STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL008034	A. BUILDING: _____ B. WING _____	R 02/12/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDSOR HOUSE	336 SOUTH RHODES AVENUE WINDSOR, NC 27983

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on February 10, 2026 and February 11, 2026.	{D 000}		
{D 358}	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION Based on these findings, the previous Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to administer medication as ordered from the primary care provider (PCP) for 1 of 5 residents sampled (#1) with orders for a medication used to treat elevated blood sugar and finger stick blood sugar checks four times daily. The findings are: Review of the facility's undated policy for Residents Receiving Diabetic Medications and Treatments revealed: -Resident receiving medication/treatments for Diabetic Care will be monitored according to Physician Orders.	{D 358}		

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{D 358}	Continued From page 1 -Every resident will have their own glucose monitor; it will be labeled with their name and placed in a bag labeled with their name. -All medications, blood sugar monitoring, and insulin will be added to the Diabetic Flowsheet. -Provider notification should include low and high parameters for resident blood sugar levels. -The medication aide (MA) will notify the Resident Care Coordinator (RCC) of any refusals and/or abnormal results per parameters given by the resident's provider. -The RCC will review any refusals and/or abnormal blood sugar reading and notify the provider and document the notification and any new orders in the resident's chart Review of the facility's undated policy for Technique of Administering Insulin Medication revealed: -Residents will be assisted with the self-administration of or administered insulin medications according to physician's orders and as allowed by state regulations. -Insulin medications are administered by subcutaneous route. -MAs may administer insulin subcutaneous injections per regulations after completing proper training and competency validation by a Registered Nurse according to the Licensed Health Professional Support (LHPS) competency validation. -Gather equipment. -Provide privacy. -Check and compare the information on the medication label with the medication administration record (MAR) and check the five rights, right resident, right medication, right time, right dosage, and right route. -Verify the resident blood sugar results. -Verify parameters of administering insulin are	{D 358}		

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{D 358}	Continued From page 2	{D 358}		

within the parameters given by the resident's provider.
-Review the MAR for previous injection site to rotate sites (injection sites should be rotated each time).
-Wash hands,
-Put on gloves.
-Locate site (back of arm, front or side of thigh or abdomen).
-Cleanse with alcohol prep.
-Stabilize skin with your non-dominant hand.
-Insert the needle briskly at a 90-degree angle with your dominant hand, unless otherwise indicated.
-Dispose of used sharps properly.
-Remove gloves and wash hands.
-Document administration and site of administration.

Review of Resident #1's current FL-2 dated 11/06/25 revealed:
-Diagnoses included mixed Alzheimer's Disease and vascular dementia, hypertension, type 2 diabetes mellitus, acute kidney injury, and chronic venous insufficiency.
-His level of care was Special Care Unit (SCU).
-There was an order to check finger stick blood sugar (FSBS) four times per day with meals and at bedtime, hold insulin if FSBS is 100 and below and call provider, if FSBS is above 400, contact provider.
-There was an order for Lantus (Lantus is a long-acting insulin used to improve blood glucose control in type 1 and type 2 diabetes) Solostar U-100 insulin, inject 7 units at bedtime.

Review Resident #1's signed physicians orders dated 11/06/25 revealed:
-There was an order to check finger stick blood sugar (FSBS) four times per day with meals and

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{D 358}	Continued From page 3 at bedtime, hold insulin if FSBS is 100 and below and call provider, if FSBS is above 400, contact provider. -There was an order for Lantus Solostar U-100 insulin, inject 7 units at bedtime Review of Resident #1's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lantus Solostar 100U/ml, inject 7 units subcutaneously at bedtime, scheduled at 8:00pm. -Lantus Solostar 7 units was documented as administered at 8:00pm on 8 occasions (12/08/25, 12/09/25, 12/10/25, 12/13/25, 12/19/25, 12/21/25, 12/26/25, and 12/30/25) with no FSBS documented and no exception documented for the FSBS on these dates. Review of Resident #1's January 2026 eMAR revealed: --There was an entry for Lantus Solostar 100U/ml, inject 7 units subcutaneously at bedtime, scheduled at 8:00pm. -Lantus Solostar 7 units was documented as administered at 8:00pm on 5 occasions (01/01/26, 01/06/26, 01/12/26, 01/19/26, and 01/31/26) with no FSBS documented and no exception documented for the FSBS on these dates. Review of Resident #1's February 2026 eMAR revealed: -There was an entry for Lantus Solostar 100U/ml, inject 7 units subcutaneously at bedtime, scheduled at 8:00pm. -Lantus Solostar 7 units was documented as administered on 7 occasions at 8:00pm (02/01/26, 02/02/26, 02/04/26, 02/05/26, 02/06/26, 02/07/26, and 02/08/26) with no FSBS	{D 358}		

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{D 358}	Continued From page 4 documented and no exception documented for the FSBS on these dates. Based on observations, interviews, and record reviews, it was determined Resident #1 was uninterviewable. Interview with a MA on 02/11/26 at 10:36am revealed: -If a resident had orders for FSBS checks, the FSBS was always documented. -She always documented a Resident #1's FSBSs but was not sure why the 8:00pm FSBSs did not show up on Resident 1's eMAR. Interview with a second MA on 02/11/26 at 10:50am revealed: -FSBSs should always be documented on the resident's eMAR. -If a resident had orders for FSBS and insulin, she always checked the FSBS before administering the insulin. -It was possible Resident #1's 8:00pm FSBSs were documented under vital signs on those dates. -She could not locate any FSBSs for Resident #1 under vital signs in the eMAR system. -She thought she may have just forgotten to document Resident #1's 8:00pm FSBS. Interview with the Resident Care Coordinator (RCC) on 02/11/26 at 11:10am revealed: -She was a MA and had recently been promoted to the RCC position. -She had been in the RCC role for about 2 weeks. -She was still learning the RCC role. -The facility had changed eMAR systems in late November 2025 and there had been some issues with the eMARs.	{D 358}		

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{D 358}	Continued From page 5 -She had not conducted eMAR audits in her role as RCC. -She was not aware there were occasions where Resident #1's 8:00pm FSBSs were not recorded on his eMAR. -The MAs were to always check and document a resident's FSBSs as ordered on the eMAR. Interview with the Administrator on 02/11/26 at 2:02pm revealed: -When a resident had orders for FSBSs, the FSBS should always be performed and documented by the MAs. -The facility had changed eMAR systems late last year and there had been kinks and glitches with the changeover. -She felt the MAs always checked Resident #1's FSBS at 8:00pm but was not sure why his 8:00pm FSBSs were not always recorded. -She was not aware that there were occasions when Resident #1's 8:00pm FSBSs were not documented. -The MAs had not reported any issues to her pertaining to recording the residents' FSBSs on the eMAR. -The RCC was new to her role, and she did not think periodic eMAR audits had been done by the previous RCC. Interview with Resident #1's primary care provider (PCP) on 02/11/26 at 11:22am revealed: -Resident #1 had orders for short-acting insulin with meals and long-acting insulin at bedtime for type 2 diabetes. -She ordered FSBSs three times a day with meals and at bedtime for Resident #1. -Her main concern was if Resident #1's FSBS was less than 100, receiving insulin could cause his blood sugar to drop further resulting in hypoglycemia which could cause lethargy,	{D 358}		

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{D 358}	Continued From page 6 drowsiness, drooling, cramping, and the resident could become less or unresponsive. -Resident #1 had a history of being a brittle diabetic, which meant there were frequent highs and lows with his blood sugar but for the past several months his blood sugar had been better controlled. -She expected Resident #1's FSBS to be checked prior to administration of his insulin as ordered.	{D 358}		