STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL011296	A. BUILDING: _____ B. WING _____	03/25/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WINDWOOD ASSISTED LIVING	6 WINDWOOD DRIVE CANDLER, NC 28715

(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 an annual survey on 03/24/26 and 03/25/26.	D 000		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure follow-up to meet routine health care needs for 1 of 3 sampled residents (Resident #3) related to an order for a mammogram. The findings are: Review of Resident #3's current FL2 dated 04/29/25 revealed diagnoses include diabetes, hypertension and schizoaffective disorder. Review of Resident #3's primary care provider's (PCP) office visit note dated 10/13/25 revealed an order for a mammogram. Review of Resident #3's record revealed mammogram results were not available to review. Interview with Resident #3 on 03/25/26 at 9:20am revealed: -She had an appointment with her PCP in October 2025 and was told to have a mammogram. -The facility staff member who transported her to the PCP appointment was responsible for scheduling the mammogram, but she never did.	D 273		

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D 273	Continued From page 1 -The last mammogram she had was several years ago. Interview with a staff member on 03/25/26 at 12:05pm revealed: -She was responsible for transporting residents to appointments and scheduling appointments that were ordered. -She took Resident #3 to a PCP appointment in October 2025 and remembered a mammogram was ordered at that appointment. -She thought she took Resident #3 to have a mammogram and would call the provider to obtain the results, if she could. Interview with the Administrator on 03/25/26 at 10:20am revealed: -The staff member who transported residents to appointments was also responsible for scheduling any follow-up appointments ordered. -She did not know the mammogram was not completed. -A consulting Registered Nurse (RN) conducted chart audits twice a month and she did not know why that missed order was not identified during the chart audit. Attempted telephone interview with Resident #3's PCP on 03/24/26 at 1:38pm was unsuccessful.	D 273		
D 325	10A NCAC 13F .0906(e) Other Resident Care and Services 10A NCAC 13F .0906 Other Resident Care and Services (e) Personal Lockable Space. (1) Personal lockable space shall be provided for each resident to secure his personal valuables. One key shall be provided free of charge to the	D 325		

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D 325	Continued From page 2	D 325		

resident. Additional keys shall be provided to residents at cost upon request. It is not the home's obligation to pay for additional keys; and (2) While a resident may elect not to use lockable space, it shall still be available in the home since the resident may change his mind. This space shall be accessible only to the resident and the administrator or supervisor-in-charge. The administrator or supervisor-in-charge shall determine at admission whether the resident desires lockable space, but the resident may change his mind at any time.

This Rule is not met as evidenced by:
Based on interviews the facility failed to provide residents with a personal lockable space to secure personal valuables.

The findings are:

Interview with a resident on 03/25/26 at 10:50am revealed:
-He had clothes, an electric razor and a nail clipper set go missing recently.
-He did not have any way to secure his personal items.

Interview with another resident on 03/25/26 at 11:34pm revealed:
-His closet and bedroom door each had a lock, but he did not have a key.
-He had a pocketknife go missing a few weeks ago and he confronted the person he suspected of taking it.
-His pocketknife appeared on his dresser a few days later so he sent it home with a family member so it would not go missing again.
-When missing items were reported to management he was told there was nothing that

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D 325	Continued From page 3	D 325		

could be done unless the person was caught red-handed.

Interview with a third resident on 03/25/26 at 11:45am revealed:
-The closet door had a lock, but she never had a key for it.
-When she requested a key a few years ago, the supervisor told her she did not know what key fit her closet.
-She had many items go missing over the years she lived at the facility.
-When missing items were reported to management she was told to "get over it".
-One resident was known to "have sticky fingers."

Interview with a fourth resident on 03/25/26 at 11:51am revealed:
-The closet door had a lock, but she did not have a key.
-She had money go missing a few years ago, so she no longer kept anything of value at the facility.

Interview with a fifth resident on 03/25/26 at 11:54am revealed his closet door had a lock, but he did not have a key.

Interview with the Supervisor-in-Charge on 03/25/26 at 1:46pm revealed:
-Residents were provided a key when they were admitted to the facility but they usually lost it.
-She told the Administrator once that the facility was the resident's home and they had a right to secure their personal items.

Interview with the Administrator on 03/25/26 at 12:17pm revealed:
-She thought every resident that wanted a key had one.

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D 325	Continued From page 4 -Noone had requested a key. -She kept a key to every closet in the office.	D 325		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE B VIOLATION Based on interviews the facility failed to protect resident's rights related to personal lockable space resulting in residents having personal items missing. The findings are: Review of the census dated 03/24/26 revealed there were nine residents residing in the facility. Interviews with a resident on 03/24/26 at 8:58am during initial tour and 03/25/26 at 10:50am revealed: -He moved into the facility in October 2025 and received "a lot" of clothes for Christmas. -Last week he went to get some clothes out of his dresser drawer and discovered they were all missing. -He also had a new electric razor and a nail clipper set which went missing about the same time. -The Supervisor gave him a single nail clipper to replace the nail clipper set. -His roommate had a history of taking things that	D 338		

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did not belong to him and trading them.
-He and his roommate got in an argument in the hallway about the clothes because he thought the roommate took them so he could sell them in exchange for cigarettes.
-He did not have any way to secure his personal items to prevent them from being taken.
-He was very concerned about the missing items and said "What is going to prevent him from stealing all my [expletive]? Everyone knows my roommate is a thief and I hate a thief. I'll put an end to it; I'll knife him."

Interviews with another resident on 03/24/26 at 3:25pm and 03/25/26 at 11:34pm revealed:
-It was well known at the facility that one resident got free clothes from the local donation center and traded them for cigarettes so when a Resident's clothes went missing last week the Supervisor asked the roommate about them.
-He had a pocketknife go missing a few weeks ago and he confronted the person he suspected of taking it.
-His pocketknife appeared on his dresser a few days later so he sent it home with a family member so it would not go missing again.
-Some of the missing clothes were found in his roommate's closet, but the Supervisor could not locate all the clothes.

Interviews with the Supervisor on 03/25/26 at 10:09am and 1:46pm revealed:
-One resident at the facility had a long history of taking other residents' personal items without their knowledge, including cigarettes.
-Management knew the residents supsected a specific resident took their things and the resident was told he was not allowed to enter other residents' rooms uninvited.
-She was not able to always supervise that

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resident to ensure he did not enter other residents' rooms without permission.
-Since the resident often obtained clothes at the local clothing donation center, and was known to trade them at the facility, we asked him about the missing clothes when we discovered the clothes were missing.
-The Resident's missing clothes were discovered last week, and she notified the Administrator immediately.
-She thought the razor and nail clipper set were taken at the same time as the clothes.
-She gave the Resident a new fingernail nail clipper.
-Historically the Administrator replaced missing items when she found out about them.

Interview with the Administrator on 03/25/26 at 10:20am revealed:
-The Supervisor told her about the resident's missing clothes last week when he got into an argument with his roommate.
-The Supervisor told her "yesterday" about the miussing razor and nail clipper set.
-In the past she had confronted the resident who was known to take things that did not belong to him, but she had never taken any preventative actions.
-She replaced items as she was told about them.

[Refer to tag 0325 10A NCAC 13F .0906(e)(1) Other Resident Care And Service]

_____

The facility failed to ensure residents were provided with a personal lockable space for valuables resulting in their belongings being taken by a resident that had a history of taking others property. This failure was detrimental to the health and welfare of the residents and constitutes a Type B Violation.

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D 338	Continued From page 7 _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/25/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED May 09, 2026.	D 338		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, record reviews and	D 367		

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interviews the facility failed to ensure the Medication Administration Record (MAR) was accurate for 1 of 3 sampled residents (Resident #3) related to an anti-psychotic medication.

The findings are:

Review of Resident #3's current FL2 dated 04/29/25 revealed diagnoses include diabetes, hypertension and schizoaffective disorder.

Review of Resident #3's record revealed:
-There was an order dated 11/03/25 for olanzapine (an anti-psychotic medication) 2.5mg, one tablet daily.
-There was an order dated 11/18/25 for olanzapine 2.5mg, 1 ½ tablet at night.

Review of Resident #3's January 2026 MAR revealed:
-There was an entry for olanzapine 2.5mg, one tablet daily.
-There was an entry for olanzapine 2.5mg, 1 ½ tablet at night.
-Both were documented as administered from 01/01/26 through 01/31/26.

Review of Resident #3's February 2026 MAR revealed:
-There was an entry for olanzapine 2.5mg, one tablet daily.
-There was an entry for olanzapine 2.5mg, 1 ½ tablet at night.
-Both were documented as administered from 02/01/26 through 02/28/26.

Review of Resident #3's March 2026 MAR revealed:
-There was an entry for olanzapine 2.5mg, one tablet daily and it was documented as

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administered from 03/01/26 through 03/24/26.
-There was an entry for olanzapine 2.5mg, 1 ½ tablet at night and it was documented as administered from 03/01/26 through 03/23/26.

Observation of medications on hand on 03/24/26 at 11:31am revealed:
-Olanzapine 2.5mg, 1 ½ tablet at night was available to administer.
-Olanzapine 2.5mg one tablet daily was not available.

Interview with the medication aide (MA) on 03/24/26 at 11:31am and 2:15pm revealed:
-Resident #3's olanzapine was always administered one time a day in the evening.
-When the dose increased on 11/18/25 it was written for nightly administration rather than daily administration.
-She did not realize the morning dose of olanzapine was still on the MAR and it was a mistake if she was documenting administration.
-She "should slow down and read more thoroughly" when she was administering medications.

Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 03/24/26 at 11:45am revealed:
-They received a renewal order for olanzapine on 11/03/25 and another order on 11/18/25 to increase the dose and the time to administer it was changed from daily to at night.
-They received clarification after they received the 11/18/25 order that the 11/03/25 order was discontinued when the 11/18/25 order was written.
-They dispensed the 11/03/25 order only one time.

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D 367	Continued From page 10 Interview with the Administrator on 03/25/26 at 10:20am revealed: -She expected the MA to document on the MAR accurately. -A consulting Registered Nurse (RN) conducted chart audits and MAR reconciliations twice a month and she did not know why that error was not identified. Attempted telephone interview with Resident #3's PCP on 03/24/26 at 1:38pm was unsuccessful.	D 367		