		ID HUMAN SERVICES MEDICAID SERVICES				M APPROVED
						O. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,			E SURVEY IPLETED
		345339	B. WING		11	C / 26/2024
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	R REHABILITATION AND	HEALTHCARE CENTER		306 SOUTH KING STREET VINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F 000			
	conducted from 11/21 additional information 11/26/2024. Onsite va action plans was cond Therefore, the exit da # SYK711. The follow investigated: NC0022	23307 and NC00224404. mplaint allegations did not				
	(J)	e was identified at: 760 at a scope and severity 770 at a scope and severity				
	Care. Immediate jeopardy b removed on 11/14/20	uted Substandard Quality of began on 10/25/2024, was 24, and the facility came ffective 11/14/2024. A partial				
F 760 SS=J		conducted. f Significant Med Errors	F 760			
	medication errors. This REQUIREMENT by: Based on observatio interview, staff intervi	ure that its- hts are free of any significant is not met as evidenced n, record review, resident ew, nurse practitioner hterview, pharmacist, and		Past noncompliance: no plan of correction required.		
			_			(X6) DATE
		SUPPLIER REPRESENTATIVE'S SIGNATUR	=	TITLE		. ,
Electroni	cally Signed					12/09/2024

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

	-	ID HUMAN SERVICES				FORM	/ APPROVED
	S FOR MEDICARE & DEFICIENCIES	PLE CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY				
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING	3	COMF	LETED
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2024
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 760	psychiatry nurse prace failed to administer 6 antipsychotic medicat of one resident review medication errors. Re- psychotic event after antipsychotic medicat broken shoulder and repair, acute blood los #11 has been bedbou Findings included: Resident #11 was adm 1/20/2023 with a diag schizophrenia. Resident #11 had a p milligrams (mg) Cloza administered as one f day for paranoid schiz 7/9/2024. The admini 8:00 AM and 8:00 PM Documentation in the Clozapine revealed th half-life of Clozapine was 8 hours with a ra the average elimination steady state with 100 hours. Half-life is the of a drug's active sub by half. Anemia and w be a rare side effect of The abrupt stopping of associated with agitat psychosis.	titioner interview the facility doses of a required tion for one (Resident #11) ved for significant isident #11 had an acute missing 6 doses of his tion resulting in a fall with a hip that required surgical ss and acute pain. Resident and since the incident. mitted to the facility on nosis of paranoid hysician's order for 200 apine, an antipsychotic, to be tablet by mouth two times a zophrenia initiated on stration times listed were 1. manufacturer's label for ne average elimination after a singe 75 mg dose, nge of 4 to 12 hours, while on half-life after achieving a mg twice a day dose, of 12 time it takes for the amount stance in the body to reduce vitamin B12 deficiency can of the medication Clozapine. of Clozapine has been tion and a rapid onset of	F	76			

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345339	B. WING				C /26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 760	9/19/2024 revealed R schizophrenia was "c documentation also ir adhering to his medic "a stable mental state Documentation on a c assessment dated 10 as cognitively intact w Resident #11 was coc up/cleanup for eating was dependent for to personal hygiene, and was coded as requirir with mobility. Resident #11 had a p initiated on 9/19/2024 complete blood count metabolic panel (CMR days for anemias and completed on 10/19/2 pharmacy requires blo a resident on the med the neutrophil counts There was no evidence record of the CBC an 10/19/2024. Resident #11 had an written by Nurse Prace 10/22/2024 at 11:17 A Clozapine to be held Documentation in a p #1 on 10/22/2024 at 7 "[Resident #11's] schi	Aesident #11's paranoid hronic" and "stable." The ndicated Resident #11 was ation regimen and indicated a." quarterly Minimum Data Set /10/24 coded Resident #11 vith no moods or behaviors. ded as requiring set and personal hygiene, but ileting, showers/bathing, d dressing. Resident #11 ng substantial assistance hysician's order dated as for blood to be drawn for a (CBC) and a complete P) on the night shift every 30 l vitamin deficiencies to be 2024 at 7:00 PM. The bood tests every 30 days for dication Clozapine to monitor in the blood. ce in the electronic medical d CMP test results dated additional physician's order stitioner (NP) #1 dated AM for the medication for 2 days until 10/24/2024. rogress note written by NP 7:55 PM revealed in part,	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345339	B. WING				C / 26/2024
NAME OF P	ROVIDER OR SUPPLIER	L		S	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	prescribed. Obtain ST (complete blood coun metabolic panel)." Documentation on a l Resident #11 reveale 10/23/2024 at 10:31 / at 10:31 AM, and rep 10/23/2024 at 11:15 / Documentation on the Administration Record #11 had the medicatio practitioner for the 8:00 the 8:00 AM dose on dose on 10/23/2024, 10/24/2024. Document indicated Resident #1 scheduled Clozapine 10/24/2024, and the 8 indicating an explana progress notes. Documentation in the administration record notes dated 10/24/20 medication Clozapine #11. Documentation in the dated 10/25/2024 at 9 for why the Clozapine to Resident #11. Medication Aide (Mec on 11/26/2024 at 9:04 confirmed she was as	a continue with therapy as TAT (immediate) CBC at) and CMP (comprehensive ab results report for d the collection date was AM, received at 10/23/2024 orted to the physician on AM. e October Medication d (MAR) indicated Resident on Clozapine on hold by the D0 PM dose on 10/22/2024, 10/23/2024, the 8:00 PM and the 8:00 AM dose on intation on the same MAR 11 did not receive the for the 8:00 PM dose on 3:00 AM dose on 10/25/2024 tion would be in the electronic medication (e-MAR) administration 24 at 9:01 PM indicated the a was on order for Resident e-MAR administration notes 0:23 AM had no explanation a dose was not administered 4 Aide) #1 was interviewed 4 AM. Med Aide #1	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE
F 760	10/25/2024 on the ev recalled that the medi at one point and then was administering me shift on 10/24/2024 at recalled that on the e Resident #11 did not was acting out with be seem like he was "po stated she was aware required laboratory va very important medica take. Med Aide #1 tho absence of the medica #11 to a nurse, but sh which nurse or the de Nurse #6 was intervie AM. Nurse #6 confirm assigned to administe #11 on the morning of stated she did inform #5) that the Clozapine available on the morn stated Nurse #5 conta sent the required labor pharmacy so that the be sent to the facility for onsite practitioner. Ne the Clozapine was pu on 10/22/2024 was be needed laboratory va to filling another 30-da to Resident #11. The	ening shift. Med Aide #1 ication Clozapine was held was not available when she edications on the evening ind 10/25/2024. Med Aide #1 vening shift on 10/24/2024, have a good night in that he ehaviors that made him ssessed." Med Aide #1 e the medication Clozapine alues monthly and was a ation for Resident #11 to bught she had reported the ation Clozapine for Resident the could not remember statis of the conversation. ewed on 11/25/2024 at 11:36 hed she was the nurse er medication to Resident f 10/25/2024. Nurse #6 the unit manager (Nurse e for Resident #11 was not sing of 11/25/2024. Nurse #6 the unit manager (Nurse e for Resident #11 was not ing of 11/25/2024. Nurse #6 acted the pharmacy and bratory report to the medication Clozapine would for Resident #11. ed on 11/22/2024 at 9:52 AM. blowing information. NP #1 hoday through Friday as an P #1 explained the reason at on hold for Resident #11 eccuse the pharmacy lues to be sent to them prior ay supply of the medication	F	760			

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		E CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 760	to filling the Clozapine known to the facility a order for blood to be of laboratory values eace explained by NP #1, w for Resident #11 were 10/19/2024 and were pharmacy. NP #1 exp entered an additional blood count) with diffe be completed STAT (if differential measures cells in your blood to conditions to include a immunodeficiencies.) Documentation in a p Resident #11 dated 1 written by Medical Do "Today, he was quite psychosis event at this reconcile, redirect and actually verbally offen the staff members as residents. The patien at the nursing station. wheelchair and I susp take a swing at a staff backward and fell on move him, but I did as on the floor. He denie However, I am concel injury from his fall. He Neurologically, he had this point. Neurologic his baseline other tha	e for Resident #11 was well nd there was a reoccurring drawn from Resident #11 for h month. The problem, as was that the laboratory tests e not drawn as ordered on then not faxed to the blained on 10/22/2024 she order for a CBC (complete erential for Resident #11 to mmediately). (A CBC with the number and types of help diagnose a variety of anemia, infection, or hysician's progress note for 0/25/2024 at 1:00 PM ctor (MD) #1 stated in part, ornery. He is having acute is point. Very difficult to d calm down. He was usive and abusive to many of well as me and other t became very angry while Attempted to get out of his bect probably attempted to f member when he fell the ground. We did not ssess him the best I could es complaints at this point. rned about his ongoing e did not strike his head. d no changes from his fall at cal assessment otherwise is n psychosis. Brief nt could not be completed to the patient being	F	760			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	D: 12/19/2024 MAPPROVED D. 0938-0391
STATEMENT C	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		E CONSTRUCTION	COMF	SURVEY PLETED
		345339	B. WING				C / 26/2024
NAME OF PF	ROVIDER OR SUPPLIER		·	S	STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOP		HEALTHCARE CENTER		1	1306 SOUTH KING STREET		
				V	WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	otherwise are stable a 15 minutes earlier, he (intermuscular) injecti calm him down I belie antihistamine that car	Services). His vital signs at this point. Approximately e received an IM ion of Benadryl in his arm to eve." Benadryl is an n have a sedative effect.	F	760			
	Resident #11, MD #1 MD #1 explained that around in his wheelch abusively threatening MD #1 on 10/25/2024 #11 was yelling, cuss and acting in a way h this resident. MD #1 explain rose up out of his whe to him "attempted to the staff members nearby ground. MD #1 explain periodically have vert something else." MD definitively say Resid doses of Clozapine at fall on 10/25/2024 wat accident because he the medication. (The accurate indication of effect of the drug pers confirmed there was a should have missed of completed and missed	the length of time that the sists in an individual.) MD #1 no reason Resident #11 getting the required lab work d doses of Clozapine.					
	revealed, "Nurse calle of resident's Clozapin Pharmacist requested	1:46 PM written by Nurse #5 ed pharmacy to check status ee oral tablet 200 mg. d to have copy of labs. oer request. [NP #1] made					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING (X3) DATE SURVEY COMPLETED NAME OF PROVIDER OR SUPPLIER 345339 MING 11/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 11/26/2024 WINDSOR REHABILITATION AND HEALTHCARE CENTER STREET ADDRESS, CITY, STATE, ZIP CODE 1306 SOUTH KING STREET		-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
345339 B. WING 11/26/2024 NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE WINDSOR REHABILITATION AND HEALTHCARE CENTER 1306 SOUTH KING STREET							COMP	LETED
WINDSOR REHABILITATION AND HEALTHCARE CENTER			345339	B. WING _				-
WINDSOR REHABILITATION AND HEALTHCARE CENTER	NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE	-	
THILDOON, NO 21000	WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			806 SOUTH KING STREET /INDSOR, NC 27983		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (x5) PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLETION TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI		COMPLETION
F 760 Continued From page 7 aware." F 760 Nurse #5 was interviewed on 11/25/2024 at 9:52 F 760 AM. Nurse #5 was interviewed on 11/25/2024 at 9:52 F 760 AM. Nurse #5 was in the office adjacent to the nursing station with NP #1 when Resident #11 1ell. Nurse #5 revealed Resident #11 usually had a calm demeanor when he received his medication Ciozapine, but when he did not receive his antipsycholic medication, he became almost "demonic." Nurse #5 explained that the medication Ciozapine required liab work to be completed prior to the pharmacy filling the medication. Nurse #5 further explained the nurses working at the facility should know Resident #11 required the medication Clozapine and that the lab work must be sent to the pharmacy for him to obtain it from the pharmacy. Nurse #5 stated the nurses who were working on the medication cart should know to call the pharmacy for him to obtain it from the pharmacy. Nurse #5 stated when she saw the manic state Resident #11 was in on 10/25/2024 she called the pharmacy for him to 2022/024 she called the pharmacy for him to Dizapine to the pharmacy be she surmis to the pharmacy, notified her the laboratory report was needed. Nurse #5 indicated after the pharmacy, notified her the laboratory report was needed, she immediately faxed the results to the pharmacy, and the pharmacy sent the Clozapine to the facility. Resident #11 had a physician's order dated 10/25/2024 initiated at 1:46 PM for 50 mg of Benadryl to be injected intramuscularly one time only for agitation for one day and may repeat in one hour if needed.	F 760	aware." Nurse #5 was intervie AM. Nurse #5 stated and she was in the of station with NP #1 wh #5 revealed Resident demeanor when he re Clozapine, but when I antipsychotic medicat "demonic." Nurse #5 medication Clozapine completed prior to the medication. Nurse #5 nurses working at the Resident #11 required and that the lab work pharmacy for him to c Nurse #5 stated the n the medication cart sh pharmacy if Resident Clozapine and the ph told the nurse the labo Nurse #5 stated when Resident #11 was in c pharmacy because sh had not received his a Nurse #5 indicated af her the laboratory rep immediately faxed the and the pharmacy set facility. Resident #11 had a p 10/25/2024 initiated a Benadryl to be injected only for agitation for c	ewed on 11/25/2024 at 9:52 she was the unit manager, fice adjacent to the nursing nen Resident #11 fell. Nurse #11 usually had a calm eceived his medication he did not receive his tion, he became almost explained that the required lab work to be a pharmacy filling the further explained the facility should know d the medication Clozapine must be sent to the obtain it from the pharmacy. urses who were working on hould know to call the #11 did not have his armacy would have readily oratory report was needed. In she saw the manic state on 10/25/2024 she called the ne surmised, he probably antipsychotic medication. ther the pharmacy notified oort was needed, she a results to the pharmacy, in the Clozapine to the hysician's order dated it 1:46 PM for 50 mg of ad intramuscularly one time	F	760			

Facility ID: 922993

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			LE CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345339	B. WING				C / 26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u>.</u>	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 760	Documentation on a t initiated on 10/25/202 Nurse #5 indicated R hospital because, "Re floor." Documentation on the #11 was administered Benadryl on 10/25/200 Documentation on a S Background, Assess Recommendation) co progress note dated 7 PM written by Nurse a assessment, "Reside behavior toward staff. Documentation in the dated 10/25/2024 at 3 stated, "Resident up a wheel[chair] with note and other residents. F having out [bursts] to attempted to stand up fell at nursing station. pain, refused help fro Physician] onsite, EM resident to ER (emerg family aware/unit mar Nurse #6 was intervie AM. Nurse #6 explain nurse and was not ve #11, but she did recal nurses' station. Nurse was rolling all around a very agitated state of	ransfer form dated as 24 at 1:57 PM written by esident #11 was sent to the esident threw himself on the e MAR revealed Resident d the ordered dose of 24 at 2:30 PM by Nurse #6. SBAR (Situation, ment, and mmunication form and 10/25/2024 initiated at 3:15 #6 revealed in the nursing nt having outburst with ." nursing progress notes 3:21 PM written by Nurse #6 and down the hall in ed behavior fussing at staff Resident talking to self, ward others. Resident o to hit at staff when resident Resident complained of m staff, [Primary Care IS/Police called to escort gency room). Resident nager aware."	F	760			

Facility ID: 922993

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	Resident #11 falling a had administered Ber obtained from NP #1. she went to the unit m know Resident #11 di Clozapine for adminis Resident #11 was cur up out of his wheelch either MD #1 or herse #11 fell, but was in su allow anyone to asses transport him to the h called. Documentation on the Resident #11 did not Clozapine for the 8:00 indicating an explanat progress notes. Documentation in the dated 10/25/2024 at 1 medication Clozapine #11. Record review of an e 10/25/2024 for Reside was uncooperative fo with continuous refus administered medicat him down enough to p shoulder. The x-ray o Resident #11 had a fr between the shoulder #11 was transferred b long-arm splint and sl	t the nurses' station, she hadryl to him with an order Nurse #6 stated, in addition hanager, Nurse #5, to let her d not have any more stration. Nurse #6 revealed rsing at MD #1 when he rose air and attempted to hit eff. Nurse #6 stated Resident ch a state he would not as him or for EMS to ospital so, the police were e October MAR indicated receive the scheduled 0 PM dose on 10/25/2024 tion would be in the e-MAR administration notes 10:24 PM indicated the e was on order for Resident r an x-ray of his left shoulder at #11 revealed resident r an x-ray of his left shoulder als. Resident #11 was ions intramuscularly to calm perform an x-ray of the left f the shoulder revealed acture of the long bone, r and the elbow. Resident was on orthopedics the	F	760			

If continuation sheet Page 10 of 36

			()(0) 1			10.0938-03	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	TE SURVEY MPLETED	
			A. DOILDING			С	
		345339	B. WING		11/26/2024		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
				1306 SOUTH KING STREET			
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		WINDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 760	Continued From page	e 10	F 76	0			
1 700		ed on 11/22/2024 at 9:52 AM	F 70	0			
		ation was provided. NP #1					
		th differential was completed					
		2024, but the results were					
		macy until 10/25/2024,					
		#11 missing seven doses of					
		e pharmacy sent another 30-					
	day supply on 10/26/	2024. NP #1 indicated the					
	medication Clozapine	e did not make Resident #11					
	lucid but did make hi	m manageable, so he was					
		ing all the time. NP #1					
		r office near the nursing					
		4 when Resident #11 started					
	yelling obscenities ar						
		around him. NP #1 stated					
		back away from Resident					
		actually see Resident #11					
		sident #11 hit the ground so					
		d by everyone. NP #1					
		nediately ordered for 911 to t #11 needed to be sent out.					
		ergency Medical Services uickly but Resident #11 was					
		ice had to be called to assist					
	the EMS workers.						
	An interview was cor	nducted with a pharmacist					
		armacy on 11/22/2024 at					
		macist revealed the following					
		ng to the pharmacy records,					
		of the ordered medication					
		2024. The Pharmacist called					
	-	2024 and notified them a new					
	prescription for the C	-					
		ent #11 needed to be faxed					
		hat another 30-day supply of					
		be sent to the facility. The					
	spoke to at the facility	ave any record of who she					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	ED: 12/19/2024 RM APPROVEE O. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345339	B. WING			11	C I/ 26/2024
	ROVIDER OR SUPPLIER	HEALTHCARE CENTER		13	TREET ADDRESS, CITY, STATE, ZIP CODE 306 SOUTH KING STREET /INDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETION DATE
F 760	Clozapine had an inc (Neutrophils are a typ help the body fight inf On 11/22/2024 at 11:: Resident #11 for the of pharmacy. The requir Resident #11 was not 10/22/2024. The phar with differential dated #11 on 10/25/2024. The phar with differential dated #11 on 10/25/2024 at set revealed, "[Resident at a [diagnosis] of close surgical neck of the left that runs from upper set unspecified fracture in fracture morphology in have enough information in the dated 10/30/2024 at set Director of Nursing re- transferred to another of a hip fracture was of	vas the value the itoring because residents on reased risk for infection. be of white blood cell that fection and heal from injury.) 20 AM a new prescription for Clozapine was sent to red CBC with differential for t sent to the pharmacy on rmacy received the CBC 10/23/2024 for Resident the pharmacy sent a 30-day ne to the facility on the 4. The Pharmacist stated if pine, used for paranoid bruptly stopped there was hosis and increase in Clozapine's short duration of 8. Nursing Progress notes 5:30 PM written by Nurse #6 #11] return from hospital with d displaced fracture of the eff humerus (the long bone shoulder to the elbow), norphology. (Unspecified means the doctor does not tion to describe the exact bone fracture.) New order to 3 days. Sling to left arm	F	760			

Facility ID: 922993

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/19/2024 M APPROVED D. 0938-0391	
STATEMENT (OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345339	B. WING				C / 26/2024	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•		
WINDSOR	R REHABILITATION AND	HEALTHCARE CENTER			306 SOUTH KING STREET			
	1			N	/INDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 760	explain the responsib was contacted to upd regarding Resident # of Resident #11 susta he fell on 10/25/2024 not had any other fall Documentation in a d hospital revealed Res hospitalization from 1 surgical repair of a ler while in the hospital F problem areas and pr loss with transfusion pain due to trauma. An interview was con (NA) #5 on 11/22/202 revealed she worked PM) and second (3:0	Alle party for Resident #11 late health information 11 and discuss the likelihood aining the hip fracture when because Resident #11 had s. lischarge summary from the sident #11 had a 0/29/2024 to 11/6/2024 for ft hip fracture. Additionally, Resident #11 had the rocedures of acute blood of 2 units of blood and acute ducted with a Nurse Aide 24 at 12:14 PM. NA #5 on the first (7:00 AM to 3:00 0 PM to 11:00 PM) shift rated she knew the care	F	760				
	Resident #11 would of with a one person stat wheelchair prior to his Resident #11 was a of now and would require of bed, but he no long NA #5 stated she knet the mechanical lift. Resident #11 was ob- asleep in bed laying of 11:10 AM, and 1:04 F An observation and in with Resident #11 on Resident #11 was lay	beccasionally get out of bed and and pivot to the s fall. NA #5 stated that completely different person re a mechanical lift to get out ger wants to get out of bed. w Resident #11 did not like served on 11/22/2024 to be on his right side 9:46 AM,						

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION		10. 0938-039
ND PLAN OF	CORRECTION	DENTIFICATION NUMBER:			CON	MPLETED
			D. MANO			С
		345339	B. WING			1/26/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD	E	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE
F 760	Continued From page	- 13	F 76	0		
1 700		in in his hip, and he longer	F /0	0		
	felt like he could get o	i i				
	An interview was con	ducted with MD #1 on				
		AM. MD #1 stated he visited				
		11/22/2024 to encourage				
		apy. MD #1 stated the it #11 was to just stay in bed				
	and not move at this					
	Documentation in a p	sychiatry progress note				
		tten by NP #2 revealed				
		resent illness portion in part,				
		Clozapine a few days ago,				
	-	ence of his delusions and ncident escalated to the point				
		to physically confront a				
		fall. Since resuming his				
		toms have subsided, and he				
	· ·	g well again. The goal is to				
	-	irrence in the future by				
		ccess to his medication. His				
		gimen will be continued a follow-up planned in a				
	few weeks."					
		ed on 11/22/2024 at 1:43 PM.				
		ard to say if the behaviors of				
		25/2024 were due to him				
	-	lozapine over two and a half ne half-life of Clozapine was				
	-	2 revealed she visited the				
		ks and usually the facility				
		onal verbal behaviors from				
	Resident #11 and nev	ver reported physical				
	behaviors.					
	The Director of Nursi	ng was interviewed on				
		ng was initel vieweu un				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/19/2024 MAPPROVED). 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í			(X3) DATE	
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
					1306 SOUTH KING STREET		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		,	WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 760	acknowledged the fac the needed laboratory pharmacy for the disp Clozapine on 10/19/2 acknowledged NP #1 order for the faxing of pharmacy after it was further delaying the di Clozapine to Residen The facility was notifie jeopardy on 11/22/202 The facility submitted action plan on 11/23/2 Address how corrective accomplished for those been affected by the of On 10/22/24 at 8:00 p medication could not by the provider due to When the nurse notifie medication not being pharmacy stated the n work to be completed prior to dispensing the the provider was notifion obtained to draw stat results of the labs were the morning and the p physician order to fax so the medication coul 10/25/24 at 1:26 pm t pharmacy the medication	cility initially failed to obtain r report required by the rensing of the medication 024. The DON also failed to give a separate the laboratory report to the obtained on 10/23/2024, aspensing of the medication t #11. ed of the immediate 24 at 3:39 PM. the following corrective 2024: we action will be se residents found to have deficient practice : om. Resident #11's be administered as ordered o it not being available. ed the pharmacy of the available to administer the medication required lab and faxed to the pharmacy e medication. On 10/22/24. The re received on 10/23/24 in provider failed to place a the results to the pharmacy ild be dispensed. On	F	760			

Facility ID: 922993

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/19/2024 MAPPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´			(X3) DATE	E SURVEY PLETED
		345339	B. WING				C / 26/2024
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	1 11/	20/2024
					1306 SOUTH KING STREET		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	pharmacy stated they results to dispense th was notified and state completed and neede pharmacy. The lab re pharmacy and receive 1:42PM. The pharma at 1:59pm. The facility medication on 10/26/2 Resident #11's medic administered at 8:00a ordered by the provid Address how the facil residents having the p the same deficient pra An audit of all current the Director of Nursin if any other residents to medication distribuio other residents requir medication distribuio no other residents affi practice of significant Address what measur systemic changes ma deficient practice will Licensed nurses were process that the provi order for lab work. Th Medication Administra Nurse will ensure a la placed in the lab book Results of the lab are electronic medical rec	 a had not received the lab a medication. The provider a the lab work had been a to be faxed to the asults were faxed to the astice: residents was completed by g on 10/23/24 to determine required lab work previous tion from pharmacy. No astice lab work prior to n indicating that there were acted by the deficient medication errors. res will be put into place or ade to ensure that the not recur: a educated on the new der will enter a physician a order will be on the ation Record. The Licensed b form is completed and c for the lab to be drawn. 	F	760			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/19/2024 MAPPROVED D. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 17	20/2024
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER			306 SOUTH KING STREET VINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 760	review. When applicate placed on the medicate when a lab is required pharmacy for medicate providers were educate process by the Direct order appears on the record the licensed medicate results are faxed to the Education was provide Nursing to licensed sist staff on 11/12/24 to 1 enter a physician order will be on the Medicate The Licensed Nurse were completed and placed to be drawn. Results the electronic medicate the results are received applicable will order for the pharmacy. The or medication administrate required to be faxed to medication distribution on the medication addition addition licensed nurse will em faxed to the pharmace Indicate how the facil performance to make sustained: On 11/4/24 the Qualitt (Administrator, Director Director of Nursing, m Director, social service	ble, a separate order will be tion administration record d to be faxed to the tion distribution. The ted on 11/8/24 of the new or of Nursing. When the Medication Administration urse will ensure the lab he pharmacy. Hed by the Director of taff and licensed agency 1/13/24 that the provider will er for lab work. The order tion Administration Record. will ensure a lab form is d in the lab book for the lab of the lab are integrated with I records system and once ed the provider when or lab results to be faxed to der will be placed on the ation record when a lab is to the pharmacy for n. When the order appears ministration record the sure the lab results are y.	F	760			

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	MENT OF HEALTH AN	ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/19/2024 M APPROVED O. 0938-0391
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · /	E CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345339	B. WING			C / 26/2024
NAME OF P	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 760	was made that the Di Designee will audit th provider entered a ph the order was placed Administration Record and placed in the lab drawn; an order was pharmacy for medicat applicable; the results pharmacy when appli administered as order prevent a significant r the order appears on administration record ensure the lab results All ordered lab work w previous day to ensur reviewed by the provi to the pharmacy timel medication error on M ordered lab work thro Monday for two week weeks. Results of the by the Director of Nur facility Quality Assura Improvement (QAPI) three months for revie action. Alleged date of imme and compliance date: The corrective action 11/26/24. Interviews w sample of nurses to v conducted for nurses results and pharmacy Documentation of in-s	rector of Nursing or at includes the following: the ysician order for lab work; on the Medication d; a lab form was completed book for the lab to be placed to fax the results to tion distribution when a were received and faxed to cable; and the medication is red by the provider to medication error; and when the Medication the licensed nurse will a re faxed to the pharmacy. will be reviewed from the re results have been der and as applicable faxed by to prevent a significant fonday through Friday with ugh the weekend reviewed s and then weekly for ten ese audits will be presented rsing or Designee to the nce and Performance Committee monthly for ew and, if warranted, further diate jeopardy removal date 11/14/2024 plan was validated on were conducted with a erify education was regarding processing lab notification of lab results.	F 760			

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	-				FORM APPROVE OMB NO. 0938-039		
DEPARTMENT OF HEALTH AND HUMAN SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: AMB PLAN OF CORRECTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION NAME OF PROVIDER OR SUPPLIER WINDSOR REHABILITATION AND HEALTHCARE CENTER Continued From page 18 (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 760 Continued From page 18 the ongoing monitoring audits to identify residents that required labs for medication administration were verified to be completed. In an interview with the Director of Nursing on 11/26/24 at 12:00 pm, she stated that nurses, had been educated on the process for physician orders for medications that required lab monitoring and the completion of labs, to include to fax results to the pharmacy where indicated. The providers were also educated on the new process. Resident #11's medical record revealed the resident had received all prescribed doses of Clozapine from 11/14/24 through present. He had an order for labs and a separate order to fax lab results related to the medication, clozapine to the pharmacy every 28 days. The facility's immediate jeopardy removal date and compliance date of 11/14/24 was validated. F 770 Laboratory Services CFR(s): 483.50(a)(1)(i)		. ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED C			
		345339	B. WING _			26/2024	
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP CODE	•		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983			
PREFIX	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 770	the ongoing monitorin that required labs for were verified to be co the Director of Nursin she stated that nurses process for physician required lab monitorin labs, to include to fax where indicated. The educated on the new medical record reveal received all prescribe 11/14/24 through press labs and a separate of related to the medicat pharmacy every 28 da jeopardy removal date 11/14/24 was validate Laboratory Services CFR(s): 483.50(a)(1)(§483.50(a) Laborator §483.50(a) Laborator §483.50(a)(1) The fac laboratory services to residents. The facility and timeliness of the (i) If the facility provid services, the services requirements for labo of this chapter. This REQUIREMENT by: Based on observatio interview, and psychia interview the facility fac	g audits to identify residents medication administration mpleted. In an interview with g on 11/26/24 at 12:00 pm, s, had been educated on the orders for medications that ag and the completion of results to the pharmacy providers were also process. Resident #11's ed the resident had d doses of Clozapine from sent. He had an order for order to fax lab results tion, clozapine to the ays. The facility's immediate e and compliance date of ad. (i) y Services. es its own laboratory must meet the applicable ratories specified in part 493 f is not met as evidenced n, record review, resident ew, nurse practitioner nterview, pharmacist	F 7				

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		D HUMAN SERVICES				FORM	APPROVED
	S FOR MEDICARE & I	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	E CONSTRUCTION	(X3) DATE	0. 0938-0391 SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:					LETED
		345339	B. WING				C
	ROVIDER OR SUPPLIER	345339	B. WING		STREET ADDRESS, CITY, STATE, ZIP CODE	11/	26/2024
					1306 SOUTH KING STREET		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		۷	WINDSOR, NC 27983		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION	_	(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
					DEFICIENCY)		
F 770		40					
F 770	15		F	770			
	the pharmacy as requ	for one (Resident #11) of					
	-	for laboratory services.					
		acute psychotic event after					
	-	e not obtained and faxed to renewal of his antipsychotic					
		#11 suffered a fall with a					
		hip that required surgical					
		ss and acute pain. Resident					
	#11 has been bedbou	m since the incident. m the medication can cause					
		udden return of psychotic					
	symptoms). Findings						
		nitted to the facility on					
	1/20/2023 with a diag schizophrenia.	nosis of paranoid					
	-	hysician's order for 200					
		pine, an antipsychotic, to be					
	administered as one t day for paranoid schiz	ablet by mouth two times a					
		stration times listed were					
	8:00 AM and 8:00 PM						
	Documentation in the	manufacturer's label for					
		e average elimination					
	half-life of Clozapine	after a singe 75 mg dose					
		nge of 4 to 12 hours, while					
		on half-life after achieving a mg twice a day dose, of 12					
		pping of Clozapine has					
	been associated with	agitation and a rapid onset					
	of psychosis.						
	Documentation in the	assessment and plan					
	portion of a psychiatry	/ progress note date					
		esident #11's paranoid					
	schizophrenia was "cl	hronic" and "stable." The					

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	M APPROVED D. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			PLE CONSTRUCTION	(X3) DATE COM	E SURVEY PLETED
		345339	B. WING				C / 26/2024
NAME OF PI	ROVIDER OR SUPPLIER		•		STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 770	adhering to his media "a stable mental state Resident #11 had a p initiated on 9/19/2024 complete blood count metabolic panel (CMF days for anemias and completed on 10/19/2 and vitamin B12 defici- effect of the medication Documentation on a c assessment dated 10 as cognitively intact w behaviors. Resident # substantial assistance Documentation on the Administration Record 10/19/2024 at 7:00 Pl order for a CBC and a There was no evidend record for Resident # laboratory results from Nurse #2 was intervie AM. Nurse #2 explain on the 7:00 PM to 7:0 acknowledged she ch Resident #11's CBC a 10/19/2024, but it was further explained the for Resident #11 invo the necessary paperv so that when the phle	hysician's order dated as for blood to be drawn for a (CBC) and a complete P) on the night shift every 30 vitamin deficiencies to be 2024 at 7:00 PM. Anemia ciency can be a rare side on Clozapine. quarterly Minimum Data Set V10/24 coded Resident #11 vith no mood issues or #11 was coded as requiring with mobility and transfers. e October Medication d (MAR) revealed on M Nurse #2 completed the a CMP for Resident #11. ce in the electronic medical 11 of the CBC and CMP n 10/19/2024. ewed on 10/22/2024 at 11:01 hed she worked in the facility 00 AM shift. Nurse #2 hecked off on the MAR that and CMP were completed on s not completed. Nurse #2 order for laboratory services lved the nursing staff putting vork into a laboratory book abotomist came to draw	F	77			
		botomist came to draw ght and 5:00 AM, they would					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	FIPLE	E CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _			LETED
		345339	B. WING				C 26/2024
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	1	
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1	306 SOUTH KING STREET		
WINDOON				V	WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	Continued From page have the necessary in #2 stated that usually services for the reside and the information for completed by the day stated she must have forgot on 10/19/2024 information into the la phlebotomist who corr blood for Resident #1 understand the syster to obtain laboratory so was the first time she services for Resident Resident #11 had an written by Nurse Prace 10/22/2024 at 11:17 A Clozapine to be held at 11:17 AM. NP #1 was interviewe NP #1 revealed the for explained the reason hold for Resident #11 because the pharmace be sent to them prior supply of the medicat	e 21 Information to do so. Nurse the orders for laboratory ents were acknowledged or the laboratory book was shift nursing staff. Nurse #2 been distracted or just to put the required boratory book for the nes to the facility to draw the 1. Nurse #2 stated she did m and process for residents ervices, but she thought this had to obtain laboratory #11. additional physician's order titioner (NP) #1 dated AM for the medication for two days until 10/24/2024 ed on 11/22/2024 at 9:52 AM. ollowing information. NP #1 the Clozapine was put on on 10/22/2024 was ey needed laboratory tests to to filling another 30-day ion to Resident #11. The	F	770			
	puts a resident at high requirement for the la	e CBC because Clozapine her risk for infections. The boratory tests to be sent to filling the Clozapine for					
	Resident #11 was we there was a reoccurrin drawn from Resident	II known to the facility and ng order for blood to be #11 for laboratory tests time prior to Resident #11					
	explained by NP #1, v	was that the laboratory tests e not drawn as ordered on					

Facility ID: 922993

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	-	D HUMAN SERVICES				FORM	12/19/2024 APPROVED
	<u>S FOR MEDICARE & I</u> DF DEFICIENCIES		()(0) 1411				0.0938-0391
	CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ì í		E CONSTRUCTION	(X3) DATE COMP	LETED
				- ¹⁰			C
		345339	B. WING				26/2024
NAME OF PI	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDOOD				1	1306 SOUTH KING STREET		
WINDSOR	REHABILITATION AND	HEALINCARE CENTER		۱	WINDSOR, NC 27983		
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE
1/10					DEFICIENCY)		
			1				
F 770	Continued From page	22	F	770			
	10/19/2024 and were	then not faxed to the					
		lained on 10/22/2024 she					
	entered an additional						
	STAT (immediately) w	nt #11 to be completed					
		of his Clozapine. (A CBC					
		ures the number and types					
		to help diagnose a variety of					
	conditions to include i	nfection.)					
	An interview was con	ducted with a Pharmacist					
		macy on 11/22/2024 at					
		nacist revealed that because					
		tory tests, the medication					
	-	ailable for the nurses to					
		ronic medication dispensing					
	cabinet for Resident #	bry tests were required					
		could be dispensed from					
		ere was no other way of					
	obtaining the medicat	ion for Resident #11.					
	_						
		rogress note written by NP /:55 PM revealed in part,					
	"[Resident #11's] schi	• •					
		t therapy. Will order lab					
		I continue with therapy as					
		AT (immediate) CBC and					
		MP measure the number					
	and types of cells in y a variety of conditions	our blood to help diagnose					
	Documentation on a I	ab results report for					
	Resident #11 reveale	d the collection date was					
		AM, received at 10/23/2024					
		orted to the physician on					
	10/23/2024 at 11:15 /	NIVI.					
	Documentation on the	e October Medication					

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		ID HUMAN SERVICES MEDICAID SERVICES				F	NTED: 12/19/2024 ORM APPROVED 3 NO. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED		
		345339	B. WING				C 11/26/2024	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADD	RESS, CITY, STATE, ZIP CODE			
				1306 SOUTH	I KING STREET			
WINDSOF	R REHABILITATION AND	HEALTHCARE CENTER		WINDSOR,	NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	-	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION ROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 770	Administration Record #11 had the medication practitioner for the 8:0 the 8:00 AM dose on dose on 10/23/2024, 10/24/2024. Document indicated Resident #1 scheduled Clozapine 10/24/2024, the 8:00 and the 8:00 PM dose Documentation in a p Resident #11 dated 1 written by Medical Doc "Today, he was quite psychosis event at the reconcile, redirect and actually verbally offer the staff members as residents. The patient at the nursing station, wheelchair and I susp take a swing at a staff backward and fell on move him, but I did as on the floor. He denie However, I am conce injury from his fall. H Neurologically, he hat this point. Neurologic his baseline other that orthopedic assessme after a fall secondary stabilized on the grout [Emergency Medical otherwise are stable a 15 minutes earlier, he	d (MAR) indicated Resident on Clozapine on hold by the 00 PM dose on 10/22/2024, 10/23/2024, the 8:00 PM and the 8:00 AM dose on intation on the same MAR 11 did not receive the for the 8:00 PM dose on AM dose on 10/25/2024, e on 10/25/2024. hysician's progress note for 0/25/2024 at 1:00 PM octor (MD) #1 stated in part, ornery. He is having acute is point. Very difficult to d calm down. He was asive and abusive to many of well as me and other at became very angry while . Attempted to get out of his bect probably attempted to f member when he fell the ground. We did not assess him the best I could es complaints at this point. rned about his ongoing e did not strike his head. d no changes from his fall at cal assessment otherwise is n psychosis. Brief nt could not be completed to the patient being nd awaiting EMS Services]. His vital signs at this point. Approximately e received an IM on of Benadryl in his arm to	F	770				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT C	F DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPLE	ECONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	NG _		COMPLETED	
		345339	B. WING				26/2024
NAME OF PF	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			1306 SOUTH KING STREET NINDSOR, NC 27983		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 770	An interview was com Resident #11, MD #1 MD #1 explained that around in his wheelch abusively threatening MD #1 on 10/25/2024 #11 was yelling, cussi and acting in a way he this resident. MD #1 er rose up out of his whe to him "attempted to t staff members nearby ground. MD #1 explai periodically have vert something else." MD definitively say missin at the time of the incid was a direct cause of was unsure of the hal (The half-life provides) the length of time that persists in an individu was no reason Reside getting the required la missed doses of Cloz Documentation in the dated 10/25/2024 at 1 revealed, "Nurse calle of resident's Clozapin Pharmacist requested Nurse [#5] faxed lab p aware."	h have a sedative effect. ducted with the physician for , on 11/22/2024 at 1:23 PM. Resident #11 was rolling hair acting very verbally staff, other residents, and . MD #1 explained Resident ing, and speaking in tongues e had never seen before for explained that Resident #11 eelchair and what looked like ake a swing" at one of the r, when he fell hard on the ned that Resident #11 did behaviors but "this was #1 stated he could not og the six doses of Clozapine dent and fall on 10/25/2024 the accident because he f- life of the medication. a n accurate indication of t the effect of the drug al.) MD #1 confirmed there ent #11 should have missed ab work completed and apine. nursing progress notes 1:46 PM written by Nurse #5 ed pharmacy to check status e oral tablet 200 mg. t to have copy of labs. ber request. [NP #1] made	F	770			
		she was the unit manager, fice adjacent to the nursing					

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		ID HUMAN SERVICES MEDICAID SERVICES			FOF	ED: 12/19/202 RM APPROVE O. 0938-039	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE (A. BUILDING	CONSTRUCTION	(X3) DAT	E SURVEY IPLETED	
		345339	B. WING		C 11/26/2024		
NAME OF P	ROVIDER OR SUPPLIER	I	STI	REET ADDRESS, CITY, STATE, ZIP CODE	•		
		HEALTHCARE CENTER	130	6 SOUTH KING STREET			
WINDSON	REHABILITATION AND	HEALINGARE GENTER	wi	NDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE	
F 770	#5 revealed Resident demeanor when he re Clozapine, but when antipsychotic medica "demonic." Nurse #5 medication Clozapine be completed prior to medication. Nurse #5 nurses working at the Resident #11 required and that the laborator pharmacy for the med the pharmacy. Nurse were working on the 1 known to call the phar not have his Clozapin have readily told the 1 was needed. Nurse # manic state Resident she called the pharmach he probably had not r medication. Nurse #5 pharmacy, and the pharmack pharmacy, and the pharmack to the facility.	hen Resident #11 fell. Nurse #11 usually had a calm eccived his medication he did not receive his tion, he became almost explained that the e required laboratory tests to the pharmacy filling the further explained the e facility should have known d the medication Clozapine by tests must be sent to the dication to be obtained from #5 stated the nurses who medication cart should have rmacy if Resident #11 did he and the pharmacy would nurse the laboratory report to stated when she saw the #11 was in on 10/25/2024 acy because she surmised, received his antipsychotic indicated after the r the laboratory report was ately faxed the results to the harmacy sent the Clozapine SBAR (Situation, ment, and ommunication form and 10/25/2024 initiated at 3:15 #6 revealed in the nursing nt having outburst with	F 770				
		nursing progress notes 3:21 PM written by Nurse #6 and down the hall in					

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		ID HUMAN SERVICES			FOF	ED: 12/19/202 RM APPROVE	
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE C A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345339	B. WING		C 11/26/2024		
NAME OF P	ROVIDER OR SUPPLIER		STF	REET ADDRESS, CITY, STATE, ZIP COD			
			130	6 SOUTH KING STREET			
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER	wii	NDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 770	wheel[chair] with note and other residents. If having out [bursts] to attempted to stand up fell at nursing station. pain, refused help fro Physician] onsite, EW resident to [emergend aware/unit manager a Nurse #6 was intervite AM. Nurse #6 reveale who only periodically #6 stated that Reside state rolling around th swearing at everyone Nurse #6 indicated sh Nurse #6 indicated sh Nurse #5, when durin administration, she m have his antipsychoti Nurse #6 stated Nurse pharmacy and was to laboratory tests to be to the distribution of to pharmacy. Record review of an e 10/25/2024 for Resid was uncooperative fo with continuous refus administered medicat him down enough to shoulder. The x-ray o Resident #11 had a fi between the shoulder #11 was transferred to long-arm splint and s	ed behavior fussing at staff Resident talking to self, ward others. Resident o to hit at staff when resident Resident complained of m staff, [Primary Care IS/Police called to escort cy room]. Resident family aware." ewed on 11/25/2024 at 11:36 ed she was an agency nurse worked at the facility. Nurse ent #11 was in an agitated he facility in a wheelchair e around him on 10/25/2024. he notified the charge nurse, ng her medication pass oted Resident #11 did not c medication, Clozapine. he #5 contacted the old Resident #11 required sent to the pharmacy prior	F 770				

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/19/2024 MAPPROVED O. 0938-0391
STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED C
		345339	B. WING		11	/26/2024
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP COD	•	
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER	1:	306 SOUTH KING STREET		
			N	VINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
F 770	Continued From page	e 27	F 770			
	and the following add provided. NP #1 rever differential was comp 10/23/2024, but the r pharmacy until 10/25 #11 missing seven do the pharmacy sent ar 10/26/2024. NP #1 in Clozapine did not ma did make him manag hollering and yelling a she was in her office 10/25/2024 when Re obscenities and could everyone around him #1 step back away fr did not actually see h Resident #11 hit the g heard by everyone. N immediately ordered Resident #11 needed indicated Emergency arrived very quickly b belligerent the police EMS workers. NP #1 incident on 10/25/202 results of the CBC fro faxed to the pharmacy was acting like he wa medication. NP #1 st called the pharmacy laboratory results for An interview was com from the facility's pha 10:25 AM. The Pharm	bleted as ordered on esults were not faxed to the /2024, resulting in Resident obses of his Clozapine until nother 30- day supply on dicated the medication like Resident #11 lucid but eable, so he was not all the time. NP #1 stated near the nursing station on sident #11 started yelling d be heard threatening h. NP #1 stated she saw MD om Resident #11, but she sim fall. NP #1 stated ground so hard it could be NP #1 explained MD #1 for 911 to be called as d to be sent out. NP #1 Medical Services (EMS) but Resident #11 was so had to be called to assist the indicated that after the 24 she questioned if the om 10/23/2024 were ever by because Resident #11 as not on his psychoactive ated at that point someone to check if they received the				

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		ID HUMAN SERVICES MEDICAID SERVICES				FC	TED: 12/19/2024 DRM APPROVED NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU			CONSTRUCTION	(X3) D.	ATE SURVEY OMPLETED	
		345339	B. WING			C 11/26/2024		
NAME OF P	ROVIDER OR SUPPLIER		•	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER		13	806 SOUTH KING STREET			
WINDSON	REHADIEITATION AND			w	/INDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 770	Clozapine on 10/22/2 the facility on 10/22/2 need for a CBC differ faxed to the pharmac supply of the medicat facility. The Pharmac of who she spoke to a Pharmacist explained blood test CBC with of a resident on the medicat the neutrophil counts. Nei fight off infection in the very low levels of neu- vulnerable to infection differential for Reside pharmacy on 10/22/2 the CBC with different Resident #11 on 10/2 a 30-day supply of the the morning of 10/26/ stated if the medication paranoid schizophrent there was usually reb increase in behaviors duration of action. Documentation in the dated 10/25/2024 at a revealed, "[Resident a a [diagnosis] of close surgical neck of the lef fracture morphology. Orthopedics in 3 days The humerus is the log upper shoulder to the	of the ordered medication 2024. The Pharmacist called 2024 and notified them of a ential for Resident #11 to be by so that another 30-day tion could be sent to the ist did not have any record at the facility. The d the pharmacy requires the differential every 30 days for dication Clozapine to monitor in the blood. Residents develop dangerously low eutrophils are the cells that the body and if someone had utrophils; he or she can be ns. The required CBC with not #11 was not sent to the 024. The pharmacy received tial dated 10/23/2024 for 25/2024. The pharmacy sent e Clozapine to the facility on 2024. The Pharmacist on Clozapine, used for nia, was abruptly stopped round psychosis and a related to Clozapine's short	F	770				

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/19/2024 M APPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE	E SURVEY PLETED
		345339	B. WING		11	C / 26/2024
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		1306 SOUTH KING STREET WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 770	enough information to or pattern of a bone fi Documentation in a n 10/29/2024 at 6:07 Pl #11 was sent to the e difference in legs and Documentation in a d hospital revealed Res hospitalization from 1 surgical repair of a lef while in the hospital F additional problem ar blood loss with transf acute pain due to trau An interview was con (NA) #5 on 11/22/202 revealed she worked PM) and second (3:00 routinely. NA #5 indic needs of Resident #1 Resident #11 would c with a one person sta wheelchair prior to his Resident #11 was a c now and required a m bed, but he no longer #5 stated she knew F mechanical lift. Resident #11 was ob asleep in bed laying c 11:10 AM, and 1:04 F	b describe the exact shape racture. ursing progress note dated M revealed that Resident mergency room for a swelling to his knee. ischarge summary from the sident #11 had a 0/29/2024 to 11/6/2024 for ft hip fracture. Additionally, Resident #11 had the eas and procedures of acute usion of 2 units of blood and uma. ducted with a Nurse Aide 4 at 12:14 PM. NA #5 on the first (7:00 AM to 3:00 0 PM to 11:00 PM) shift ated she knew the care 1 well. NA #5 stated boccasionally get out of bed and and pivot to the s fall. NA #5 stated that completely different person hechanical lift to get out of wants to get out of bed. NA Resident #11 did not like the served on 11/22/2024 to be on his right side at 9:46 AM, PM.	F 770			
	11:10 AM, and 1:04 F An observation and ir with Resident #11 on	PM. nterview were conducted				

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		ND HUMAN SERVICES MEDICAID SERVICES					INTED: 12/19/2024 FORM APPROVED IB NO. 0938-0391	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		ONSTRUCTION) DATE SURVEY COMPLETED	
		345339	B. WING			C 11/26/2024		
NAME OF P	ROVIDER OR SUPPLIER	•		STR	EET ADDRESS, CITY, STATE, ZIP CODE	•		
WINDSOF	REHABILITATION AND	HEALTHCARE CENTER			6 SOUTH KING STREET IDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 770	with a sling on his left he had consistent par felt like he could get of An interview was con 10/25/2024 at 11:22 / with Resident #11 on him to work with thera mentation of Residen and not move at this Documentation in a p dated 11/14/2024 wri under the history of p "Patient ran out of his which led to a resurg hallucinations. This ir where he attempted to doctor, resulting in a medication, his symp is reported to be doin prevent such an occu ensuring consistent a current medication re without changes, with few weeks." NP #2 was interviewed NP #2 explained that with one of them bein decrease in white blo was a possibility. NP pharmacy was requir by receiving the labor monthly prior to send facility to make sure f adverse side effects. say if the behaviors of	t arm. Resident #11 stated in in his hip, and he longer but of bed. ducted with MD #1 on AM. MD #1 stated he visited 11/22/2024 to encourage apy. MD #1 stated the it #11 was to just stay in bed point. by NP #2 revealed resent illness portion in part, is clozapine a few days ago, ence of his delusions and noident escalated to the point to physically confront a fall. Since resuming his toms have subsided, and he ig well again. The goal is to urrence in the future by access to his medication. His egimen will be continued in a follow-up planned in a ed on 11/22/2024 at 1:43 PM. Clozapine had side effects ing the possibility of a severe iod cell counts, although rare #2 further explained the ed to monitor the neutrophils ratory values of Resident #11 ing the Clozapine to the ne was not having any NP #2 stated it was hard to	F	770				

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		ID HUMAN SERVICES				FORM	D: 12/19/2024 APPROVED
	DF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	LE CONSTRUCTION	(X3) DATE	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDI	ING .		COMPLETED	
		345339	B. WING			C 11/26/2024	
NAME OF PI	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	20/2024
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER	1306 SOUTH KING STREET		1306 SOUTH KING STREET		
					WINDSOR, NC 27983		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	Clozapine over two and the half-life of Clozapi #2 revealed she visited weeks and usually the occasional verbal beh and never reported pl The Director of Nursir on 10/22/2024 at 10:2 felt the root cause of the Clozapine medication with Nurse #2 not folk and not putting the re- laboratory book for the carried out. The DON additional root cause separate out the order obtain the laboratory of then a second order of fax the results to the p The facility was notified jeopardy on 11/22/2027 The facility submitted action plan on 11/23/27	nd a half days. NP #2 stated ine was 26 to 36 hours. NP ed the facility every two e facility staff reported haviors from Resident #11 hysical behaviors. ng (DON) was interviewed 45 AM. The DON stated she the failure to obtain the of r Resident #11 began owing the physician order quired information in the e laboratory order to be stated she felt like an was the failure of NP #1 to rs so that one order was to services for Resident #1 and should have been written to oharmacy. ed of the immediate 24 at 3:39 PM. the following corrective 2024: we action will be se residents found to have		770			
	by the provider due to When the nurse notifi medication not being pharmacy stated the	-					

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	-	ID HUMAN SERVICES				FORM	APPROVED	
		MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	OMB NO. 0938-0391 (X3) DATE SURVEY		
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:				COMPLETED		
		345339	B. WING			C 11/26/2024		
NAME OF PF	ROVIDER OR SUPPLIER	040000			STREET ADDRESS, CITY, STATE, ZIP CODE	11/	26/2024	
WINDOOD					1306 SOUTH KING STREET			
WINDSOR	REHABILITATION AND				WINDSOR, NC 27983			
(X4) ID PREFIX TAG				x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 770	the provider was notif obtained to draw stat results of the labs were the morning and the p physician order to fax so the medication cou 10/25/24 at 1:26 pm t pharmacy the medicat administer. Upon notif pharmacy stated they results to dispense th was notified and state completed and needer pharmacy. The lab re- pharmacy and received 1:42PM. The pharman at 1:59pm. The facility medication on 10/26/2 Resident #11's medic administered at 8:00a ordered by the provid Address how the facil residents having the p the same deficient pra An audit of all current the Director of Nursin if any other residents to medication distribution no other residents affer practice of not obtainii by the provider.	e medication. On 10/22/24 ied, and an order was lab work on 10/22/24. The re received on 10/23/24 in provider failed to place a the results to the pharmacy uld be dispensed. On he nurse notified the tion was not available to fying the pharmacy the had not received the lab e medication. The provider ed the lab work had been ed to be faxed to the esults were faxed to the esults of Clozapine was in to the resident as er. ity will identify other potential to be affected by actice: residents was completed by g on 10/23/24 to determine required lab work previous tion from pharmacy. No ed lab work prior to n indicating that there were ected by the deficient ng lab services as ordered res will be put into place or	F	770				
	Address what measur							

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE	
		345339	B. WING				C 26/2024
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE	<u>. </u>	
			1306 SOUTH KING STREET				
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER		١	WINDSOR, NC 27983		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 770	process that the prov	not recur: e educated on the new ider will enter a physician	F	770			
	Nurse will ensure a la placed in the lab book Results of the lab are electronic medical rec results are received th review. When applica placed on the medical when a lab is required pharmacy for medical providers were educal process by the Direct order appears on the	ation Record. The Licensed b form is completed and c for the lab to be drawn. integrated with the cords system and once the ne provider is notified to ble, a separate order will be tion administration record d to be faxed to the tion distribution. The ted on 11/8/24 of the new or of Nursing. When the Medication Administration urse will ensure the lab					
	staff on 11/12/24 to 1 enter a physician orde will be on the Medical The Licensed Nurse v completed and placed to be drawn. Results the electronic medical the results are receive applicable will order for the pharmacy. The or medication administra required to be faxed t medication distributio on the medication adm	aff and licensed agency 1/13/24 that the provider will er for lab work. The order tion Administration Record. will ensure a lab form is d in the lab book for the lab of the lab are integrated with I records system and once ed the provider when or lab results to be faxed to der will be placed on the ation record when a lab is o the pharmacy for n. When the order appears ministration record the sure the lab results are					

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345339	B. WING _				26/2024	
NAME OF PF	ROVIDER OR SUPPLIER		1	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
WINDSOR	REHABILITATION AND	HEALTHCARE CENTER			06 SOUTH KING STREET INDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE	
F 770	Continued From page	34	F 7	70				
	Indicate how the facility plans to monitor its performance to make sure that solutions are							
	Alleged date of imme and compliance date:	diate jeopardy removal date 11/14/2024						

Facility ID: 922993

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		ONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345339	B. WING _				_ 26/2024	
	ROVIDER OR SUPPLIER	HEALTHCARE CENTER		130	REET ADDRESS, CITY, STATE, ZIP CODE 6 SOUTH KING STREET NDSOR, NC 27983			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 770	on 11/26/24. Interview sample of nurses to v conducted for nurses results and pharmacy Documentation of in-s reviewed. The initial a ongoing monitoring an obtained were verified interview with the Dire at 12:00 pm, she state educated on the proc medications that require completion of labs, to the pharmacy where it were also educated of Resident #11's medic resident had received Clozapine from 11/14 an order for labs and results related to the pharmacy every 28 di	on action plan was validated vs were conducted with a erify education was regarding processing lab r notification of lab results. service records were audit was verified as well as udits to ensure labs were d to be completed. In an ector of Nursing on 11/26/24 ed that nurses had been ess for physician orders for iried lab monitoring and the include to faxing results to indicated. The providers n the new process. al record revealed the l all prescribed doses of /24 through present. He had a separate order to fax lab medication, clozapine to the ays. The facility's immediate e and compliance date of	F7	770				

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