DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0004 SS = F	Develop EP Plan, Review and Update Annually CFR(s): 483.73(a) §403.748(a), §416.54(a), §418.113(a), §441.184(a), §460.84(a), §482.15(a), §483.73(a), §483.475(a), §484.102(a), §485.68(a), §485.542(a), §485.625(a), §485.727(a), §485.920(a), §486.360(a), §491.12(a), §494.62(a). The [facility] must comply with all applicable Federal, State and local emergency preparedness requirements. The [facility] must develop establish and maintain a comprehensive emergency preparedness program that meets the requirements of this section. The emergency preparedness program must include, but not be limited to, the following elements: (a) Emergency Plan. The [facility] must develop and maintain an emergency preparedness plan that must be [reviewed], and updated at least every 2 years. The plan must do all of the following: * [For hospitals at §482.15 and CAHs at §485.625(a):] Emergency Plan. The [hospital or CAH] must comply with all applicable Federal, State, and local emergency preparedness requirements. The [hospital or CAH] must develop and maintain a comprehensive emergency preparedness program that meets the requirements of this section, utilizing an all-hazards approach. * [For LTC Facilities at §483.73(a):] Emergency Plan. The LTC facility must develop and maintain an emergency preparedness plan that must be reviewed, and updated at least annually. * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years.	E0004	1. Corrective action for affected residents The facility immediately completed a comprehensive review of the Emergency Preparedness Plan, including the all-hazards risk assessment, communication plan, evacuation procedures, shelter-in-place protocols, and emergency contact lists. The plan was reviewed, updated, and signed by the Administrator and Director of Nursing on 1.20.26. 2. Identification of other residents This deficiency had the potential to affect all residents. No resident-specific harm occurred. The corrective action applies to facility wide. 3. Measures to prevent recurrence The Emergency Preparedness Plan has been added to the facility’s annual regulatory compliance calendar and will be updated as needed with management changes throughout the calendar year. Responsibility for annual review has been assigned to the Administrator with secondary oversight by the Director of Nursing. Emergency preparedness review will be included in the facility’s QAPI agenda each month. 4. Monitoring The Regional Vice President of Operations will verify annual completion and signature of the Emergency Preparedness Plan. Compliance will be reviewed monthly through QAPI, with no stop date of monthly reviews and auditing. 5. Completion date 2.3.26	02/03/2026

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See reverse for further instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E0004 SS = F	Continued from page 1 . This STANDARD is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to review and update their emergency preparedness plan annually. The deficient practice had the potential to affect all residents residing in the facility. Findings included: Review of the emergency preparedness plan provided by the facility revealed the last time the plan was signed as reviewed was 9/15/24. During an interview on 1/8/26 at 9:00 AM the Administrator stated she started working at the facility on 12/15/25. She stated she had not had the opportunity to review the emergency preparedness plan as her attention had been pulled elsewhere during her time in the facility. She stated she was not aware it had not been reviewed or updated since September of 2024 and could not speak to why the previous administration had not reviewed the emergency preparedness plan since September 2024 as they should have.	E0004		
F0000	INITIAL COMMENTS The survey team entered the facility on 1/4/26 to conduct a recertification and complaint investigation survey and exited on 1/8/26. Additional information was obtained on 1/13/26. Therefore, the exit date was 1/13/26. Event ID#1DF8C1-H1. The following intakes were investigated 2695980, 2662590 , 2646635, 2640798, and 2613255 . 7 of the 19 complaint allegations resulted in a deficiency.	F0000		02/02/2026
F0552 SS = D	Right to be Informed/Make Treatment Decisions CFR(s): 483.10(c)(1)(4)(5) §483.10(c) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including: §483.10(c)(1) The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.	F0552	1. Corrective action for affected resident For Resident #54, nursing leadership reviewed the medical record and made documented attempts to contact the Responsible Party (RP). Once contact was established, the RP was informed of the purpose, risks, benefits, and alternatives to the psychotropic medications. Consent was obtained and documented in the medical record. This was completed on 01/6/2026. Resident and resident representative had no ill effects. 2. Identification of other residents	02/03/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0552 SS = D	Continued from page 2 §483.10(c)(4) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care. §483.10(c)(5) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers. This REQUIREMENT is NOT MET as evidenced by: Based on record review, staff and Nurse Practitioner (NP) interview, the facility failed to obtain consent and inform the resident's Responsible Party (RP) of the risks and benefits of psychotropic medications prior to initiation or the treatment alternatives available. The deficient practice was identified for 1 of 5 residents reviewed for unnecessary medications (Resident #54). Findings included: Resident #54 was admitted to the facility on 8/13/25 with diagnoses that included stroke and non-Alzheimer's dementia. Review of Resident #54's physician orders revealed: - Mirtazapine (antidepressant) 7.5 mg, 1 tablet to be given by mouth at bedtime for depression with a start date of 10/7/25. - Trazodone (antidepressant) oral tablet 100 milligram (mg), 1 tablet to be given by mouth in the afternoon for depression with a start date of 11/13/25. Resident #54's quarterly Minimum Data Set (MDS) Assessment dated 11/29/25 indicated she was severely cognitively impaired, had no behaviors and received antidepressant medications. Resident #54's Medication Administration Record for January 2026 revealed the Mirtazapine and Trazodone were initialed by a nurse indicating they had been administered daily. Resident #54's medical record revealed no information	F0552	Continued from page 2 All residents on psychotropic medications have the potential to be affected. A facility-wide audit of all residents receiving psychotropic medications was conducted on 01/29/26 to ensure informed consent documentation was present. Any missing consents were immediately addressed. Any identified concern noted was immediately corrected. A psychotropic medication consent UDA assessment has been implemented. 100% audit completed on all residents on psychotropic medications have confirmed/verified consent. Any issues noted were corrected immediately. The audit was completed by 01/29/26. No further issues were identified. 3. Measures to prevent recurrence All Nursing staff/Agency staff completed 100% education regarding this policy. All licensed nursing staff are responsible for ensuring consent is obtained prior to initiation of psychotropic medications. Nursing staff, social services, and providers were re-educated on consent requirements before or by 2/2/.26. Agency staff will be educated prior to the start of their shift and new hires during orientation. New or changed psychotropic orders are reviewed 5x a week via the PCC Dashboard, order listing report by DON/Designee and consent verification is obtained prior to administration. 4. Monitoring The DON or designee will audit all new/changed psychotropic medication consents weekly for four weeks, then monthly for three months. Results will be reviewed in QAPI. 5. Completion date 02/03/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0552 SS = D	Continued from page 3 indicating her RP was informed in advance of the risks and benefits of initiating treatment with Trazodone and Mirtazapine or the treatment alternatives available or that consent was obtained. Attempts to reach Resident #54’s RP were unsuccessful. In an interview with the Assistant Director of Nursing (ADON) on 1/7/26 at 3:44 PM she stated she was unsure who was responsible for obtaining consent for the use of psychotropic medications. During an interview with the Director of Nursing (DON) on 1/7/26 at 3:53 PM she stated that she had been aware that some consents for psychotropic medications were not signed because the Social Worker (SW) had previously been responsible for obtaining the consents, but nursing had not always informed the SW when a new psychotropic medication was ordered. During an interview with the SW on 1/7/26 at 4:02 PM, she stated she had been responsible for obtaining consents for psychotropic medication until recently. The SW explained that nursing staff were expected to notify her whenever a new psychotropic medication order was issued; however, this did not always occur, resulting in some missed consents. In an interview with the Nurse Practitioner (NP) on 1/7/26 at 4:15 PM, she stated nursing staff were responsible for obtaining consent for the use of newly prescribed psychotropic medications. During an interview with the Administrator on 1/8/26 at 9:54 AM, she stated she had not been aware Resident #54 lacked a signed consent for the psychotropic medications Trazodone and Mirtazapine. She further stated that she had been aware consents should have been obtained prior to the implementation of the medications.	F0552		
F0576 SS = C	Right to Forms of Communication w/ Privacy CFR(s): 483.10(g)(6)-(9) §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where	F0576	1. Corrective action for affected residents Mail delivery procedures were corrected to ensure mail is collected and delivered to residents, including weekends. Manager on Duty scheduled for Saturday, January 31, 2026, has been re-educated that the MOD is	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0576 SS = C	Continued from page 4 calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense. §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to: (i) A telephone, including TTY and TDD services; (ii) The internet, to the extent available to the facility; and (iii) Stationery, postage, writing implements and the ability to send mail. §483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to: (i) Privacy of such communications consistent with this section; and (ii) Access to stationery, postage, and writing implements at the resident's own expense. §483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research. (i) If the access is available to the facility (ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident. (iii) Such use must comply with State and Federal law. This REQUIREMENT is NOT MET as evidenced by: Based on interviews with residents and staff, the facility failed to ensure residents' right to receive mail delivered on Saturdays. This had the potential to affect 67 of 67 residents in the facility. The findings included:	F0576	Continued from page 4 responsible for collecting, sorting and mail distributions to our residents on Saturday. 2. Identification of other residents All residents were potentially affected. No resident harm or ill effects occurred. 3. Measures to prevent recurrence Weekend managers are now responsible for collecting, sorting and delivering mail on weekends. Managers on Duty will be re-educated before or by 2.2.26. When the manager on duty collects mail from the mailbox of Saturday's deliveries. The manager on duty will record residents' names that has mail to be delivered in manager on duty book and deliver mail directly to the resident. A written mail distribution procedure was implemented, and education was provided to staff assigned to Manager on Duty mail delivery. This was completed before or by 2.2.26. Alert and oriented residents were educated on the weekend mail delivery process on 1.29.26 by the social worker and business office manager. Manager on Duty will collect and distribute mail on Saturdays. 4. Monitoring The Administrator will conduct random audits of mail delivery for weekends, + once a week for four weeks, then monthly for three months. Results will be reviewed through the monthly QAPI process. 5. Completion date 2.2.26	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER: Windsor Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1306 South King Street , Windsor, North Carolina, 27983	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0576 SS = C	Continued from page 5 During a Resident Council meeting on 1/6/26 at 1:00 PM, members reported that mail was not delivered on Saturdays. Residents present included #71, #14, #19, #56, and #62. They stated that the Activities Director delivered mail Monday through Friday and only on Saturdays if she was in the facility. An interview was conducted on 1/6/26 at 1:16 PM with the Activities Director and she stated that on weekends, the manager on duty retrieved mail from the outdoor mailbox and placed it in the Business Office Manager's office. However, mail was not delivered to residents' rooms on Saturdays. The mail was given to her on Monday for delivery to residents. An interview was conducted with the Business Office Manager on 1/6/26 at 1:25 PM and she confirmed that weekend managers retrieved mail but did not distribute it because they were unsure which mail belonged to residents. She stated that managers gave the mail to her, and she passed it to the Activities Director on Mondays for delivery. An interview was conducted with the Administrator on 1/6/26 at 1:30 PM, she stated that her expectation was for staff to deliver mail Monday through Saturday, including Saturdays, by the manager on duty.	F0576		
F0580 SS = D	Notify of Changes (Injury/Decline/Room, etc.) CFR(s): 483.10(g)(14)(i)-(iv)(15) §483.10(g)(14) Notification of Changes. (i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is- (A) An accident involving the resident which results in injury and has the potential for requiring physician intervention; (B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications); (C) A need to alter treatment significantly (that is, a	F0580	1. Corrective action for affected residents For Resident #51, nursing leadership reviewed medication availability processes and notified the medical provider when the issue was identified. No ill effects noted. For Resident #78, nursing leadership reviewed wound documentation and ensured RP notification procedures were reinforced. No ill effects noted. 2. Identification of other residents A facility-wide audit was conducted to identify residents with missed doses, unavailable medications, or new skin issues to ensure provider and RP notification was completed. This audit was completed on 01/30/2026. Any discrepancies were immediately	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 6 need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or (D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii). (ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician. (iii) The facility must also promptly notify the resident and the resident representative, if any, when there is- (A) A change in room or roommate assignment as specified in §483.10(e)(6); or (B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section. (iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s). §483.10(g)(15) Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9). This REQUIREMENT is NOT MET as evidenced by: Based on record review, and Medical Director, Nurse Practitioner (NP), staff and Responsible Party (RP) interviews, the facility failed to notify the physician/medical provider when an ordered medication was unavailable for administration (Resident #51) and failed to notify the resident's RP when a deep tissue pressure injury (DTI) developed on his right heel (Resident #78) for 2 of 3 residents reviewed for notification of changes (Resident #51 and Resident #78).	F0580	Continued from page 6 identified and corrected. 3. Measures to prevent recurrence The Change in Condition Notification Policy was re-educated and reinforced to all licensed and agency nursing staff, with focus on SBAR utilization, on 01/30/206. All licensed Nurses/Agency nurses were re-educated on immediate provider and RP notification requirements on 01/30/2026. . 4. Monitoring The DON or designee will audit change-in-condition documentation, provider and RP notification weekly for four weeks, then monthly for three months. Will be reviewed in our monthly QAPI process. 5. Completion date 02/02/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 7 Findings included: 1. Resident #51 was admitted to the facility on 4/13/23 with a diagnosis of diabetes mellitus type 2 (DM II). Resident #51's quarterly Minimum Data Set (MDS) assessment dated 9/25 25 revealed she was cognitively intact. A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous (under the skin) solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously one time a day every 7 days related to DM II. A pharmacy packing slip proof of delivery received via email communication with Pharmacist #1 on 1/6/26 at 10:09 AM revealed a confirmation signature on 10/22/25 at 12:34 AM by Nurse #10 that she received Ozempic 4mg/3ml for Resident #51 from the pharmacy. Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/30/25 at 9:30 AM by Nurse #4 indicating she did not administer Resident #51's Ozempic per the physician's order. On 1/5/2026 at 4:27 PM in a telephone interview Nurse #4 stated she recalled caring for Resident #51 on 10/30/25 on the 7AM to 3PM shift. She reported when she went to administer Resident#51's Ozempic medication that morning, it had not been available. She indicated she had looked everywhere, including in the medication room. She stated there had been other days when Resident #51 was due to receive this medication, but it had not been available. She stated she had not notified anyone including Resident #51's medical provider that the medication had not been available. Nurse #4 reported she did not know why she had not done this. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/20/25 at 9:30 AM by Nurse #3 indicating that she had not administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 4:24 PM in a telephone interview Nurse #3 stated she recalled caring for Resident #51 on 11/20/25 on the 7AM to 3PM shift. She reported Resident #51's Ozempic medication had not been available for her to administer. She stated she had not notified a provider that Resident #51's Ozempic had not been available for administration on 11/20/25. She could not say why.	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 8 Resident #51's November 2025 MAR further revealed documentation on 11/27/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order. Resident #51's December 2025 MAR revealed documentation on 12/4/25 at 9:30 AM by Nurse #9 indicating that she had not administered Resident #51's Ozempic per the physician's order. Attempts at telephone interview with Nurse #9 were not successful. On 1/6/26 at 8:20 AM an interview with the Assistant Director of Nursing (ADON) indicated she was familiar with Resident #51. She stated she recalled an issue where nurses including Nurse #4 had been documenting that Resident #51's Ozempic medication had not been available but had not notified a provider. The ADON reported Nurse #4, and the other nurses had not followed the proper protocol when the medication had not been available to administer to Resident #51, which would have been to immediately notify a medical provider to see if any alternate medications or other orders were required. On 1/7/26 at 12:31 PM an interview with the NP indicated a medical provider should have been made aware immediately when Resident #51's Ozempic was not available. On 1/6/26 at 10:45 AM in a telephone interview the facility's Medical Director stated there had been no harm to Resident #51 as a result of this incident because she had not experienced any blurred vision, recurrent urinary tract infections, or hospitalizations. The Medical Director reported he would have expected for a medical provider to be notified immediately when Resident #51's Ozempic medication was not available so alternate medication and monitoring orders could have been provided. He stated when the NP notified him of the issue, she assured him that Resident #51 was back on track. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated her understanding of the situation was that nurses were documenting Resident #51's Ozempic medication was not available but had not notified a medical provider of this. She indicated if the medication was unavailable for administration a provider should be notified immediately for alternative medications or further interventions.	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**
NAME OF PROVIDER OR SUPPLIER **Windsor Rehabilitation and Healthcare Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **1306 South King Street , Windsor, North Carolina, 27983**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 9 On 1/8/26 at 8:38 AM an interview with the Administrator indicated nurses should have notified a provider immediately when Resident #51's Ozempic was not available. 2. Resident #78 was admitted to the facility on 1/9/25. The quarterly Minimum Data Set (MDS) assessment dated 7/18/25 revealed Resident #78 was severely cognitively impaired and had one unhealed pressure ulcer. Resident #78's wound progress note dated 5/22/25 indicated that care had been reestablished at that time due to the development of a new DTI on the resident's right heel, measuring 3.5 cm (centimeters) x 3.5 cm x 0 centimeters cm. The plan included applying skin prep (creates a protective film on intact skin) to the heel once daily and offloading pressure. It was also documented that the plan had been discussed with both the staff and the resident. The progress note was signed by the Wound Care Nurse Practitioner. Resident #78's medical record did not reveal documentation indicating the previous wound care nurse contacted Resident #78's RP. Attempts to reach the Wound Care Nurse Practitioner for interview were unsuccessful. Attempts to interview the previous Wound Care Nurse about whether Resident #76's RP was notified of the new DTI on his right heel were unsuccessful. Resident #78's physician orders indicated the following: On 5/23/25, Nurse #1 entered an order to apply skin prep to the right heel daily and as needed for a DTI, and to offload pressure. On 6/2/25, an additional order was entered by Nurse #1 for Prevalon boots (special boots designed to offload pressure from the feet) to be worn while the resident was in bed.	F0580		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0580 SS = D	Continued from page 10 Attempts to contact Nurse #1 for interview were unsuccessful. In a telephone interview with Resident #78's RP on 1/4/26 at 10:59 AM, she stated that no one had notified her that the resident had developed a DTI on his right heel. She added that she had not learned of the pressure wound until he had been transferred to the hospital in September 2025. An interview was conducted with the Assistant Director of Nursing (ADON) on 1/6/26 at 12:36 PM. She stated that she had worked as a staff nurse in May 2025 and explained that when a new skin issue was identified, the process was for the nurse to contact the physician or the on-call provider to obtain orders and to notify the resident or the responsible party (RP), if applicable. The ADON reviewed Resident #78's medical record and did not find documentation that his RP was notified of the DTI on his right heel. In an interview with the Director of Nursing (DON) on 1/7/26 she stated that after reviewing Resident #78's medical record, she noted there was no documentation indicating that his RP had been notified of the (DTI) to his right heel. In an interview with the interim Administrator on 1/8/25 at 10:50 AM, she stated she had been unaware that residents' RPs were not being informed of new skin concerns, such as DTIs. The Administrator added that RPs should be notified of new skin concerns after the physician was called and orders for treatment were obtained. She reported that the nurse should document the notification in the medical record.	F0580		
F0602 SS = D	Free from Misappropriation/Exploitation CFR(s): 483.12 §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms.	F0602	1. Corrective action for affected residents Resident funds were restored. The employee involved is no longer employed by the facility. The incident was reported per state reporting requirements on 11/5/25. 2. Identification of other residents An audit of all resident trust fund accounts was completed to ensure balances were accurate and accessible on 11/05/2025. No further issues	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 11 This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to protect the residents' right to be free from misappropriation of money from their personal funds' accounts for 3 of 4 residents reviewed for misappropriation of property (Residents #51, #8, and #37). The findings included: a. Resident #51 was admitted to the facility 4/13/23. The quarterly Minimum Data Set (MDS) assessment dated 9/25/25 revealed Resident #51 was cognitively intact. An interview with Resident #51 on 1/4/26 at 2:17 PM revealed she recalled that in November 2025 her personal funds of $50.00 were not available when requested. She added after asking several times for her funds she did eventually receive the funds on another day. b. Resident #8 was admitted to the facility on 3/30/24. The annual MDS assessment dated 9/29/25 revealed Resident #8 was cognitively intact. On 1/6/26 at 10:55 AM an interview was conducted with Resident #8. He stated the facility had a personal funds account for him and didn't recall a time when he did not receive his funds when requested. c. Resident #37 was admitted to the facility on 8/12/24. The annual MDS assessment dated 9/15/25 revealed Resident #37 was cognitively intact. An interview was conducted with Resident #37 on 1/5/26 at 11:30 AM. He stated he was told by the Business Office Manager the facility did not have the cash available to give him the $30.00 he requested from his personal funds on 11/4/25. He stated he had to wait until the 6th day of the month to receive his money. He indicated he received his funds after speaking with the previous Administrator as she gave him cash from her own funds. He did not recall the reason why his funds were not available upon request. An initial allegation report was submitted to the North Carolina Department of Health and Human Services Division of Health Service Regulation by the previous Administrator on 11/5/25 at 4:06 PM. The allegation of	F0602	Continued from page 11 were identified in the auditing process. 3. Measures to prevent recurrence Business Office Manager and Social Worker were re-educated by the Assistant Director of Business Office Services on 11.05.26 on resident Funds management. Only designated staff can handle resident funds. The new administrative assistant when hired will no longer disburse resident funds. The social worker is the new designee to disburse and safeguard residents' funds. All Staff were re-educated on misappropriation prevention before or by 2.2.26. 4. Monitoring The Administrator/Designee will conduct audits once a week for four weeks, then monthly for two months of resident trust fund accounts to ensure all accounts are in order and no misappropriation of funds is noted. All monies are secured and given to residents per policy and request. The administrator will audit once a month for three months and review through the QAPI process for 3 months. 5. Completion date 02/02/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 12 misappropriation of resident property was made on 11/4/25 when Residents #51, #8, and #37 alleged that they did not receive their personal funds when requested. The local law enforcement office was notified on 11/6/25 at 2:15 PM. The facility investigation report that was completed by the previous Administrator on 11/7/25 revealed on 11/4/25 residents had requested funds from their personal trust accounts from the previous Administrative Assistant. The previous Administrative Assistant had stated she placed the funds in envelopes with all 3 residents' names (Residents #51, #8, and #37) listed on the outside of the envelope. She then placed the envelopes inside her file cabinet and walked away. The file cabinet was left unattended and unlocked and when she returned the envelopes were empty. The previous Administrative Assistant was suspended and later that day on 11/4/25 her employment was terminated. A telephone interview on 1/6/26 at 2:30 PM with the previous Administrative Assistant revealed on 11/4/25 she had put the residents' personal funds in individual envelopes with cash in her desk and then went outside to supervise residents who were smoking. When she returned to her desk, the cash was gone. The previous Administrative Assistant did recall putting cash in labeled envelopes for Residents #51 ($50.00), #8 ($50.00), and #37 ($30.00). Attempts to interview the previous Administrator were unsuccessful. Attempts to interview the law enforcement officer that took the report on 11/4/25 regarding the misappropriation of resident funds was unsuccessful. An interview was held on 1/6/26 at 11:00 AM with the Business Office Manager. She stated that the previous Administrative Assistant told her on 11/4/25 she had placed Residents #51's, #8's, and #37's requested personal funds in separate envelopes labeled with their names in her desk drawer and then went outside, leaving the desk unattended and unlocked. The Business Office Manager stated she did not believe there was a system breakdown with the personal funds accounts that caused the funds unavailability but rather a "bad employee". An interview was conducted on 1/6/26 at 11:20 AM with the Social Services Director. She stated that since the 11/4/25 incident of misappropriation of residents' personal funds, she had been tasked with dispersing personal funds to residents upon request.	F0602		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0602 SS = D	Continued from page 13 An interview with the Regional Business Office Manager was conducted on 1/6/26 at 2:00 PM. She stated in November 2025 she was in the facility when the allegation of misappropriation of residents' personal funds occurred. The Regional Business Office Manager reported she spoke with the previous Administrative Assistant on 11/4/25. She indicated when she asked the previous Administrative Assistant why the funds were not available upon the residents' request, the previous Administrative Assistant told her she had put the money in envelopes to be dispersed to residents, but when she returned to her desk, the envelopes were empty. The Regional Business Office Manager added that the facility requested funds from the corporate office and restored the resident accounts. An interview was conducted on 1/6/26 at 3:45 PM with the Administrator. She revealed she would expect the Business Office Manager or designee to administer and disperse residents' funds when requested. She added that the Administrative Assistant that was employed when the allegation of misappropriation of personal funds occurred on 11/4/25 was no longer employed by the facility. She went on to say the procedure for personal funds had been changed since this incident on 11/4/25 and stated the current Administrative Assistant was no longer involved in the personal funds' procedures for the residents.	F0602		
F0641 SS = D	Accuracy of Assessments CFR(s): 483.20(g)(h)(i)(j) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. §483.20(i) Certification. §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed. §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.	F0641	1. Corrective action for affected resident Resident #51's MDS was reviewed and corrected to accurately reflect medication administration of insulin on 01/26/26. 2. Identification of other residents An audit of all MDS assessments was completed to ensure insulin medication coding accuracy on 01/26/2026. Any identified concern noted was modified immediately and resubmitted to maintain accuracy of MDS assessments. 3. Measures to prevent recurrence MDS staff were re-educated on accurate medication coding, including insulin vs. non-insulin injectables. This education was completed by the	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 14 §483.20(j) Penalty for Falsification. §483.20(j)(1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. §483.20(j)(2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the area of medications for 1 of 5 residents reviewed for medication administration (Resident #51). Findings included: Resident #51 was admitted to the facility on 4/13/23 with a diagnosis of diabetes mellitus type 2. Resident #51's quarterly Minimum Data Set (MDS) assessment with an Assessment Reference Date (ARD, the last day of the assessment period) of 9/25/25 revealed she received insulin injections on 7 of the last 7 days. A review of Resident #51's September 2025 Medication Administration Record (MAR) revealed documentation of liraglutide (a non-insulin injectable medication for diabetes mellitus type 2) subcutaneous solution pen injector 1.8 milligrams (mg) subcutaneously (under the skin) one time a day for diabetes mellitus type 2 was administered at 8:00 AM daily from 9/18/25 through 9/25/25. On 1/13/26 at 2:04 PM a telephone interview with MDS Nurse #1 indicated she coded the medication section of Resident #51's MDS assessment dated 9/25/25. She reported she coded insulin injections for 7 of 7 days because Resident #51 received liraglutide injections daily during this period. MDS Nurse #1 stated she had a reference sheet she found that she went by when coding medications and liraglutide was listed under insulins.	F0641	Continued from page 14 Regional Director of Clinical Reimbursement and completed on 01/26/2026. 4. Monitoring The Regional Director of Clinical Reimbursement/Designee will review a sample of MDS assessments weekly to ensure proper coding of insulin medications x 12 weeks 5. Completion date 02/02/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0641 SS = D	Continued from page 15 On 1/13/26 at 2:07 PM a telephone interview with the Director of Nursing indicated MDS Nurse #1 coded Resident #51 as receiving insulin on the MDS assessment dated 9/25/25 because she had received liraglutide injections for her diabetes. She reported MDS assessments should be coded to accurately reflect the medications residents received. On 1/13/26 at 2:09 PM a telephone interview with the Administrator indicated residents' MDS assessments should be coded accurately.	F0641		
F0658 SS = D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is NOT MET as evidenced by: Based on record review and resident, staff, Medical Director and Nurse Practitioner (NP) interviews the facility failed to administer medication as ordered by the physician for 1 of 5 residents reviewed for medication administration (Resident #51). Findings included: Resident #51 was admitted to the facility on 4/13/23 with a diagnosis of diabetes mellitus type 2 (DM II). Resident #51's quarterly Minimum Data Set (MDS) assessment dated 9/25 25 revealed she was cognitively intact. A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous (under the skin) solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously one time a day every 7 days related to DM II. On 1/5/26 at 3:15 PM an interview with Resident #51 indicated she was originally supposed to receive her first dose of Ozempic on 10/23/25, but she didn't receive her first dose until December. She reported since this had been resolved, she had begun getting her	F0658	1. Corrective action for affected resident Resident #51's medication regimen was reviewed and restored on 01/06/2026. Provider notification and pharmacy coordination were completed on 01/06/2026 by the Director of Nursing 2. Identification of other residents A facility-wide medication availability audit was completed on 01/09/2026. No further discrepancies noted. 3. Measures to prevent recurrence Medication unavailability will be identified via the Medication Administration Report/missed medication report. DON/Designee will address if medication is omitted for whatever reason 5 times a week and correct immediately via the daily clinical stand up auditing process. All licensed Nursing/Agency staff were re-educated on Medication administration report documentation, what to do and communicate if a medication is unavailable, provider/pharmacy notification if a medication is unavailable or unable to be located. Education by the Director of nursing or designee will be completed on 02/2/2026. All new hires will receive the education during orientation process. 4. Monitoring Medication administration audits will be conducted weekly x 12 weeks and reviewed through the QAPI process for 3 months. The administrator is responsible for bringing this to QAPI.	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 16 injections weekly. A pharmacy packing slip proof of delivery received via email communication with Pharmacist #1 on 1/6/26 at 10:09 AM revealed a confirmation signature on 10/22/25 at 12:34 AM by Nurse #10 that she received Ozempic 4mg/3ml for Resident #51 from the pharmacy. On 1/6/26 at 2:21 PM in a telephone interview Nurse #10 stated she did not recall what happened on 10/22/25. She reported that if her signature appeared on the proof of delivery slip on 10/22/25, this would indicate she received the medication from the pharmacy. She stated she did not usually work with Resident #51, so she would have given the medication to the nurse assigned to Resident #51 at that time. On 1/6/26 at 3:26 PM an interview with the Assistant Director of Nursing (ADON) indicated she was assigned to care for Resident #51 on 10/22/25 when her Ozempic medication was delivered from the pharmacy. She reported she recalled receiving the medication from Nurse #10, and she placed the medication into the medication refrigerator because Resident #51 had not been due for a dose on her shift. Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/23/25 at 9:30 AM by Nurse #7 indicating she administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 9:46 in a telephone interview Nurse #7 stated she recalled being assigned to care for Resident #51 on 10/23/25 on the 7AM to 3PM shift. She reported her documentation on 10/23/25 at 9:30 AM indicating that she administered Resident #51's Ozempic was an error. She reported she recalled looking for the medication but not being able to find it. She stated she should have called the pharmacy that day to find out why the medication had not been available, but she had gotten distracted and had forgotten. Resident #51's October 2025 Medication Administration Record (MAR) further revealed documentation on 10/30/25 at 9:30 AM by Nurse #4 indicating she did not administer Resident #51's Ozempic per the physician's order and to see the progress note. There was no corresponding nursing progress note for 10/30/25 to indicate why the medication was not given. On 1/5/2026 at 4:27 PM in a telephone interview Nurse #4 stated she recalled caring for Resident #51 on 10/30/25 on the 7AM to 3PM shift. She reported when she	F0658	Continued from page 16 5. Completion date 02/04/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 17 went to administer Resident#51's Ozempic medication that morning, it had not been available. She indicated she had looked everywhere, including in the medication room. She stated there had been other days when Resident #51 was due to receive this medication, but it had not been available. She stated she called the pharmacy at one point and had been told that a 28-day supply of the medication had been sent to the facility on 10/22/25, and no more could be sent. She stated she had not notified anyone that the medication had not been available. Nurse #4 reported she did not know why she had not done this. Resident #51's November 2025 Medication Administration Record (MAR) revealed documentation on 11/6/25 at 9:30 AM by Nurse #8 indicating that she administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 8:09 AM an interview with Nurse #8 indicated she really couldn't recall exactly what happened on 11/6/25. She reported her documentation of Resident #51's MAR on 11/6/25 indicated that she had administered Resident #51's Ozempic per the physician's order. She stated she did not recall where she had gotten Resident #51's Ozempic medication or what she did with the pen after administering it to Resident #51. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/13/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order. A nursing progress note dated 11/13/25 at 2:40 PM written by Nurse #4 indicated she had spoken to the pharmacy regarding Resident #51's Ozempic medication not being available for administration. Resident #51 had last received a dose of the medication on 11/6/25. The pharmacy had advised that a 28-day dose of the medication had been sent on 10/22/25, and a new 28-day supply could not be sent until 11/17/25. Nurse #4 reported this to Resident #51. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/20/25 at 9:30 AM by Nurse #3 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note. There was no corresponding nursing progress note for 11/20/25 to indicate why the medication was not given. On 1/6/26 at 4:24 PM in a telephone interview Nurse #3	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street , Windsor, North Carolina, 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 18 stated she recalled caring for Resident #51 on 11/20/25 on the 7AM to 3PM shift. She reported Resident #51's Ozempic medication had not been available for her to administer. She stated she recalled calling the pharmacy on 11/20/25, and being told the medication would be sent. Nurse #3 reported she didn't know what happened after this. Resident #51's November 2025 Medication Administration Record (MAR) further revealed documentation on 11/27/25 at 9:30 AM by Nurse #4 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note. There was no corresponding nursing progress note for 11/27/25 to indicate why the medication was not given. Resident #51's December 2025 Medication Administration Record (MAR) further revealed documentation on 12/4/25 at 9:30 AM by Nurse #9 indicating that she had not administered Resident #51's Ozempic per the physician's order and to see the progress note. There was no corresponding nursing progress note for 12/4/25 to indicate why the medication was not given. Attempts at telephone interview with Nurse #9 were not successful. A nursing progress note dated 12/5/25 at 11:51 PM written by Nurse #4 revealed Resident #51 reported to her that she had not been receiving her Ozempic medication and would like for someone to tell her what the status was. Resident #51 was her own Responsible Party (RP). Nurse #4 would continue to monitor this. On 1/6/26 at 8:20 AM an interview with the ADON indicated she was familiar with Resident #51. She stated she recalled an issue where nurses including Nurse #4 had been documenting that Resident #51's Ozempic medication had not been available, but had not notified her, the Director of Nursing, or a provider. The ADON stated she had initially become aware of the issue when she saw it documented on the 24-hour Nursing Report sheet by Nurse #4. She stated she thought this had been sometime in November or December 2025. She indicated as soon as she became aware there was an issue, she checked all the medication carts, and the medication refrigerator and could not locate the medication. The ADON reported she had no idea what could have happened to the Ozempic that was delivered by the pharmacy for Resident #51 on 10/22/25. She stated she had immediately notified the Nurse Practitioner (NP) and called the pharmacy to see how	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 19 they could get the medication. On 1/7/26 at 12:31 PM an interview with the NP indicated as soon as she was notified by the facility that Resident #51 had not received her Ozempic as ordered, she addressed the issue. On 1/6/26 at 9:18 AM in a telephone interview Pharmacist #1 stated the first 28-day supply of Ozempic was set to the facility on 10/22/25. Pharmacist #1 went on to say the next fill for the medication would have been due on 11/13/25, but due to the high cost of the medication, a preauthorization for filling the medication had been sent to the facility but had not been received back. He reported that due to the pharmacy not receiving this authorization back, there had been a delay in filling the Ozempic prescription for Resident #51, and the next supply had not been sent to the facility until 12/11/25. On 1/6/26 at 10:45 AM in a telephone interview the facility's Medical Director stated he had been made aware that Resident #51 had not been receiving her Ozempic as ordered by the Nurse Practitioner (NP). He stated there had been no harm to Resident #51 as a result of this incident because she had not experienced any blurred vision, recurrent urinary tract infections, or hospitalizations. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated her understanding of the situation was that nurses were documenting Resident #51's Ozempic medication was not available but had not notified a provider of this. She reported it seemed some nurses had contacted the pharmacy, but they had not reported any issue with getting Resident #51's Ozempic to herself, or the ADON so the issue could be resolved. The DON stated if an ordered medication was not available, medication carts and all medication storage areas should be searched, the medication should be obtained from the back-up supply if available or the nurse should call the pharmacy for a refill and ask when it would arrive. She went on to say the nurse should also notify her or the nurse manager on call to let them know if there were issues. In a follow up interview on 1/8/26 at 8:06 AM the DON stated the preauthorization for filling Resident #51's Ozempic prescription would have been sent by the pharmacy to a facility fax machine. She reported she did not know what happened to this authorization form, as there was not a process in place regarding which fax machine they were set to, who retrieved them, or for getting them to her so she could follow-up.	F0658		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0658 SS = D	Continued from page 20 On 1/8/26 at 8:38 AM an interview with the Administrator indicated nurses should have communicated with the DON or ADON when Resident #51's Ozempic was not available. She indicated pharmacy communications and pre-authorizations should be followed up on. She stated as a result of the lack of communication, medication doses were missed, and it just became a cyclical issue.	F0658		
F0756 SS = D	Drug Regimen Review, Report Irregular, Act On CFR(s): 483.45(c)(1)(2)(4)(5) §483.45(c) Drug Regimen Review. §483.45(c)(1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. §483.45(c)(2) This review must include a review of the resident's medical chart. §483.45(c)(4) The pharmacist must report any irregularities to the attending physician and the facility's medical director and director of nursing, and these reports must be acted upon. (i) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug. (ii) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility's medical director and director of nursing and lists, at a minimum, the resident's name, the relevant drug, and the irregularity the pharmacist identified. (iii) The attending physician must document in the resident's medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident's medical record. §483.45(c)(5) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps	F0756	1. Immediate corrective action: Implemented immediate process to review all pending pharmacy recommendations from last 60 days; providers notified and actions documented. No further issues identified via the auditing process that was completed by the Director of Nursing on 01/23/2026. 2. Identification of other residents. All residents have the potential to be affected by this deficient practice 100 audit completed by the Director of Nursing on 01/30/2026 to ensure no other pharmacy recommendations had not been addressed. No other issues identified. 3. Measures to prevent recurrence: Established policy: Pharmacy Recommendations must be reviewed within 72 hours of receipt, routed to provider/medical director, and documented (action/no change + rationale Added back-up reviewer (ADON/designee) and required daily check of designated pharmacy communication inbox. DON/ADON/Nursing administration were reeducated on this process by the pharmacy consultant/designee 01/7/2026. 3. Monitoring: ADON/DON audits 100% of Pharmacy recommendations weekly x 12 weeks and review through QAPI process. 4. Completion date: 2/2/2026	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0756 SS = D	Continued from page 21	F0756		

the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

This REQUIREMENT is NOT MET as evidenced by:

Based on record review and staff, Pharmacist, Medical Director, Nurse Practitioner and Physician interviews, the facility failed to ensure the attending physician was informed of the pharmacy recommendation to clarify a physician’s order for carvedilol (medication in the class of alpha and beta blockers used to treat conditions affecting the heart and blood vessels) for 1 of 5 residents reviewed for unnecessary medications (Resident #7).

Findings included:

Resident #7 was admitted to the facility on 12/3/25 with diagnoses of hypertension (high blood pressure) and heart failure.

A Report of Consultation document from Resident #7’s Cardiologist dated 12/5/25 included a handwritten portion completed and signed by Physician #2 which revealed Resident #7 had coronary and peripheral artery disease (narrowing or blockage of the arteries in the heart and legs, pelvic area or arms). The recommendation was to increase Resident #7’s carvedilol to 37.5 mg twice daily and to check Resident #7’s blood pressure with a goal of systolic (the hearts contraction phase measuring peak pressure in the arteries) blood pressure of 110 (mmHg-millimeters of mercury) to 130 (mmHg-millimeters of mercury). A printed portion of the document titled “After Visit Summary Instructions” revealed increase carvedilol to 3.125 milligrams twice daily. An additional printed portion titled “Your Medication List” revealed carvedilol 25 mg take 1.5 tablets (37.5 mg total) by mouth in the morning and 37.5 mg by mouth in the evening.

A physician’s order for Resident #7 with a start date of 12/5/25 entered by Nurse #12 revealed carvedilol 3.125 mg twice daily by mouth for hypertension.

The pharmacist recommendation for Resident #7 dated 12/8/25 written by Pharmacist #2 revealed Physician #2 increased Resident #7’s carvedilol on 12/5/25. Resident #7’s carvedilol went from 25 mg twice daily to 3.125 mg daily on her Medication Administration Record (MAR). This was a big decrease in carvedilol. Clarify the carvedilol dose and order on her MAR. There was no indication this had been reviewed by a medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0756 SS = D	Continued from page 22 provider. On 1/7/26 at 11:35 AM a telephone interview with Pharmacist #2 indicated she completed Resident #7's initial medication regime review (MRR) on 12/8/25. She reported she noted the discrepancy between Resident #7's initial admission carvedilol dose of 25 mg twice daily, the recommendation by Physician #2 on 12/5/25 to increase Resident #7's carvedilol to 37.5 mg twice daily, and the facility's order for a significantly decreased dose of carvedilol 3.125 mg twice daily. Pharmacist #2 stated she had sent a recommendation to the DON to clarify this discrepancy by email on 12/8/25. On 1/7/25 at 12:54 PM an interview with the Director of Nursing (DON) indicated she would have received the Consultant Pharmacist's Progress Note Admission MRR for 12/8/25 on 12/8/25 or a few days later in her email. She reported she did not check her email daily and had not been aware of the recommendation to clarify the physician's order for Resident #7's carvedilol until 1/7/26. She reported it would have been her responsibility to provide this clarification recommendation to the provider for review, but she had not gone through these reviews for December 2025 yet. On 1/7/26 at 12:31 PM an interview with the Nurse Practitioner (NP) indicated she did not receive any pharmacy recommendations from the facility. She reported these would be handy to have. The NP stated if she had been given Resident #7's pharmacy recommendation from 12/8/25, she would have addressed it. On 1/7/26 at 2:12 PM a telephone interview with the Medical Director indicated he received the pharmacy recommendations from facilities if they gave them to him. He reported he had not received the recommendation from 12/8/25 for Resident #7. He stated this should have been provided to him within a few days of the facility's receiving it so he could have addressed it. The Medical Director indicated it should not have taken a month. On 1/8/26 at 8:38 AM an interview with the Administrator indicated there should be a be an effective process in place for addressing pharmacy recommendations.	F0756		
F0760 SS = E	Residents are Free of Significant Med Errors CFR(s): 483.45(f)(2)	F0760	1. Immediate corrective action: Resident #7's medication	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = E	Continued from page 23 The facility must ensure that its- §483.45(f)(2) Residents are free of any significant medication errors. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff, Pharmacist, Medical Director and Physician interviews, the facility failed to clarify and resolve a discrepancy with an order for carvedilol (medication in the class of alpha and beta blockers used to treat conditions affecting the heart and blood vessels) which resulted in a significant medication error for 1 of 5 residents reviewed for unnecessary medications (Resident #7). Findings included: Resident #7's hospital discharge summary dated 12/3/25 revealed her discharge medications included carvedilol 25 milligrams (mg) by mouth twice daily. Resident #7 was admitted to the facility on 12/3/25 with diagnoses of hypertension (high blood pressure) and heart failure. A physician's order for Resident #7 with a start date of 12/3/25 revealed carvedilol 25 mg by mouth twice daily for essential hypertension. Resident #7's December 2025 Medication Administration Record (MAR) revealed documentation indicating carvedilol 25 mg was administered to Resident #7 twice daily from 12/3/25 through 12/4/25. A Report of Consultation document completed by Resident #7's Cardiologist dated 12/5/25 included a handwritten portion completed and signed by Physician #2 which revealed Resident #7 had coronary and peripheral artery disease (narrowing or blockage of the arteries in the heart and legs, pelvic area or arms). The recommendation was to increase Resident #7's carvedilol to 37.5 mg twice daily and to check Resident #7's blood pressure with a goal of systolic (the hearts contraction phase measuring peak pressure in the arteries) blood pressure of 110 (mmHg-millimeters of mercury) to 130 (mmHg-millimeters of mercury). A printed portion of the document titled "After Visit Summary Instructions" revealed increase carvedilol to 3.125 milligrams twice daily. An additional printed portion titled "Your Medication List" revealed carvedilol 25 mg take 1.5 tablets (37.5 mg total) by mouth in the morning and 37.5 mg by mouth in the evening.	F0760	Continued from page 23 was immediately corrected/clarified per the physician order on 1/7/2026 by the Director of Nursing. Resident #7 suffered no ill effects. 2. Systemic changes: DON or designee completed 100% audit on current residents to ensure no significant med errors were made and was completed on 1/30/26. 3. Measure to prevent recurrence Reinforce "new order verification" process (transcription, indication, dose range, duplicate medications/clarification check) via the clinical meeting and verification with the consultant physician medication recommendations. All licensed nursing/CMA/ agency were reeducated on prevention of significant medication errors on 1/30/2026 by the Director of Nursing. All new Hires will get education in orientation moving forward. 4. Monitoring DON or Designee will audit 100% of doctor's consultations to assure no significant med error has been made 5 times weekly x 12 weeks. The administrator will review through the QAPI process for 3 months. 5. Completion date 02/04/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = E	Continued from page 24 A physician's order for Resident #7 with a start date of 12/5/25 entered by Nurse #12 revealed carvedilol 3.125 mg twice daily by mouth for hypertension. On 1/7/26 at 10:10 AM in an interview Nurse #12 stated recalled being assigned to Resident #7 on 12/5/25 when Resident #7 returned from her appointment with her Cardiologist (heart specialist physician). She reported as the nurse assigned to Resident #7, it was her duty to review the consultation report documents that returned with Resident #7 and to enter any new orders. She stated she saw the handwritten portion completed by Physician #2, and noticed the discrepancy between what he hand wrote, what was printed in the instructions portion, and what was printed in the medication list portion. Nurse #12 reported it was her understanding she was supposed to use what was printed in the instructions portion to enter the medication order. She indicated she knew she should have called a provider to clarify the discrepancy before she entered the order. She stated she normally would have called Physician #2's office, but it had been late in the evening, and she had not. Resident #7's December 2025 MAR revealed documentation indicating carvedilol 3.125 mg was administered to her twice daily from 12/5/25 at 8:00 PM through 12/31/25 at 8:00 PM. Resident #7's January 2026 MAR revealed documentation indicating carvedilol 3.125 mg was administered to her twice daily from 1/1/26 at 8:00 AM through 1/7/2 at 8:00 AM. Resident #7's blood pressure readings from 12/3/25 through 12/31/25 revealed Resident #7's blood pressure was checked twice daily. Resident #7's systolic blood pressure (SBP is the top number in a blood pressure reading indicating the pressure in the arteries when the heart beats with normal adult SBP being less than 120) ranged from a low of 100 to a high of 180. Resident #7's diastolic blood pressure (DBP is the lower number in a blood pressure reading, measur ing the pressure in your arteries when your heart rests between beats with normal adult DBP being between 60 and 80) ranged from a low of 48 to a high of 94. Resident #7's blood pressure reading from 1/1/26 through 1/7/26 revealed Resident #7's blood pressure was checked twice daily. Resident #7's SBP ranged from a low of 111 to a high of 172. Her DBP ranged from a low of 55 to a high of 87.	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = E	Continued from page 25 On 1/7/26 at 10:25 AM a telephone interview with Physician #2 indicated he was Resident #7's Cardiologist. He stated he recommended an increase in the dose of Resident #7's carvedilol at her appointment on 12/5/25 because Resident #7's blood pressure had not been well controlled. Resident #7's twice daily documented blood pressure and pulse readings for December 2025 and January 2026 were reviewed with Physician #2 via telephone. Physician #2 stated that while these readings were not optimal, they weren't terrible either. He reported while he did not feel that receiving the lower dose of 3.125 mg of carvedilol twice daily since 12/5/25 had caused Resident #7 any harm, it was very important that she begin receiving the correct dose of 37.5 mg of carvedilol twice daily now. On 1/7/26 at 10:36 AM in a return telephone call Physician #2 stated he was now very concerned about Resident #7 going from 3.125 mg of carvedilol twice daily to 37.5 mg of carvedilol twice daily. He stated because she had been receiving the much lower dose for so long, there could be potentially adverse consequences to Resident #7 which included a sudden drop in heart rate and blood pressure. Physician #2 reported he would need to provide titration orders to the Director of Nursing (DON) for a gradual increase in Resident #7's carvedilol from 3.125 mg twice daily to the goal of 37.5 mg twice daily. On 1/7/26 at 10:40 AM an interview with the DON indicated Nurse #12 should have immediately clarified Resident #7's carvedilol order when she saw the discrepancy in the document. The DON stated Physician #2 had just given her verbal telephone orders for increasing Resident #7's carvedilol to 12.5 mg twice daily for one week, 25 mg twice daily for one week, then 37.5 mg twice daily continuously after that and for monitoring Resident #7's heart rate and blood pressure twice daily. She reported she would consider this a significant medication error. On 1/7/26 at 11:35 AM a telephone interview with Pharmacist #2 indicated she completed Resident #7's initial medication regime review on 12/8/25. She reported she noted the discrepancy between Resident #7's initial admission carvedilol dose of 25 mg twice daily, the recommendation by Physician #2 on 12/5/25 to increase Resident #7's carvedilol to 37.5 mg twice daily, and the facility's order for a significantly decreased dose of carvedilol 3.125 mg twice daily. Pharmacist #2 stated she had sent a recommendation to the DON to clarify this discrepancy on 12/8/25. She reported carvedilol was a medication that required	F0760		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0760 SS = E	Continued from page 26 gradual dose titration. She stated Resident #7 going from carvedilol 25 mg twice daily to 3.125 mg twice daily could have had significant adverse effects such as heart rate changes and increased blood pressure consequences. On 1/7/26 at 2:12 PM a telephone interview with the Medical Director indicated it was a problem that the Cardiology visit summary was not accurate. He stated he did not feel Resident #7 experienced any harm as a result of this problem. He reported although carvedilol was a medication that required gradual titration up or down as it could affect heart rate, he did not feel it had been clinically significant in Resident #7's case. The Medical Director stated someone from the facility should have picked up on the discrepancy and contacted a provider for clarification. On 1/8/26 at 8:38 AM an interview with the Administrator indicated there were providers on call for the facility at all times. She stated Nurse #12 should have immediately called a provider for clarification when she noted a discrepancy.	F0760		
F0761 SS = D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a	F0761	1. Immediate corrective action: Conducted immediate facility-wide sweep to ensure all medication/treatment carts are locked when unattended; no further issues noted. Completed by the Director of Nursing on 01/05/2026. 2. Systemic changes: Immediate education was done with wound nurse Kelly to ensure that she locks the cart when not 100% visible at all times. Reeducation on Medication/Treatment cart security policy and added shift-change checklist item: "carts secured/keys controlled." Retraining from the Director of Nursing to all licensed nursing/agency staff on Medication/Treatment cart security and key control on 1/29/26 and ongoing. 3. Monitoring: DON/designee will perform random audits of Medication/Treatment carts 2x/shift weekly x 12 weeks. Review through the QAPI process times 3 months.	02/02/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	Continued from page 27 missing dose can be readily detected. This REQUIREMENT is NOT MET as evidenced by: Based on observations and staff interviews, the facility failed to keep medications in a locked treatment cart for 1 of 2 treatment carts observed (Treatment Cart #1). Findings included: During observation on 1/5/26 at 8:32 AM Treatment Cart #1 was observed with the locking mechanism in the unlocked position on the 100-hall outside of a resident's room. The face of the cart was pointed at a resident's room and the resident's room door was open. The privacy curtain was pulled around the resident as well as the Wound Care Nurse. The transport driver was approximately 15 feet away from the unlocked treatment cart and there were no other individuals observed. The surveyor was able to step between the resident's doorway and the unlocked treatment cart without touching the treatment cart. The Wound Care Nurse was behind the privacy curtain and could not be seen by the surveyor. At 8:35 AM the Wound Care Nurse returned to the treatment cart from behind the privacy curtain. During an interview on 1/5/26 at 8:35 AM the Wound Care Nurse stated she was unable to visualize the unlocked treatment cart while in the resident's room and did not know the surveyor was standing there. Upon observing Treatment Cart #1 she stated it was unlocked and should be locked when unattended. The Wound Care Nurse confirmed the treatment cart was out of her sight while she was providing care. During observation on 1/5/26 at 8:36 AM the contents of Treatment Cart #1 were observed to include A&D ointment (a topical emollient that contains vitamin A and vitamin D to treat diaper rash, dry skin, and skin irritation), Manuka Honey (a gel treatment for wound care, offering antibacterial, anti-inflammatory, and healing properties), Chymosin topical (a skin barrier ointment that provides protection and relief from irritation, commonly used for diaper rash, minor cuts, and other skin conditions), Cadexomer Iodine Gel 10 grams/0.35 ounce (a sterile antimicrobial dressing formulation of Cadexomer Iodine), Diclofenac Gel diclofenac sodium topical gel 1% (a nonsteroidal anti-inflammatory drug (NSAID) that helps reduce inflammation and pain when applied to the skin), Triamcinolone cream 0.5% (a topical corticosteroid used to treat various inflammatory skin conditions such as eczema, psoriasis, dermatitis, and rashes), Collagenase	F0761	Continued from page 27 4. Completion date: 02/02/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0761 SS = D	Continued from page 28 Santyl ointment 250 units/gram (a sterile enzymatic debriding ointment used to help clean and remove dead tissue from wounds, such as ulcers and severe burns), triamcinolone acetonide cream 0.1% (a topical corticosteroid used to treat various inflammatory skin conditions such as eczema, dermatitis, psoriasis, and rashes. It works by reducing itching, redness, and swelling associated with these conditions), nystatin topical powder (an antifungal medication used to treat fungal or yeast infections of the skin, particularly those caused by the Candida species), and Dyna-hex 4 Chlorhexidine Gluconate 4% solution (a Chlorhexidine Gluconate 4% solution used as an antiseptic for skin disinfection and surgical scrubs). During an interview on 1/5/26 8:41 AM the Director of Nursing stated any time any treatment or medication cart was out of view of the nurse, it should be locked.	F0761		
F0842 SS = E	Resident Records - Identifiable Information CFR(s): 483.20(f)(5),483.70(h)(1)-(5) §483.20(f)(5) Resident-identifiable information. (i) A facility may not release information that is resident-identifiable to the public. (ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so. §483.70(h) Medical records. §483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are- (i) Complete; (ii) Accurately documented; (iii) Readily accessible; and (iv) Systematically organized §483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the	F0842	1. Immediate corrective action: MAR/TAR review for all residents identified in the tag; MAR/TARs corrected per policy. Completed by the Director of Nursing on 1/7/2026. No further issues identified 2. Systemic changes: All residents have the potential to be effected by this deficient practice. 100% Medication Admin Audit report was ran on 1/30/26 and corrected. The Admin Audit report shows all the holes on the MAR/TARS, and the Nurses/CMA will be called to verify if the medication/treatment was completed and have them come back within appropriated timeframe to ensure that all medications/treatments were completed. The medication admin audit report will be ran 5 days a week by Director of Nursing or Designee, and all follow up will be followed up within 24 hours. 3. Measures to prevent recurrences: Education to all licensed nursing staff regarding MAR/TAR reconciliation at end of each shift will be completed before or by 2.2.26. Required education on documentation accuracy with medication administration completed by the Director of	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 29 records, except when release is- (i) To the individual, or their resident representative where permitted by applicable law; (ii) Required by Law; (iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506; (iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. §483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use. §483.70(h)(4) Medical records must be retained for- (i) The period of time required by State law; or (ii) Five years from the date of discharge when there is no requirement in State law; or (iii) For a minor, 3 years after a resident reaches legal age under State law. §483.70(h)(5) The medical record must contain- (i) Sufficient information to identify the resident; (ii) A record of the resident's assessments; (iii) The comprehensive plan of care and services provided; (iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State; (v) Physician's, nurse's, and other licensed professional's progress notes; and (vi) Laboratory, radiology and other diagnostic	F0842	Continued from page 29 Nursing with all licensed nursing/agency before or by 2/2/26, and ongoing due agency and new hires. 4. Monitoring: DON/designee will audit 5 MARs/TARs weekly x 12 weeks. Will review in QAPI for 3 months by the administrator. 5. Completion date: 02/04/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 30 services reports as required under §483.50. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interviews, the facility failed to have a complete and accurate Treatment Administration Record (TAR) and failed to have a complete and accurate Medication Administration Record (MAR) for 4 of 19 residents reviewed for medical record accuracy (Resident #76, Resident #36, Resident #54, and Resident #51). Findings included: 1. Resident #76 was admitted to the facility on 8/20/25. Review of Resident #76's physician orders revealed on 8/26/25 the resident had an order entered for his surgical left foot incision to be cleansed with Dakin's (a dilute solution bleach solution used as an antiseptic for wounds), pat dry, collagen particles Dakin's moistened gauze and abdominal gauze roll every day and as needed for wound care. Please read over the highlighted and revise- does not make sense. Review of Resident #76's TAR for September 2025 revealed there was no documented wound care on 9/2/25, 9/8/25, 9/13/25, 9/15/25, and 9/17/25. Review of Resident #76's wound care notes from 8/27/25 through 9/18/25 revealed his wound was decreasing in size and the wound care physician documented the wound as improving. During a telephone interview on 1/6/25 at 8:20 AM the previous Wound Care Nurse who was responsible for wound care for Resident #76 on 9/2/25, 9/8/25, 9/15/25, and 9/17/25 stated she completed wound care on those days but did not document it. During an interview on 1/5/26 at 3:56 PM the Assistant Director of Nursing who was responsible for wound care for Resident #76 on 9/13/25 stated she was covering the medication aide on 9/13/25 and did complete the wound care according to orders. She stated until it was just brought to her attention, she thought she had documented her wound care on the TAR but must have forgotten to document it. During an interview on 1/6/26 at 9:13 AM the Director of Nursing stated if wound care was completed it should be documented on the TAR to ensure the accuracy of their medical records.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 31 During an interview on 1/6/26 at 9:20 AM the Administrator stated her expectation was when wound care was completed, the wound care would be documented on the TAR to ensure the accuracy of their medical records. 2. Resident #36 was admitted to the facility on 7/5/23. Resident #36's physician orders dated 4/28/25 revealed: -For the left leg with lymphedema: staff cleaned the leg with soap and water, applied triamcinolone, then applied a special gauze with Calamine, followed by rolled gauze and an ace wrap from the base of the toes to one inch below the knee, two times a week on Mondays and Thursdays. -For the right leg with lymphedema: staff cleaned the leg with soap and water, applied triamcinolone, then applied special gauze with Calamine, followed by rolled gauze and an ace wrap from the base of the toes to one inch below the knee, two times a week on Mondays and Thursdays. Review of the Treatment Administration Record (TAR) for August 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 8/21/25. Review of the TAR for September 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 9/8/25. During a telephone interview on 1/6/25 at 8:20 AM, Nurse #11 stated she completed the treatment orders for Resident #36 in August and September 2025 but forgot to mark them as complete on the TAR. She confirmed she was assigned to Resident #36 on the days in August and September that were not marked as complete. Nurse #11 further stated she always completed her treatments as assigned. Review of the TAR for November 2025 revealed Resident #36's treatments for the right and left leg were not marked completed as ordered on 11/24/25. During an interview on 1/6/25 at 9:10 AM, Nurse #8 stated she completed the treatments for Resident #36 on 11/24/25 but forgot to mark the task complete on the TAR. Review of the TAR for December 2025 revealed Resident #36's treatments for the right and left leg were not	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 32 marked completed as ordered on 12/25/25. During an interview on 1/5/26 at 4:35 PM, the Assistant Director of Nursing (ADON) stated she was assigned to provide treatments for Resident #36 in 12/25/25. She added she provided the treatments but forgot to mark them as completed on the TAR. During an interview on 1/6/26 at 9:15 AM, the Director of Nursing (DON) stated staff should document treatments complete when they finish the task. An interview with the Administrator was conducted on 1/6/26 at 9:25 AM. She stated she would have expected the treatments to be documented as complete when the tasks were completed in real time. 3. Resident #54's physician orders revealed an order dated 8/13/25 for Lispro insulin 3 units to be administered subcutaneously 3 times a day with meals. Resident #54's Electronic Medication Administration Record (EMAR) for November 2025 revealed no nurse signature that indicated Lispro insulin 3 units was administered the following dates and times: - 11/20/25 at 8:30 AM, 12:00 PM, and 5:30 PM. - 11/21/25 at 8:30 AM - 11/29/25 at 5:30 PM In a telephone interview with Nurse #4 on 1/6/26 at 2:06 PM who was scheduled to work on 11/21/25 at 8:30 AM and 11/29/25 at 5:30 PM, she stated she did not recall those particular days, however, if she did not give insulin the EMAR should have been coded with a reason why. Nurse #4 added that she must have forgotten to sign the EMAR which left the boxes blank. During a telephone interview with Nurse #5 on 1/7/26 at 12:45 PM, she stated that she had been responsible for Resident #54 on 11/20/25 during the 7:00 AM to 7:00 PM shift. She explained that if the EMAR lacked a signature or code, it was because she had forgotten to sign it. Nurse #5 added that she did not recall a time she was not able to give insulin to Resident #54.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER: Windsor Rehabilitation and Healthcare Center	STREET ADDRESS, CITY, STATE, ZIP CODE: 1306 South King Street , Windsor, North Carolina, 27983		

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 33 In the final interview with the DON on 1/8/26 at 10:00 AM, she stated that there was no reason for Nurse #4 and Nurse #5 to have forgotten to sign the EMAR for Resident #54's insulin, as the resident name would have shown up as red when a medication had not been signed off as given, and green once it had been administered. She further stated that the EMAR system was set up this way to help nurses know which medications had been signed for and which had not. In an interview with the Administrator on 1/8/26 at 10:08 AM, she stated she was unaware there were medications unsigned for in Resident #54's EMAR. She further stated the EMAR system was set up to help nurses remember to give and sign off medications by highlighting the resident name with red if not signed off and green when it was signed off. 4. Resident #51 was admitted to the facility on 4/13/23 with a diagnosis of diabetes mellitus type 2 (DM II). A physician's order for Resident #51 with a start date of 10/22/25 and a discontinue date of 12/12/25 revealed Ozempic (semaglutide- medication for management of DM II and weight loss) (1 mg (milligram)/dose) subcutaneous solution pen injector 2 mg/1.5ml. Inject 1 mg subcutaneously (under the skin) one time a day every 7 days related to DM II. Ozempic (1 mg/dose) subcutaneous solution pen injector 2 mg/1.5ml (semaglutide) Inject 1 mg subcutaneously one time a day every 7 days related to DM II. Resident #51's October 2025 Medication Administration Record (MAR) revealed documentation on 10/23/25 at 9:30 AM by Nurse #7 indicating she administered Resident #51's Ozempic per the physician's order. On 1/6/26 at 9:46 in a telephone interview Nurse #7 stated she recalled being assigned to care for Resident #51 on 10/23/25 on the 7AM to 3PM shift. She reported her documentation on 10/23/25 at 9:30 AM indicating that she administered Resident #51's Ozempic was an error. She reported she recalled looking for the medication but not being able to find it. On 1/6/26 at 12:12 PM an interview with the Director of Nursing (DON) indicated that Nurse #7 should not have documented on Resident #51's MAR on 10/23/25 that she administered Ozempic 1 mg subcutaneously to Resident #51 if she had not actually administered it.	F0842		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: **345339**	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED **01/13/2026**
NAME OF PROVIDER OR SUPPLIER **Windsor Rehabilitation and Healthcare Center**		STREET ADDRESS, CITY, STATE, ZIP CODE **1306 South King Street , Windsor, North Carolina, 27983**	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = E	Continued from page 34 On 1/8/26 at 8:38 AM an interview with the Administrator indicated that Nurse #7 should not have documented on Resident #51's MAR on 10/23/25 that she administered Ozempic 1 mg subcutaneously to Resident #51 if she had not actually administered it.	F0842		
F0880 SS = E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to:	F0880	Immediate corrective action: Immediate re-education and return demonstration for staff observed noncompliant with donning and doffing isolation procedures process, handling of soiled lined, and Covid exposure testing processes were completed on 1/4/2026. Director of Nursing provided proof of education for staff observed noncompliant with donning and doffing isolation procedure process, on 01/04/2026. The Director of Nursing and ADON completed the same day all shift rounding on all isolation/EBP rooms to verify supplies/signage and compliance on 01/04/2026. No further issues were identified, and no residents had a covid exposure that would warrant testing on 1/5/2026. Systemic changes: All residents have the potential to be affected by this deficient practice. 100% observation by DON or Designee, proper soiled linen handled, and post- Covid testing workflow will be completed by 2/2/26. DON or designee will observe all residents on EBP/contact precautions to ensure staff are using the appropriate donning/ doffing infection control procedures and processes before or by 2/2/26. No other issues have been identified. If issues are identified during audits, immediate education will be provided. 3. Measurement to prevent recurrence: The Infection Prevention did education to include PPE expectations by precaution type, soiled linen handling, EBP workflow for high-contact care, and post-exposure COVID testing workflow completed by the director of	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 35 (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is NOT MET as evidenced by: Based on observations, record review and staff and Nurse Practitioner (NP) interviews, the facility failed to: 1.) to follow their infection control practices and procedures for Contact Precautions when Nurse Aide (NA) #1 entered resident's room under contact precautions without wearing a gown or gloves to pick up a meal tray 2.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when NA #2 provided a bed bath without wearing a gown and when NA #2 left dirty linens on the floor of the resident's room instead of placing them in a bag and later picked them up and held them against her body. 3.) follow CDC guidance for testing residents exposed to covid 4.) to implement their infection control policies and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident receiving enteral feedings when Nurse #2 failed to don (to put on) personal protective equipment	F0880	Continued from page 35 nursing before or by 2/2/26. All new hires will get education in orientation. Completed all PPE/Isolation -education for all nursing, CNA, housekeeping and therapy staff 2/2/26. Al l new hires will receive education in orientation. 4. Monitoring: DON/designee will conduct 5 observations/all shifts weekly x 12 weeks to ensure that soiled linen is handled properly and is worn appropriately for precaution type, and Covid testing any resident that is symptomatic, and follow up testing for covid. Review through the QAPI process for 3 months by the administrator. 5. Completion date: 02/04/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 36 (PPE) to include a gown. The deficient practice was identified for 4 of 17 staff observed for infection control practices (NA #1, NA #2, Nurse #2, and the previous Assistant Director of Nursing). Findings included: 1. The policy regarding contact precautions, dated October 2018, stated staff and visitors were required to perform hand hygiene and don disposable gloves and a gown upon entering the residents' room and remove them before exiting the room, performing hand hygiene upon exit. Observation of Resident #54's room door on 1/4/26 at 12:41 PM revealed signage titled Contact Precautions. The signage instructed everyone to perform hand hygiene and don gloves and a gown before entering the room and discard the gown and gloves before exiting the room and to then perform hand hygiene. Further observation revealed Nurse Aide (NA) #1 entered Resident #54's room without performing hand hygiene or donning gloves or a gown, picking up the residents' meal tray, exiting the room and placing the tray on the meal tray cart without follow-up hand hygiene. During an interview with NA #1 on 1/4/26 at 12:43 PM, she stated she had received training on infection control and contact precautions when she returned to work in December 2025. NA #1 acknowledged she should have performed hand hygiene, donned a gown and gloves before entering Resident #54's room and performed hand hygiene when leaving the room. She explained that Resident #54 was not her assigned resident and she was in a hurry, so she didn't look for the sign. On 1/4/26 at 12:49 PM, the Director of Nursing (DON) stated she and the Assistant Director of Nursing (ADON) provided infection control training, including contact precautions, to all new hires. The DON confirmed NA #1 should have performed hand hygiene and donned a gown and gloves before entering Resident #54's room and performed hand hygiene after exiting the room. She indicated that these precautions were implemented for the protection of both the staff and other residents. During an interview with the Assistant Director of Nursing (ADON), who also served as the Infection Preventionist (IP), on 1/4/26 at 12:57 PM, she stated NA #1 should have performed hand hygiene and donned a gown and gloves before entering Resident #54's room and should have performed hand hygiene after exiting the room. The facility had implemented contact precautions for Resident #54 due to a communicable disease. Contact	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026
NAME OF PROVIDER OR SUPPLIER: Windsor Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE: 1306 South King Street , Windsor, North Carolina, 27983	

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 37	F0880		

precautions protected both the resident from any disease-causing microorganisms the NA could have introduced into the room and protected the NA from carrying disease-causing microorganisms from the resident to other residents and staff in the facility.
The ADON added that she reminded nursing staff about contact precautions at least weekly and there was no reason for them to be unaware, as signs posted on the door stated hand hygiene and a gown and gloves were required before entering the room and hand hygiene was required upon exit. She confirmed NA #1 had received this training upon hire.

In an interview with the Administrator on 1/4/26 at 2:54 PM, she stated that NA #1 should have noticed the contact precaution sign on Resident #54's door and followed the recommendations to perform hand hygiene and wear a gown and gloves before she entered the room and to perform hand hygiene upon exit.

During an interview with the Nurse Practitioner on 1/6/26 at 2:55 PM, she stated that contact precautions were implemented for Resident #54 due to a diagnosis of a communicable disease. She added that contact precautions protected both the resident and staff from disease-causing microorganisms and prevented the spread of infections throughout the facility.

2. The policy regarding Enhanced Barrier Precautions (EBP) stated staff and visitors were required to perform hand hygiene and don a gown and gloves only for high-contact resident care with examples that included bathing/dressing and handling linens.

Observation of Resident #24's door revealed signage for EBP on 1/5/26 at 10:21 AM. The signage indicated that staff providing high contact care to Resident #24 were required to wear gowns and gloves for high contact care such as bathing/dressing or changing linens. Further observation revealed a hanging organizer in Resident #24's room, to the left of the door, that contained Personal Protective Equipment (PPE) including gowns and gloves.

After knocking on the door and receiving a reply, the door to Resident #24's room was opened and entered on 1/5/26 at 10:21 AM. NA #2 was observed in Resident #24's room wearing gloves and no gown and handling what appeared to be soiled linens. NA #2 dropped the linens onto a pile on the floor at the end of the resident's bed. When asked if she had been providing care, she stated she had just given the resident a bed bath. When asked if she had been wearing a gown, she questioned

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 38 whether one was needed in that room as she did not think Resident #24 required EBP. When directed to the EBP sign on the door, she replied “Oh, I didn’t even notice because I was in a hurry and this resident always rushes me. I guess I should have been wearing a gown.” While discussing the gown, NA #2 picked the pile of linen up off the floor, held it against her body, carried it across the room and dropped it on the floor next to the trash can by the door. NA #2 then took her personal fleece jacket off of a chair, while still wearing dirty gloves, and put her jacket on. When asked if the linens should be on the floor, she stated she just set them there for a minute while she put on her jacket. When asked if the soiled linen had been on the floor at the end of the bed, she stated “Oh, yeah.” NA #2 went on to say that soiled linens should not be on the floor and that she should have put them directly into a plastic bag when removed from the resident or bed. NA #2 indicated she had had training on EBP and handling soiled linen when she was hired about 5 months ago. During an interview with the Assistant Director of Nursing (ADON), who also served as the Infection Preventionist (IP), on 1/5/26 at 10:30 AM, she stated NA #2 should have been wearing a gown while providing a bed bath to Resident #24 and handling his soiled linens. The facility had implemented EBP for Resident #24 due to a chronic wound. EBP protected both the resident from any disease-causing microorganisms the NA could have introduced into the room and protected the NA from carrying disease-causing microorganisms from the resident to other residents and staff in the facility. The ADON added that she reminded nursing staff about wearing EBP at least weekly and there was no reason for them to be unaware, as signs posted on the door stated a gown and gloves were required during close contact care such as bed baths and handling dirty linens. She further stated that staff were not to place soiled linens anywhere except in a plastic bag immediately after removing them from the resident or the bed and confirmed NA #2 had received this training upon hire. During an interview with the Director of Nursing (DON) on 1/5/26 at 10:34 AM she stated that NA #2 received education on checking resident room doors for precaution signs and following the recommended guidelines, including the safe handling of soiled linen. NA #2 should have worn a gown and gloves while performing a bed bath and handling soiled linens, and the linens should have been placed directly into a plastic bag. These measures were intended to prevent disease-causing microorganisms from transferring	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 39 between the NA and the resident spreading to other residents in the facility. In an interview with the Administrator on 1/5/26 at 10:50 AM, she stated that NA #2 should have noticed the EBP sign on Resident #24's door and followed the recommendations to wear a gown and gloves. She added that NA #2 should have placed soiled linens directly into a plastic bag rather than on the floor to prevent disease-causing microorganisms from spreading throughout the room and being tracked into the facility. During an interview with the Nurse Practitioner on 1/6/26 at 2:45 PM, she stated that EBP was implemented for Resident #24 due to a chronic wound. She added that EBP protected both the resident and staff from disease-causing microorganisms and prevented the spread of infections throughout the facility. 3. Review of the Centers for Disease Control and Prevention (CDC) recommendations titled Infection Control Guidance: SARS-CoV-2 dated 6/24/24 revealed the CDC recommended "asymptomatic patients with close contact with someone with SARS-CoV-2 infection should have a series of three viral tests for SARS-CoV-2 infection. Testing is recommended immediately (but not earlier than 24 hours after the exposure) and, if negative, again 48 hours after the first negative test and, if negative, again 48 hours after the second negative test. This will typically be at day 1 (where day of exposure is day 0), day 3, and day 5." Review of the policy and procedure for the facility titled "Guidance and Protocol-COVID-19" dated 5/16/23 revealed when a resident was exposed to COVID-19, test immediately but generally not earlier than 24 hours after the exposure. Resident #76 was admitted to the facility on 8/20/25. Review of a grievance for Resident #76 dated 9/5/25 revealed the resident felt he should be tested for COVID since his roommate had tested positive on 9/2/25. He was tested on 9/5/25 as a response to the grievance and was negative. During an interview on 1/5/26 at 2:57 PM the Assistant Director of Nursing stated she was a floor nurse during Resident #76's stay in the facility. Resident #76's roommate tested positive for COVID on 9/2/25. She stated if a resident was exposed to COVID the resident should be tested no sooner than 24 hours after exposure but as soon as possible and she would have tested	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street , Windsor, North Carolina, 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 40 Resident #76 prior to 9/5/25. The Assistant Director of Nursing explained she was not over infection control at that time, it was the Previous Assistant Director of Nursing. She concluded Resident #76 should have been tested prior to 9/5/25 according to their policy which reflects the CDC guidance for nursing homes. During an interview on 1/6/26 at 11:57 AM the previous Assistant Director of Nursing stated she remembered Resident #76 and she was over infection control in September 2025 and she was new to infection control at that time. She stated the previous Administrator told her they do not test for COVID unless a resident was symptomatic. She stated she was surprised by this because the other places she had worked had tested the entire hall after a resident ended up being positive for COVID. She stated Resident #76 was eventually tested but could not remember the specific details around why he was tested. During an interview on 1/6/26 at 1:51 PM the Director of Nursing stated she was not working for the facility at the time of this occurrence. Upon reviewing the timing of Resident #76's testing, and the fact that he had to complete a grievance to get tested after his initial exposure to COVID on 9/2/25, the Director of Nursing stated the previous infection preventionist did not follow their COVID testing policy which reflected the CDC guidance for nursing home testing. She concluded she would expect COVID testing to be completed according to their policy and CDC guidance. 4. Review of the facility policy titled "Isolation-Categories of Transmission-Based Precautions" and last revised in October 2018 read in part; Enhanced Barrier Precautions (EBP), appropriate notification is placed above the residents bed so personnel and visitors are aware of the need for enhanced barrier precautions, the signage informs the staff of instructions for personal protective equipment (PPE) use while providing high contact care. The policy also stated in part, EBP requires the use of gown and gloves for high contact resident care activities in the resident room such as feeding tube. On 1/7/26 at 12:20 PM during an observation of enteral nutrition (delivers liquid nutrients and fluids directly into the gastrointestinal (GI) tract via a tube bypassing the mouth and throat) Nurse #2 entered Resident #8's room which had an EBP sign posted on the exterior of the door, to administer nutrition via gastrostomy tube (a hollow tube inserted directly through the skin of the abdomen into the stomach to deliver nutrition, hydration and medication). Nurse #2	F0880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street , Windsor, North Carolina, 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0880 SS = E	Continued from page 41 performed hand hygiene prior to entering the room and donned (put on) a clean pair of gloves but did not don a gown. Nurse #2 administered nutrition using a feeding syringe (a large 2-part syringe used to administer nutrition) through a gastrostomy tube. An interview was conducted with Nurse #2 on 1/7/26 at 12:30 PM. She stated she forgot to don a gown during the enteral feeding activity, she went on to say she should have worn a gown. An interview with the Director of Nursing (DON) was conducted on 1/7/26 at 12:45 PM. She stated Nurse #2 should have worn a gown while providing enteral nutrition when an EBP sign was posted. An interview with the Administrator was held on 1/7/26 at 12:55 PM. She stated she expected Nurse #2 to wear a gown while providing enteral nutrition to a resident in a room where there was an EBP sign posted.	F0880		
F0883 SS = D	Influenza and Pneumococcal Immunizations CFR(s): 483.80(d)(1)(2) §483.80(d) Influenza and pneumococcal immunizations §483.80(d)(1) Influenza. The facility must develop policies and procedures to ensure that- (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza	F0883	1. Immediate corrective action: 100% audit of all current resident immunization records for influenza consent completeness was done by the ADON who then obtained and documented/corrected any missing consents. Resident #80 family was called on 1/29/26 and were notified that facility gave infulenza shot and did not have the consent. Consent was given and Any concern identified was corrected immediately by the Director of Nursing on 01/28/2026. 2. Systemic changes: All residents have the ability to be affected by this deficient practice. 100% audit of all current resident immunization records for influenza consent completeness; obtained and documented/corrected any missing consents. Resident #80 family was called on 1/29/26 and were notified that facility gave influenza shot and did not have the consent. Consent was given at that time. Any concern identified was corrected immediately by the Director of Nursing on 01/28/2026. All influenza consents will be reviewed by the DON/Designee for completeness prior to vaccine administration. The DON/designee will communicate during the clinical daily meetings: 5 days/week about	02/04/2026

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	**1306 South King Street , Windsor, North Carolina, 27983**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0883 SS = D	Continued from page 42 immunization due to medical contraindications or refusal. §483.80(d)(2) Pneumococcal disease. The facility must develop policies and procedures to ensure that- (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's representative has the opportunity to refuse immunization; and (iv)The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is NOT MET as evidenced by: Based on record review and staff interview, the facility failed to ensure a consent was documented prior to administering the Influenza vaccination for 1 of 5 residents reviewed for vaccination status (Resident #80). Findings included: Resident #80 was admitted to the facility on 9/24/24. Review of Resident #80’s Medication Administration Record for September 2025 revealed she received the Influenza vaccine on 9/22/25. Review of Resident #80’s only immunization consent form in her medical record dated 11/20/25 revealed Resident #80 left the Influenza vaccination selection blank and did not sign consent for the Influenza vaccine.	F0883	Continued from page 42 the vaccines cannot be administered unless consent/declination documented. Added admissions/readmissions immunization consent verification. 3. Measures to prevent recurrences: All licensed nurses were educated to offer influenza and pneumococcal vaccine and consent forms are completed before administrating any vaccine before or by 2/2/26. All new hires will be educated during the orientation process. 4. Monitoring: DON/designee will audit 100% of influenza vaccine consents/declination prior to administrations 5 times a week x 12 weeks, and the administrator will bring it to QAPI for 3 months to review. 5. Completion date 02/04/2026	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345339	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED 01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Windsor Rehabilitation and Healthcare Center	1306 South King Street , Windsor, North Carolina, 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0883 SS = D	Continued from page 43 During an interview on 1/8/26 at 10:18 AM the Director of Nursing stated there was no consent on file for Resident #80 regarding the flu vaccination for 9/22/25. She further stated consents should always be acquired prior to administration of a vaccine and maintained in the resident's medical record.	F0883		