| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 345339 | A. Building<br>B. Wing | 11/14/2025 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| Windsor Rehabilitation and Healthcare Center | 1306 South King Street<br>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<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>(continued on next page) |

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.

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

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| F 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff interviews, and resident interviews, the facility failed to act in a dignified manner toward (Resident #1) and within hearing distance of (Resident #3) for 2 of 3 residents reviewed for dignity (Resident #1 and Resident #3). Findings included:Resident #1 was admitted on [DATE] and discharged on 9/25/2025. Documentation on an admission Minimum Data Set (MDS) assessment dated [DATE] coded Resident #1 as cognitively intact.Documentation in a behavior note dated 9/24/2025 at 3:29 PM written by the Administrator revealed, Resident [#1] requested to speak with Administrator concerning nursing care. [Resident #1] became very demanding requesting that the nurse who documented his refusal be brought in to see him. The issue had been addressed and taken care of two weeks ago. When suggesting that we move forward with today's plan of care [Resident #1] became belligerent, stating, you don't tell me to move forward. You can just kiss my [vulgar word]. [Resident #1] was then advised that his tone was not acceptable and would not be tolerated. He continued with raising his voice and approached the Administrator in a threatening manner. He was advised to step back because he was too close. He then went to his room. The local authorities were called due to his belligerence. Two officers came in to speak with him regarding his behavior. He was advised that any further acts of aggression could possibly lead to removal.Resident #1 was interviewed on 10/9/2025 at 3:26 PM. Resident #1 confirmed he got into a heated argument with the Administrator on 9/24/2025 in the hallway. Resident #1 stated that all the staff members came out of their offices to watch. Resident #1 stated the Administrator was just as loud as he was and called law enforcement on him. An interview was conducted with the Assistant Director of Nursing (ADON) on 10/8/2025 at 9:55 AM and the following information was obtained regarding the events on the morning of 9/24/2025. The ADON was in her office when she heard loud arguing and she got up to see the source. The Administrator and Resident #1 were in the hallway in the front of the building loudly arguing. Several of the management staff were standing in the hallway watching. The ADON called out to Nurse Aide #5 at the nursing desk to call the police. The ADON stated it was not appropriate behavior for a nursing home.Nurse Aide #5 was interviewed on 10/8/2025 at 3:17 PM. Nurse Aide #5 stated she was standing at the nursing desk and observed the Administrator and Resident #1 hollering at each other. Nurse Aide #5 confirmed that the ADON asked her to call the police to the facility, and she did so.The Activities Director was interviewed on 10/8/2025 at 10:31 AM and the following information was provided. The Activities Director was in the hair salon, located in the front hallway of the building, with Resident #3 on the morning of 9/24/2025. Resident #1 asked the Administrator a question and the Administrator responded that she did not know the answer. It was almost lunch time, and the Administrator and Resident #1 were outside the dining room. Resident #1 was swearing at the Administrator and the Administrator responded that she was not going to let him disrespect her. It was very loud, and the police were called.Documentation in an annual MDS assessment dated [DATE] revealed Resident #3 was coded as cognitively intact.Resident #3 was interviewed on 10/8/2025 at 11:40 AM and provided the following information. Resident #3 stated it was around 10:00 AM or 11:00 AM on 9/24/2025 and he was in the hair salon getting his hair done by the Activity Director. Resident #3 stated he heard it all. There was a back-and-forth verbal exchange between the Administrator and Resident #1. Resident #3 could not recall the exact words that were spoken but Resident #1 was threatening the Administrator and cursing her. Instead of diffusing the situation the Administrator was amping him up. Resident #3 stated it was undignified and unprofessional on both part of both the Administrator and Resident #1.The Rehabilitation Program Manager was interviewed on 10/8/2025 at 1:10 PM and relayed the following information. On 9/24/2025 before lunch the Rehabilitation Program Manager heard louder than normal talking outside the therapy room. The Rehabilitation Program Manager looked out into the hallway from the therapy room door and saw the Administrator, Resident #1, and other staff members standing around watching. It was very noisy out there. The Rehabilitation Program Manager asked the Administrator if she was okay, to which she replied she was fine. The Rehabilitation Program Manager returned to the therapy office and requested the Physical Therapy Assistant go out into the hallway to deescalate the situation because she had a rapport with Resident #1 and the Administrator.The Physical Therapy (PT) Assistant was interviewed on 10/08/2025 at 1:12 PM and provided the following information. The PT Assistant was working on documentation in the physical therapy room. Directly outside the room she could hear fussing and words were said back and forth. The PT Assistant opened the door and looked in the hallway to see the |

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| F 0600<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, staff interviews, and a resident interview, the facility failed to protect a resident's right to be free from resident-to-resident physical abuse when Resident #3 struck Resident #4, resulting in a bruise to the right side of the face. This occurred for 1 of 3 residents reviewed for abuse (Resident #4). Findings included:Resident #3 was readmitted to the facility on [DATE].Documentation on an annual Minimum Data Set assessment dated [DATE] revealed Resident #3 was cognitively intact.Resident #4 was admitted to the facility on [DATE].Documentation on a quarterly Minimum Data Set assessment dated [DATE] revealed Resident #4 had moderately impaired cognition.Documentation in a behavior note for Resident #3 dated 8/27/2025 at 2:45 PM written by the Assistant Director of Nursing (ADON) revealed the following information. The ADON heard yelling in the dining room area and went to the dining room. Resident #3 indicated to the ADON that Resident #4 needed help getting through the doorway in his wheelchair from the outside. Resident #4 began to curse and call Resident #3 a racially charged name. As the ADON removed Resident #4 from the doorway, both Resident #3 and Resident #4 began to curse at each other. Resident #3 propelled himself in his wheelchair toward Resident #4 with his hand raised to hit him. The ADON told Resident #3 not to hit Resident #4, but Resident #3 then slapped Resident #4 on the right side of the face. Resident #4 was assisted in his wheelchair to the nursing station.The ADON was interviewed on 10/8/2025 at 12:11 PM. The ADON confirmed Resident #3 struck Resident #4 as she was attempting to pull Resident #3 out of the way. The ADON indicated Resident #4 refused to stop calling Resident #3 a racially charged name so Resident #3 slapped him. The ADON stated afterward the police were called and Resident #4 could not recall the incident. The ADON confirmed Resident #3 was charged with assault and had already made an initial court appearance. The ADON confirmed Resident #4 had a small bruise on the right side of his head after being struck by Resident #3.Resident #3 was interviewed on 10/8/2025 at 11:40 AM. Resident #3 explained that Resident #4 was outside and was trying to get into the building but was stuck in the doorway. Resident #3 further explained that he shouted for help until the ADON came into the dining room and he pointed to Resident #4 to let her know he was the one who needed help. Resident #3 stated that Resident #4 started cursing at him and called him a racially charged named that was very disrespectful. Resident #3 revealed he tried to hit Resident #4 but never made contact because the ADON pulled Resident #4 out of the way. Resident #3 confirmed the police were called but the ADON told the police Resident #3 struck Resident #4. Resident #3 confirmed he had already been to court, and the case had a continuation date. Resident #3 explained that Resident #4 had apologized to him and there were no further issues or problems between the two residents.Resident #4 was interviewed on 10/8/2025 at 11:50 AM. Resident #4 did not recall any incident or occasion for which he was slapped or hit at the facility. Resident #4 denied knowledge of any altercations he had involving Resident #3.The Administrator was interviewed on 10/8/2025 at 2:12 PM. The Administrator stated that after Resident #3 hit Resident #4 the police were called. The Administrator confirmed Resident #3 was charged with assault. The Administrator also confirmed Resident #4 was assessed by a provider, ice was applied to his face, and he was moved to a different hallway away from Resident #3. The Administrator stated Resident #3 and Resident #4 have not had any further issues. |