STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345339	A. Building B. Wing	05/28/2025

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 51386 Based on record review, and resident and staff interviews, the facility failed to maintain a resident's dignity when a resident wore a nightgown and no makeup to an outside appointment making the resident feel angry and unimportant for 1 of 1 resident (Resident # 4) reviewed for dignity and respect. Finding included: Resident #4 was admitted to the facility on [DATE]. The annual [NAME] Data Set (MDS) dated [DATE] revealed Resident #4 was cognitively intact. An interview with the Transportation Driver at 2:37pm on 5/28/2025 revealed Resident #4 was unaware of her appointment on 5/27/25. He stated that he became aware of the appointment at 4:06am by text message from the Scheduler, after he learned about the appointment, he did call the facility and informed the nurse. Transport driver stated it was the nurse's job to provide verbally communicate appointments to residents. He was aware of Resident #4 was unhappy about wearing her night gown to her doctor's appointment and he tried to console Resident #4 by provided encouragement with positive statements. An interview with Resident #4 on 5/28/2025 at 3:25pm revealed the resident went to a doctor's appointment on 5/27/2025.Resident #4 stated that 2 aids from night shift woke her up and told her about the appointment that was scheduled. Resident #4 stated, she had to wear the night gown and the underwear that she slept in. She stated she did not have time to bathe herself with soap and water, she used wipes instead. Resident #4 revealed if she had known about her appointment that she would have taken a shower, picked out her clothes, brushed her hair piece, and picked out her perfume the night before. Resident #4 stated she would inform 2nd and 3rd shift staff that she had an appointment and to wake her up an hour before she leaves for her appointment. Resident #4 stated if she had time to do her normal morning routine for a doctor's appointment she would have picked out a pair of jogging pants and a logo t-shirt, instead of her night gown, she would also put on her makeup for the appointment. Resident #4 stated that she was angry the whole day and she did not feel important. An interview conducted on 5/28/2025 at 2:19pm with Nurse #7 revealed, Resident #4 liked to go to her appointment with her hair and makeup done. Nurse #7 stated, normally if Resident #4 was aware of her appointments she would inform 3rd shift staff to wake Resident #4 up early. (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview conducted on 5/28/2025 at 9:30am with [NAME] President (VP) of Clinical Services revealed the scheduler has a personal planner that she kept all residents' appointments written down. A review of the appointment schedule revealed Resident #4 had an outside appointment on 5/27/2025 at 9:15am. An interview conducted with the Administrator and VP of Clinical Services at 4:41pm on 5/28/2025 revealed all residents have a right to choose what they want to wear when they go out of the facility.

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48230 Based on record review and staff interviews, the facility failed to maintain evidence of grievance investigation and decisions for 3 of 3 residents reviewed for grievances (Resident #1, Resident #2 and Resident #3). Findings included: A review of the facility's grievance policy dated April 2017 stated in part: 4. The investigation and report would include: f.) employee account of the alleged incident and h.) recommendations for corrective action. a.) Resident # 1 was admitted to the facility on [DATE]. A review of the grievance filed by Resident #1 on 1/3/25 revealed she was concerned that third shift Nurse Aides (NA) did not come in and check on her or answer her call bell. Resident #1 was further concerned that she received dry and burnt food from the kitchen. The grievance was not completed, as there was no documentation regarding an investigation, outcome or recommendation for corrective action. b.) Resident #2 was admitted to the facility on [DATE]. A review of the grievance filed by Resident #2 on 12/19/24 indicated she was missing a plaid varsity jacket and had last seen it about 3 weeks before. The grievance was incomplete as it did not include documentation of an investigation, outcome or recommendations for corrective action. c.) Resident #3 was admitted to the facility on [DATE]. Review of the grievance filed by Resident #3 on 12/11/24 revealed he was concerned that the NA assigned to him on 12/10/24 did not assist him with toileting. The grievance was incomplete as it did not include documentation of an investigation, outcome or recommendations for corrective action. An interview was conducted with the Social Worker (SW) on 5/28/25 at 2:10 PM. The SW stated she helped residents fill out the initial information on the grievance form that included the date, time, their name, room number, the department the grievance will go to and their concern. She then gave the grievance form to the pertinent department head, and they did the investigation. After the grievance was investigated, it was given to the Administrator to review and sign, then it came back to her to be filed. The SW was unsure how grievance forms that were not completed ended up filed in her office. (continued on next page)

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F 0585 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	In an interview with the Administrator on 5/28/25 at 2:12 PM she stated she was the last stop for grievances. The Administrator revealed she gets the completed form from the responsible department head then checks in with the complainant to ensure the grievance had been resolved.After this she gives the grievance to the SW to be filed. The Administrator was not sure how incomplete grievances ended up going to the SW to be filed.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. 48230 Based on observation, record review and staff interview, the facility failed to: a.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when Nurse #1 and Nurse Aide (NA) #1 provided wound care without wearing gowns for 2 of 2 staff observed for infection control (Nurse #1 and NA #1) and b.) to implement their policy for EPB for the current 41 of 61 residents that required the precautions due to chronic wounds or indwelling medical devices. The findings included: The facility policy titled Isolation-Categories of Transmission Based Precautions dated October 2018 stated in part: 1. EBP requires the use of gown and gloves only for high contact resident care activities (unless otherwise indicated as part of Standard Precautions). a.) High contact resident care activities: in the resident room to include: dressing, bathing/showering, transferring, providing hygiene, changing linens, changing briefs or assisting with toileting, device care or use: central line, urinary catheter, feeding tube, tracheostomy/ventilator, wound care: any skin opening requiring a dressing. 2. Residents are not restricted to their rooms and do not require placement in a private room. EBP is intended to be in place for the duration of a resident's stay or until resolution of the wound or discontinuation of the indwelling medical device that placed them at higher risk. 3. Enhanced Barrier Precautions (EBP) are recommended for residents with indwelling medical devices and wounds who do not otherwise meet the criteria for Contact Precautions, even if they have no history MDRO colonization or infection and regardless of whether others in the facility are known to have MDRO colonization. This is because devices and wounds are risk factors that place these residents at higher risk for carrying or acquiring an MDRO and many residents colonized with an MDRO are asymptomatic or not presently known to be colonized. a.) An indwelling medical device provides a direct pathway for pathogens in the environment to enter the body and cause infection. Examples include but are not limited to, central vascular lines including hemodialysis catheters, indwelling urinary catheters, feeding tubes and tracheostomy tubes. b.) A wound is defined as the care of any skin opening requiring a dressing. However, the intent of EBP is to focus on residents with a higher risk of acquiring an MDRO over a prolonged period of time. This generally includes residents with chronic wounds, and not those with only shorter-lasting wounds such as skin breaks or skin tears covered with a Band Aid or similar dressing. Examples of chronic wounds include, but are not limited to, pressure ulcers, diabetic foot ulcers, unhealed surgical wounds, and chronic venous stasis ulcers. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The policy further stated that for EBP, appropriate notification was placed above the resident's bed so personnel and visitors are aware of the need for EBP and the signage informs staff of instructions for PPE use while providing high contact resident care activities. a.) An observation of Nurse #1 and NA #1 providing wound care to Resident #5 was conducted on 5/28/25 at 11:55 AM. There was no signage indicating Resident #5 required EBP for high contact care observed inside or outside of the room. NA #1 was present to assist with repositioning Resident #5. Nurse #1 and NA #1 were observed performing hand hygiene and donning gloves before repositioning Resident #5 and starting wound care. Neither Nurse #1 nor NA #1 donned a gown before providing high contact care to Resident #5. An interview was conducted with Nurse #1 on 5/28/25 at 12:30 PM. Nurse #1 indicated she was the facility's Wound Care Nurse, and she had no residents on her wound care list that required EBP. She indicated that Resident #5 had chronic wounds that she treated daily. Nurse #1 further stated she had not received education about EBP at any time since she was hired in February 2025 and was under the impression EBP was for residents with an infectious disease such as influenza. In an interview with NA #1 on 5/28/25 at 12:35 PM she stated she had not been trained on EBP since she was hired and did not have any residents on EBP. NA #1 was not aware of indications for a resident to be on EBP. b.) Observations of resident rooms in all halls on 5/28/25 revealed no signage indicating any resident required EBP, nor any Personal Protective Equipment (PPE) used for EBP readily available. An interview was conducted with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM. The ADON indicated she was also the Infection Preventionist for the facility. She stated that there were no residents in the facility that required EBP, that she knew it was a new thing for residents with intravenous lines but hadn't looked into it yet as she just started in February 2025. The ADON revealed she was also responsible for training staff on infection prevention and control but had yet to start a training program. The ADON stated she was unaware that residents with chronic wounds and indwelling medical devices would require EBP with high contact care. In an interview with the Director of Nursing (DON) on 5/28/25 at 12:31 PM she stated the facility had no residents on EBP. She was aware EBP was to be used for residents with chronic wounds and indwelling medical devices and was able to give examples of such. She indicated that Nurse #1 and NA #1 should have been wearing gowns while completing wound care for Resident #5. The DON further stated she was unsure why EBP was not implemented in the facility as she had just started there 4 weeks ago. An interview was conducted with the Administrator on 5/28/25 at 1:38 PM. The Administrator was unable to say why EBP was not implemented in the facility or why Nurse #1 and NA #1 were not wearing gowns while proving high contact care for Resident #5. She was unsure if staff received training on EBP at any time and did not know the regulation. A list of 41 residents that had chronic wounds or indwelling medical devices and required EBP was provided by the Administrator on 5/28/25 at 2:10 PM which included resident's names and the reasons they should have been on EBP prior to 5/28/25.

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F 0882 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Designate a qualified infection preventionist to be responsible for the infection prevent and control program in the nursing home. 48230 Based on record review and staff interviews, the facility failed to designate a qualified Infection Preventionist who was certified in infection prevention and control, to be responsible for the facility's Infection Control and Prevention Program. This had the potential to affect 72 of 72 residents in the facility. The findings included: During an interview with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM the ADON indicated she was also the facility's Infection Preventionist (IP) and stated she was responsible for oversight of infection control duties. The ADON further stated she had worked at the facility since late February 2025 and had completed 13 of the 20 modules needed to obtain IP certification through the Centers for Disease Control and Prevention (CDC) IP program. The ADON was not aware she had to have IP certification to hold the position of IP. In an interview with the Director of Nursing (DON) on 5/28/25 at 1:38 PM she stated she was aware the ADON did not yet have an IP certification and the ADON was working on it through the CDC IP program. The DON further stated she had been encouraging the ADON to complete her certification as soon as possible. The DON was not aware the ADON needed to hold an IP certification to be the facility IP. She thought it was adequate that the ADON was working toward her certification. An interview was conducted with the Administrator on 5/28/25 at 2:14 PM. The Administrator stated she was aware the ADON was also the facility's IP but was unaware the ADON did not yet have her IP certification.

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F 0945 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Include as part of its infection prevention and control program, mandatory training that includes written standards, policies, and procedures for the program. 48230 Based on observation, record review, and staff interview, the facility failed to have an effective system in place to train nurses and nurse aides (NAs) and verify their competency with infection control policies for Enhanced Barrier Precautions (EBP). The Assistant Director of Nursing (ADON)/Infection Preventionist (IP) who was responsible for training staff on infection control practices and procedures was unaware that residents with chronic wounds and indwelling medical devices required EBP with high contact care. Nurse #1 and NA #1 failed to follow the infection control policy by providing wound care for a resident with chronic wounds without wearing gowns. The facility had 41 residents that required EBP due to chronic wounds or indwelling medical devices. This deficient practice was identified for 3 of 3 staff (ADON/IP, Nurse #1, and NA #1) reviewed for competency and had the potential to affect other facility residents. Findings included: This tag is cross-referenced to: F880: Based on observation, record review and staff interview, the facility failed to: a.) follow their infection control practices and procedures for Enhanced Barrier Precautions (EBP) during high contact care for a resident with a chronic wound when Nurse #1 and Nurse Aide (NA) #1 provided wound care without wearing gowns for 2 of 2 staff observed for infection control (Nurse #1 and NA #1) and b.) to implement their policy for EPB for the 41 residents that required the precautions due to chronic wounds or indwelling medical devices. An interview was conducted with the Assistant Director of Nursing (ADON) on 5/28/25 at 12:11 PM. The ADON revealed she was responsible for training staff on infection prevention but had yet to start a training program. In an interview with the Director of Nursing (DON) on 5/28/25 at 12:31 PM. She indicated she was unaware staff were not trained or competent in the use of EBP. An interview was conducted with the Administrator on 5/28/25 at 1:38 PM. She stated she was unsure if staff received training on EBP at any time.