daily. -There was an order for calcium carbonate-vitamin D3 (a calcium and vitamin D supplement) 500mg-10mcg tablet, take one tablet once per day. -There was an order for ferrous sulfate (an iron supplement) delayed release, 325mg, take one tablet daily.</p> <p>a. Observation of the 8:00am medication pass on 08/05/25 revealed: -The medication aide (MA) removed a multidose pack of medication from the medication cart for Resident #6 that included one B complex tablet. -The MA poured the medications from Resident #6's multidose pack that included the B complex tablet and administered the medications to Resident #6 with water at 8:55am.</p> <p>Review of Resident #6's signed physicians order sheet dated 07/17/25 revealed an order for B complex, take one tablet once daily.</p> <p>Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed there was no entry for B complex tablet, take one daily.</p> <p>Refer to interview with the MA on 08/06/25 at 2:35pm.</p> <p>Refer to interview with the Nurse Consultant in 08/05/25 at 12:08pm.</p> <p>Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/05/25 at 12:08pm.</p> <p>Refer to second interview with the SCC on 08/07/25 at 5:23pm.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 90</p> <p>Refer to interview with the Administrator on 08/07/25 at 5:50pm.</p> <p>Attempted telephone interview with the facility's contracted pharmacy on 08/05/25 at 12:35pm was unsuccessful.</p> <p>b. Observation of the 8:00am medication pass on 08/05/25 revealed: -The medication aide (MA) removed a multidose pack of medication from the medication cart for Resident #6 that included one biotin 10mg tablet. -The MA poured the medications from Resident #6's multidose pack that included the biotin 10mg tablet and administered the medications to Resident #6 with water at 8:55am.</p> <p>Review of Resident #6's signed physicians order sheet dated 07/17/25 revealed an order for biotin 10mg, take one tablet once daily.</p> <p>Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed there was no entry for biotin 10mg tablet, take one daily.</p> <p>Refer to interview with the MA on 08/06/25 at 2:35pm.</p> <p>Refer to interview with the Nurse Consultant in 08/05/25 at 12:08pm.</p> <p>Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/05/25 at 12:08pm.</p> <p>Refer to second interview with the SCUC on 08/07/25 at 5:23pm.</p> <p>Refer to interview with the Administrator on 08/07/25 at 5:50pm.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 91</p> <p>Attempted telephone interview with the facility's contracted pharmacy on 08/05/25 at 12:35pm was unsuccessful.</p> <p>c. Observation of the 8:00am medication pass on 08/05/25 revealed: -The medication aide (MA) removed a multidose pack of medication from the medication cart for Resident #6 that included one calcium carbonate-vitamin D3 500mg-10mcg tablet. -The MA poured the medications from Resident #6's multidose pack that included the calcium carbonate-vitamin D3 500-10mcg tablet and administered the medications to Resident #6 with water at 8:55am.</p> <p>Review of Resident #6's signed physicians order sheet dated 07/17/25 revealed an order for calcium carbonate-vitamin D3 500mg-10mcg, take one tablet once daily.</p> <p>Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed there was no entry for calcium carbonate-vitamin D3 500mg-10mcg tablet, take one daily.</p> <p>Refer to interview with the MA on 08/06/25 at 2:35pm.</p> <p>Refer to interview with the Nurse Consultant in 08/05/25 at 12:08pm.</p> <p>Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/05/25 at 12:08pm.</p> <p>Refer to second interview with the SCUC on 08/07/25 at 5:23pm.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	<p>Continued From page 92</p> <p>Refer to interview with the Administrator on 08/07/25 at 5:50pm.</p> <p>Attempted telephone interview with the facility's contracted pharmacy on 08/05/25 at 12:35pm was unsuccessful.</p> <p>d. Observation of the 8:00am medication pass on 08/05/25 revealed: -The medication aide (MA) removed a multidose pack of medication from the medication cart for Resident #6 that included one ferrous sulfate delayed release 325mg tablet. -The MA poured the medications from Resident #6's multidose pack that included the ferrous sulfate delayed release 325mg tablet and administered the medications to Resident #6 with water at 8:55am.</p> <p>Review of Resident #6's signed physicians order sheet dated 07/17/25 revealed an order for ferrous sulfate 325mg delayed release, take one tablet once daily.</p> <p>Review of Resident #6's August 2025 electronic medication administration record (eMAR) revealed there was no entry for ferrous sulfate 325mg delayed release tablet, take one daily.</p> <p>Refer to interview with the MA on 08/06/25 at 2:35pm.</p> <p>Refer to interview with the Nurse Consultant in 08/05/25 at 12:08pm.</p> <p>Refer to interview with the Special Care Unit Coordinator (SCUC) on 08/05/25 at 12:08pm.</p> <p>Refer to second interview with the SCUC on 08/07/25 at 5:23pm.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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D 367	<p>Continued From page 93</p> <p>Refer to interview with the Administrator on 08/07/25 at 5:50pm.</p> <p>Interview with the MA on 08/06/25 at 2:35pm revealed:</p> <ul style="list-style-type: none"> -When she scanned Resident #6's multi-dose medication pack, the eMAR system marked the medication as administered. -She had not noticed that Resident #6's b complex, biotin, calcium carbonate with vitamin D3, and ferrous sulfate were not on her eMAR. -If a medication expired or needed a refill, it fell off of the eMAR until it was reordered and had to be approved by the SCC. -She notified the SCUC yesterday that the 4 medications for Resident #6 needed approval. <p>Interview with the Nurse Consultant on 08/05/25 at 12:08pm revealed:</p> <ul style="list-style-type: none"> -When a prescription expired, it fell off of the eMAR and the pharmacy contacted the provider for a new prescription. -Once the new prescription was obtained the medication had to be approved by the SCUC before it appeared back on the resident's eMAR. <p>Interview with the SCUC on 08/05/25 at 12:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #6's primary care provider signed a new FL2 and orders for Resident #6 on 07/17/25. -If a prescription for a medication was expired, it came off of the eMAR. -Once a new prescription for a medication was received by the pharmacy, an alert was sent to her to verify and approve the medication. -Once the medication was verified and approved it was automatically placed back on the eMAR. -She received alerts from the pharmacy when medications needed verification and approval. 	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 367	Continued From page 94 Second interview with SCUC on 08/07/25 at 5:23pm revealed: -When she logged in to the facility's eMAR system, she received alerts if there were medications that needed approval. -She tried to check the eMAR system daily for alerts that medications needed approval but had gotten busy. Interview with the Administrator on 08/07/25 at 5:50pm revealed: -The MAs were to always compare the residents' medications to their eMAR. -If there were any questions about the eMAR or medications, the MAs were to report it to the SCUC or to her. -The SCUC was responsible for approving and verifying orders daily.	D 367		
D 375	10A NCAC 13F .1005 (a) Self-Administration Of Medications 10A NCAC 13F .1005 Self -Administration Of Medications (a) An adult care home shall permit residents who are competent and physically able to self-administer their medications if the following requirements are met: (1) the self-administration is ordered by a physician or other person legally authorized to prescribe medications in North Carolina and documented in the resident's record; and (2) specific instructions for administration of prescription medications are printed on the medication label.	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 375	<p>Continued From page 95</p> <p>This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure 1 of 5 sampled residents (#4) had physicians' orders to self-administer a medication used to treat minor pain.</p> <p>The findings are:</p> <p>Review of the facility's medication administration policy revised November 2018 revealed residents are allowed to self-administer medications when specifically authorized by the attending physician and in accordance with procedures for self-administration of medications</p> <p>Review of the facility's Self Administration of Medication policy revised November 2018 revealed:</p> <ul style="list-style-type: none"> -In order to maintain the residents' high level of independence, residents who desire to self-administer medications are permitted to do so if the facility's interdisciplinary team has determined that the practice would be safe for the resident and other residents of the facility and there is a prescriber's order to self-administer. -If a resident desires to self-administer medications, an assessment is conducted by the interdisciplinary team of the resident's cognitive (including orientation to time), physical, and visual ability to carry out this responsibility during the care planning process. -For those residents who self-administer, the interdisciplinary team verifies the resident's ability to self-administer medications by means of a skill assessment conducted on a quarterly basis or when there is a significant change in condition. -The resident is instructed in the use of the 	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 375	<p>Continued From page 96</p> <p>package, purpose of the medication, reading of the label, and scheduling of the medication dose.</p> <p>-The resident is then requested to read the label on each package and indicate what time the medication should be taken and any other special instructions for use.</p> <p>-The resident is asked to demonstrate the removal of the medication from the package and, in the case of non-solid dosage forms such as an inhaler, to verbalize the steps involved in administration.</p> <p>-The results of the interdisciplinary team assessment of resident's skills and the demonstration regarding bedside storage are recorded in the resident's medical record, on the care plan.</p> <p>-For each medication authorized for self-administration, the label contains notation that it may be self-administered.</p> <p>-If the resident demonstrates the ability to safely self-administer medications, a further assessment of the safety of bedside storage is conducted.</p> <p>-Bedside medication storage is permitted only when it does not present a risk to confused residents who wander into the rooms of, or room with, residents who self-administer.</p> <p>-When the interdisciplinary team determines that bedside or in-room storage of medications would be a safety risk to other residents, the medication of the residents permitted to self-administer are stored in the central medication cart or the medication room, the resident requests each dose from the medication administration personnel ,who provides the medication to the resident in the unopened package for the resident to self-administer, the facility personnel then records such self-administration on the medication administration record (MAR).</p>	D 375		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL008034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 08/07/2025
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NAME OF PROVIDER OR SUPPLIER WINDSOR HOUSE	STREET ADDRESS, CITY, STATE, ZIP CODE 336 SOUTH RHODES AVENUE WINDSOR, NC 27983
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D 375	<p>Continued From page 97</p> <p>Review of Resident #4's current FL-2 dated 04/24/25 revealed: -Diagnoses included dementia, hypertension, renal abdominal aneurysm, heart failure with ejection fraction, chronic obstructive pulmonary disease and peptic ulcer disease. -He was intermittently disoriented. -His level of care was special care unit.</p> <p>Review of Resident #4's Resident Register revealed he was admitted to the facility on 04/18/25.</p> <p>Review of Resident #4's current care plan dated 05/15/25 revealed: -The resident was oriented. -The resident was forgetful and needed reminders. -The resident required supervision with toileting and ambulation. -The resident required limited assistance with eating and transfers. -The resident required extensive assistance with bathing, dressing, and grooming.</p> <p>Observations of Resident #4's room on 08/05/25 at 12:26pm revealed: -There was an unopened 20-count foil pouch containing Salonpas (Salonpas is an over-the-counter medicated patch containing menthol and methyl salicylate, applied directly to the skin to provide temporary relief from minor aches and pains in the muscle and joints) pain relieving patches on the resident's bedside table. -There was also an empty 20-count foil pouch of Salonpas pain relieving patches on the resident's bedside table.</p> <p>Review of Resident #4's signed physician's order sheet dated 06/12/25 revealed</p>	D 375		

Division of Health Service Regulation

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D 375	<p>Continued From page 98</p> <p>-There was no order for Salonpas patches. -There was no self-administer medication order.</p> <p>Review of Resident #4's June 2025 electronic medication administration record (eMAR) revealed there was no entry for Salonpas patches.</p> <p>Review of Resident #4's July 2025 eMAR revealed there was no entry for Salonpas patches.</p> <p>Review of Resident #4's August 2025 eMAR revealed there was no entry for Salonpas patches.</p> <p>A request was made for an order for Salonpas patches and a self-administer order for Resident #4 on 08/06/25 at 8:32am and was not provided.</p> <p>Interview with Resident #4 on 08/05/25 at 2:29pm revealed: -He moved into the facility in mid-April of this year. -He used Salonpas patches for the past two to three years. -He usually put 2 of the Salonpas patches on his right upper arm and one Salonpas patch on his chest for "heart burn". -He left the Salonpas patches on for about 8 hours or until he stopped feeling them working. -A family member took him out shopping frequently and he purchased the Salonpas patches on these shopping trips.</p> <p>Observation of Resident #4 on 08/05/25 at 2:37pm revealed there were 2 beige patches side by side on his right upper arm.</p> <p>Interview with the Administrator on 08/05/25 at</p>	D 375		

Division of Health Service Regulation

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D 375	<p>Continued From page 99</p> <p>4:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #4's sister took him shopping frequently and let him buy whatever he wanted. -Family members have been told to give any non-food items brought in for the residents to staff. -She had a conversation with Resident #4's responsible party yesterday about items that had been found in his room such as shampoo. -She was not aware of the Salonpas patches in Resident #4's room. -Resident #4 did not have a self-administer order. -No residents in the facility had a self-administer order. <p>Interview with a Medication Aide (MA) on 08/07/25 at 11:11am revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not have a self-administer order. -None of the residents in the facility had a self-administration order because it was a memory care facility. -She had never seen Salonpas patches in Resident #4's room. -She was not aware that Resident #4 had Salonpas patches in his room. <p>Interview with a second MA on 08/07/25 at 4:01pm revealed:</p> <ul style="list-style-type: none"> -No residents were allowed to self-administer medications. -She had never seen Salonpas patches in Resident #4's room. -She had never noticed him wearing Salonpas patches. <p>Interview with the Special Care Unit Coordinator (SCUC) on 08/07/25 at 5:23pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not have a self-administer order. -No residents in the facility had self-administration orders. 	D 375		

Division of Health Service Regulation

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D 375	<p>Continued From page 100</p> <p>-She was not aware that Resident #4 had Salonpas patches in his room and applied them until 08/05/25.</p> <p>-The facility was a Special Care Unit, and the residents had cognitive issues and were forgetful.</p> <p>Interview with the Administrator on 08/07/25 at 5:51pm revealed:</p> <p>-No residents ever were allowed to self-administer medications.</p> <p>-The residents were not to have medications or over the counter medications or personal items in their rooms because of the potential to misuse.</p> <p>Interview with Resident #4's primary care provider (PCP) on 08/05/25 at 4:39pm revealed:</p> <p>-Salonpas patches were used for mild back pain and muscle pain.</p> <p>-She did not prescribe Salonpas patches for Resident #4.</p> <p>-She did not give a self-administer order for Resident #4 due to his diagnosis of dementia.</p> <p>-Residents having medications and personal care items in their rooms was a potential hazard because the residents could ingest or misuse the items.</p> <p>-She was not aware until today that Resident #4 had Salonpas patches in his room.</p> <p>-Resident #4 showed the Salonpas patch that he had on his chest and the two Salonpas patches on his upper right arm to her today.</p> <p>Second interview with Resident #4's PCP on 08/07/25 at 3:35pm revealed:</p> <p>-None of the residents in the facility should have self-administer orders.</p> <p>-She never gave a self-administer order for Resident #4.</p> <p>-She spoke with Resident #4 and told him that she could order the Salonpas patches for staff to</p>	D 375		

Division of Health Service Regulation

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D 375	Continued From page 101 administer if he felt he needed them but that he could not keep them in his room.	D 375		