Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 and complaint investigation on 11/4/2015-11/6/2015.	D 000		
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to assure the walls and floors in 4 of 4 residents' common bathrooms (100, 200, 300, 400 halls) and 6 sinks in resident rooms(100 and 200 halls) were kept in a clean, uncluttered and orderly manner. The findings are: 1. Observation of the 300 hall common bathroom on 11/4/15 at 10:25 am revealed: -There was peeling paint from the floor tiles on the bathroom floor. -There was dried black discoloration of the tile grout throughout bathroom floor. -There was a greyish, black ring of stains around the toilet base. -There was peeling paint on the wall behind the toilet, above the tile floor molding. -There was peeling paint on the left wall facing the toilet, extending from the hand rail down the wall to the tile floor molding.	D 079	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of Deficiencies or Corrective Action Report; the plan of correction is prepared solely as a matter of compliance with state law. It is the policy of Wilson House to assure that the community is an uncluttered, clean and orderly manner, free of all obstructions and hazards. The Administrator or designee will monitor the specific areas weekly. All Housekeepers and Personal Care Aides will be retrained on proper housekeeping techniques, assignments for the community bathrooms and the documentations of following the daily cleaning schedule. We will assure that there will not be any items stored in the community bathrooms. 01/15/2016. The community bathroom floors and walls will be resurfaced by 01/31/2016.	1/15/16 1/31/16

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Barbara Mclaurin — Administrator — 12/15/2015

Reviewed and accepted
12/18/15
TC

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 1 -The toilet paper holder was broken and toilet paper was sitting on the back of the toilet tank. -The call bell on the left wall of the toilet stall had no pull cord. -There was a wheelchair cushion on the bottom of the bathtub. -There were dried brown particles in the bottom of the bathtub. -There was a grey dried ring of stains around the bottom of the bathtub. -The first shower stall to the left had a rusted metal drain, peeling floor tiles and black discoloration of the tile grout. -The second shower stall to the left had a shower chair, with peeling floor tiles and black discoloration of the tile grout. -There was a two compartment linen barrel against the back wall of the bathroom. -There was a wheelchair in the back right shower stall. Interview with the Housekeeper on 11/4/15 at 10:30 am revealed: -She was responsible for cleaning all the rooms and bathrooms on 300 and 400 hall. -There was no schedule for cleaning. -All the rooms were cleaned every day. -She mopped, dusted and cleaned the bathroom of every resident's room daily. -The common shower was cleaned every day. -She had not cleaned the common bathroom today (11/4/15). -She mopped the floors, wiped down the sink, cleaned the toilet with sanitizer and replaced the toilet paper and paper towels every day. A second observation of the 300 hall common bathroom on 11/5/15 at 4:15 pm revealed: -There was a urine odor. -The first shower stall to the left had a rusted	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 2 metal drain, peeling floor tiles and a grey discoloration of the grout. -The second shower stall to the left had a shower chair, peeling floor tiles and grey discoloration of the grout. -There was a wheelchair cushion against the wall in the back, right shower stall. -There was one large plastic black trash can with closed lid. -There was a two compartment linen barrel against the back wall with two pillows without pillow cases on top. -The bathtub had a dried grey ring of stains around the bottom. -There was an unused, folded incontinence brief laying on the back side of bathtub. Observation and recheck of the 300 hall common bathroom on 11/6/15 at 11:00 am revealed: -There were two plastic black trashcans with lids against the bathroom stall door. -A covered clean linen cart was at the back of the bathroom in front of the third shower stall. -The first shower stall to the left had a rusted metal drain, peeling floor tiles and a grey discoloration of the grout. -The second shower stall to the left had a shower chair, peeling floor tiles and grey discoloration of the grout. Refer to interview with the Administrator on 11/04/15 at 4:05 p.m. 2. Observation of the common bathroom on the 400 hall in the special care unit on 11/04/15 at 11:00 a.m. revealed: - The black plastic round paper towel dispenser was loose and hanging sideways on the wall to the left of the sink. - There was a large black trash can with lid	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 3 labeled "soiled linen" in front of the only toilet stall in the bathroom. - There was a strong odor of urine throughout the bathroom. - There were yellow stains in the sink around the metal drain. - There was a walker stored between the sink and the bath tub. - The bath tub had yellow stains and dirt and debris scattered in the bottom of the tub. - The metal spigot and knobs on the bath tub were covered in a thick, hard, white substance. - There were multiple areas of the yellow top coating of the tile floor missing or rubbed off, exposing the gray tile underneath and leaving multiple areas of uneven flooring all over the bathroom. - The largest area was between the shower and the bathtub and was approximately 4 feet by 5 feet with worn off uneven floor tile. - The tile floor around the toilet had dark yellow and brown stains on the tile and in the grout of the tile. - There were yellow and brown stains on the tile walls around the toilet stall. - The white caulking around the bottom of the toilet had brown stains and was pulling away from the floor. - There was an incontinence supply cart between the toilet stall and the first shower stall on the left. - The two shower stalls on the left had a build-up of yellow and brown stains on the floor and walls of the showers and the grout of the tiles. - The second shower stall had at least two broken floor tiles near the drain in the floor of the shower with brown stains in the cracks of the broken tiles. - The second shower stall had a long shower chair the width of the shower that had packs of incontinence briefs and white trash bags stored	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 4 on it. - The third shower stall on the right at the back of the bathroom had a large black plastic trash can with lid labeled "trash only" stored in the shower stall. - There were 3 small white trash cans, a wheelchair, and a metal walking cane stored in the third shower stall with the large trash can. Interview with a personal care aide on 11/04/15 at 11:10 a.m. revealed: - Residents use the bath tub and the first shower stall on the left. - She thought the floor tile had been repaired about 3 months ago but the top coating keeps "flaking" off. - Housekeeping staff clean the bathrooms every day. - They usually store the soiled linen trash can in this bathroom toward the back of the bathroom. Interview with the Memory Care Coordinator (MCC) on 11/04/15 at 11:20 a.m. revealed: - Housekeeping staff cleaned the bathrooms in the memory care unit every day. - Housekeeping staff cleaned the bathrooms in the mornings before showers and they went back after 1:00 p.m. to clean them again. - Housekeeping staff were supposed to go back and check the bathrooms in the afternoons before they got off at 4:00 p.m. - Housekeeping staff used scrub brushes to clean the tile floors and that might be causing the floor coating to come off. - The floors have been peeling for at least a few weeks. - The paper towel dispenser had been loose for "a while" (could not give specific time frame). - The soiled linen trash can was always stored in the common bathroom	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 5 - Staff was not supposed to use the bathroom for storage of other items. Interview with the Administrator on 11/04/15 at 4:12 p.m. revealed: - The tile floors in the bathrooms had been refinished about a year ago. - The tile floors just started peeling about a month ago. - Housekeeping staff were supposed to be cleaning the bathrooms every day. - They would work on the bathrooms. A second observation of the common bathroom on the 400 hall in the special care unit on 11/05/15 at 4:20 p.m. revealed: - A roach crawled from behind the bathroom door across the floor to the toilet stall. - The paper towel dispenser had been positioned upright and secured to the wall. - Some of the brown stains on the walls and floor of the first shower stall had been cleaned and removed. - The dirt and debris had been cleaned from the tub but some yellow stains remained. - The incontinence supply cart was parked in front of the only toilet stall. - There was urine and feces in the toilet and a strong urine odor in the bathroom. - There was a roach crawling on the wall behind the bathroom sink. - Some of the white build-up had been removed from the spigot and knobs in the bath tub. - There was no soiled linen can in the bathroom but the large black trash can remained in the third shower stall. - The incontinence supplies and trash bags were still stored in the second shower stall on the shower stool. - The walker was still stored between the bath	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 6 tub and the sink. Interview with a personal care aide on 11/05/15 at 4:25 p.m. revealed: - The facility used an exterminator for routine treatments. - She had not seen any roaches in a while. - They store the walker in the bathroom in case a resident needs it while staff are assisting the resident with bathing in the bathroom. - She did not usually smell a urine odor in the bathroom. Refer to interview with the Administrator on 11/04/15 at 4:05 p.m. 3. Observations of the 100 hall common bathroom on 11/04/15 at 10:40 p.m. revealed: - A large shower curtain wide enough to move around the first and second showers was partially attached to the curtain track and the rest of the curtain was trailing down onto the floor. - The surface of the floor tiles were peeling off throughout the bathroom. - The back and both sides tile walls and floors of the first shower stall had a rust / brown colored dirty appearance. - The drain area on the floor of the first shower had a black/rust colored appearance to the grout. - The walls and floors of the second shower had discolored a light brown rust color on the tile grout. A second observation on 11/0/15 at 3:50 p.m.of the 100 hall common bathroom revealed: - The wall and floor tiles in the first shower stall had been cleaned but continued to have a stained appearance in the grout. - The shower curtain had been slid along the	D 079	Routine extermination was performed on 11/9/15. Monthly extermination services on going.	11/9/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 7 track to the second shower stall and continued to only be partially attached to the track. - The shower curtain was moved over to the second shower. - The unattached part of the shower curtain hung down and was spread along the floor outside of the second shower stall and was laying in a large puddle of water that had been covered over with towels. Interview on 11/04/15 at 3:55 p.m. with the Resident Care Coordinator (RCC) revealed: - Housekeeping staff cleaned the tiles and floors and commode area every day in the 100 hall common bathroom. - The floor tiles had been peeling off for the last 2-3 months. - The shower curtain was moved over to the second shower stall to be used for a recent resident shower. - The RCC said the curtain should be attached completely to the track. Observation on 11/04/15 at 10:50 a.m. of resident room 120 revealed: - The sink in the room had a rust colored dirty appearance around the edge of the sink where it was attached to the vanity cabinet. - The faucet had a heavy build-up of a green and white hard lumpy substance. - The metal drain cover had rust on it. - The pedestal of the commode, where it meets the floor, had broken and discolored caulking around it. Interview with a resident on 11/04/15 at 10:50 a.m. revealed: - The faucet had the blue, green and white build-up and the commode caulking had the broken discolord caulking for years.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 8 - Housekeeping cleaned up usually daily but the build-up would take more work to get it off of the sink. Refer to interview with the Administrator on 11/04/15 at 4:05 p.m. 4. Observations during the facility tour on 11/4/15 of the 200 hallway revealed: - The sinks in resident 5 rooms were dirty with a brown substance on the caulking surrounding the outside of the bowl. - The sink in room 202 had toothpaste and a black substance in the sink. - The sink in room 210 had soap scum in the bowl and corrosion on the faucet, with a brown substance on the caulking surrounding the bowl. - The sink in room 212 was covered with a grimy substance inside the bowl and a dark brown substance on the caulking surrounding the bowl. - The sink in room 213 was covered with soap, scum in the bowl and on the faucet and a brown substance on the caulking surrounding the bowl. - The sink in room 220 had grime and toothpaste inside the bowl and a brown substance on the caulking surrounding the bowl. - A cockroach crawled out of the bathroom across the floor in resident room 202. The common bathroom on the 200 hallway revealed: - There was peeling linoleum on the bathroom floors and the walls. - Bathroom wall tiles were dirty and covered with soap scum. - There was a black substance in the corners of the floor in the shower stalls. - There was dirt and a peeling textured substance peeling off of the walls in the shower	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 9 stalls. - The sink was stained with rings of a grimy substance, soap scum and toothpaste. - The bath tub was covered with debris and tiny particles of dirt and dead insects. A second observation of the 200 hallway on 11/6/15 at 4:00pm revealed: - The brown substance surrounding the outside of the sinks in all 5 of the resident rooms in the hallway was gone; the caulking was clean and white. - The inside of all of the sinks in the residents ' rooms had been cleaned. - The black substance in the corners of the floor in the shower stalls of the common bathroom were no longer there. - The sink and the bath tub in the common bathroom was clean. - There was no soap scum on the bathroom wall tiles. Refer to interview with the Administrator on 11/04/15 at 4:05 p.m. --- Interview with the Administrator on 11/04/15 at 4:05 pm revealed: -The tiles on the floor of the common bathrooms started peeling a few months ago (amount of time unknown). -The tiles on the bathroom floor were uneven due to the peeling paint. -A company was hired to do an overlay on the floor tiles of the community bathrooms using a "Miracle Method". -The soiled linen barrels were kept in the common bathrooms. -The housekeepers cleaned the bathrooms every day.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 079	Continued From page 10 -The housekeepers used a brush to clean the grout. -She had tried 3 different brands of cleaners to clean the tiles and grout in the bathroom. -She had contacted corporate and someone was supposed to redo the bathroom floors (time unknown).	D 079		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on interview and record review, the facility failed to assure therapeutic diets were served as ordered for 1 of 8 residents (#7) sampled who had orders for a low phosphorus diet and a 1.2 liter fluid restriction. The findings are: Review of Resident #7's current FL-2 dated 07/29/15 revealed: - The resident's diagnoses included congestive heart failure. - The section on the FL-2 for nutritional information noted "no" for special nutritional needs. Review of hospital admission and discharge form dated 07/29/15 revealed: - Resident #7 was admitted to the hospital on 07/22/16 with left sided chest pain, congestive	D 310	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of Deficiencies or Corrective Action Reports; the plan of correction is prepared solely as a matter of compliance with state law. It is the policy of Wilson House to assure liberalized diets offered by Meridian Policy will be followed by the order of the resident's physician. The facility will contact physician and inform of the liberalized diets that Meridian offers to receive clarification. RCC will audit all diets and receive clarification if needed by the Physician.	1/20/16 1/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 310	Continued From page 11 cardiac failure, and hyponatremia. - Other diagnoses included prolonged QT interval, elevated troponin, chronic kidney disease stage 5 on hemodialysis, diabetes mellitus, hypertension, and history of non-compliance. - Diet order included 80 gram protein, 2 gram sodium, 60mEq potassium, ADA 1800 calorie diet and fluid restriction of 1 liter. Review of Resident #7's record revealed a subsequent physician's order dated 09/22/15 for low phosphorus diet 1,000mg daily. Interview on 11/06/15 at 4:10 p.m. with Resident #7 revealed: - The resident went to dialysis three times per week and left at 6 a.m. without eating breakfast. - The resident was provided two sandwiches to take to dialysis on those days. - The sandwiches were usually two slices of bread each with pimento cheese spread because she liked those. - The resident did not eat breakfast and only ate the two sandwiches after returning to the facility at about 11:30 a.m. - 12:00 p.m on dialysis days. - The resident's diet was not a special one and the resident received a regular diet at the facility. - The resident understood not to eat too much dairy-cheese and milk, no greens, potatoes and string beans. - On occasion the resident would go to the store and get a bottle of juice, not soda. - Resident #7 was only to have 8 ounces of fluid per day, and the resident got that much with the two medication cupfuls (4 ounces each) when taking medications. - The resident would drink tea, milk and water with breakfast on the days in the facility. - The resident has taken a bottle of water to dialysis and drinks about half of it while there.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 310	Continued From page 12 - The resident also received nutritional shakes at the facility and the resident drank the whole container but refused them sometimes. - The resident had not seen anyone write down how much liquid was taken by the resident. - The resident ate the two sandwiches and the regular lunch meal for the day on 11/06/15 when she returned from dialysis during the 12 noon lunch meal. - The resident ate the lunch meal on 11/06/15 which consisted of fried fish, french fried potatoes, greens and tea - about 6 ounces or so. Review of a note to the physician dated 10/30/15 revealed: - Facility staff are constantly redirecting Resident #7 about fluids. - The resident becomes upset and agitated. - The resident was witnessed with a bag of snacks and soft drinks when the resident returned from a visit to your office this morning. Review of a telephone order form for Resident #7 revealed: - On 10/30/15, the Resident Care Coordinator (RCC) requested a discontinue order for fluid restriction of 1.2 liters daily due to the resident's non-compliance. - On 11/02/15, the physician responded and wanted the facility to continue with the 1.2 liter fluid restriction. Review of the facility diet list posted in the kitchen on 11/06/15 revealed Resident #7 was listed as regular diet with 1.2 liter fluid restriction daily. Interview on 11/06/15 at 12:25 p.m. with the dietary manager revealed: - Each resident with fluid restriction had a sheet written out as to how much was to be served with	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 310	Continued From page 13 meals, and snacks for the guidance of dietary staff. - The dietary staff did not document how much fluid was served to the residents with fluid restriction because it was written down on the amounts to be served sheet already. - The dietary manager supervised the serving of the drinks to all residents and would watch to ensure fluid restrictions were served correctly. Interview with dietary staff on 11/06/15 at 3:00 p.m. revealed: - They use the posted diet list in the kitchen to serve the residents. - Resident #7 was on a regular diet with a fluid restriction. - He was not aware of any diet changes for Resident #7. - The facility did not have a low phosphorus diet menu to his knowledge. Interview with the RCC on 11/06/15 at 1:25 p.m. revealed: - Resident #7 went to dialysis 3 times a week. - The resident gets a certain amount of fluids at meals and with medications. - She could not recall the specifics but they had a guide sheet that they go by. - The resident was non-compliant with the fluid restriction and the physician and dialysis center were aware. - The resident received a regular diet. - She was unaware of the diet order for low phosphorus diet. - The facility offers regular diets and no added table salt diets. Review of the November 2015 medication administration records (MARs) revealed: - The resident was being administered mighty	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 310	Continued From page 14 shakes twice daily at 8:00 a.m. and 8:00 p.m. Review of a handwritten form for Resident #7 provided by the RCC revealed: - The resident was served 8 ounces of liquids at breakfast, lunch, and supper. (Total of 24 ounces). - The resident was served 6 ounces for one snack, 3 ounces for a second snack and no liquids for a third snack. (Total of 9 ounces). - The resident was served 5 ounces of liquids at medication pass 3 times a day for a total of 15 ounces. - There was no total of liquids offered calculated on the form. - The amounts listed on the guide form totaled 48 ounces or 1,440 milliliters (1.44 liters). - There was no documentation of the resident's 4 ounce supplements given twice daily on the guide form. (Total of 8 additional ounces.) Interview with the RCC on 11/06/15 at 2:40 p.m. revealed: - She did not realize the total of fluids on their guide form exceeded the 1.2 liters ordered. - The medication aide or the RCC are responsible for notifying dietary staff of any new diet orders or order changes. - She did not recall seeing any diet order changes in Resident #7's record. - She thought the order changes may have been overlooked. - She just contacted the physician's office and the physician was not available. - The nurse at the physician's office stated the resident should be on a low phosphorus diet. - She would try to contact the dialysis center also. Telephone interviews with the nurse manager at	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 310	Continued From page 15 the dialysis center on 11/06/15 at 3:10 p.m. and 3:34 p.m. revealed: - They were very much aware of Resident #7's non-compliance. - She spoke with the nephrologist today and the resident needs a to be on a renal diet. - She would fax an order to the facility. Review of a diet order dated 11/06/15 and faxed by dialysis to the facility on 11/06/15 revealed: - Order for 1800 calorie ADA renal diet, 80 gram protein daily, 60mg potassium daily, 2 gram sodium daily, 1000mg phosphorus daily, and 1.2 liter fluid restriction daily. - The justifications for the diet order included end stage renal disease, diabetes mellitus, hyperkalemia, and hyperphosphatemia. - There was a list of high phosphorus foods to avoid and high potassium foods to avoid attached to the diet order. Review of the list of foods to avoid that are high in phosphorus revealed it included foods the resident stated she had eaten or drank including milk and cheese products. Review of the list of foods to avoid that are high in potassium revealed it included foods the resident stated she had eaten or drank including milk, juice, potatoes, and greens. Review of labwork faxed from the dialysis center on 11/06/15 revealed: - Resident #7's most recent phosphorus level was 3.8 (reference range 2.5 - 5.0) on 11/03/15.	D 310	Response to the cited deficencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the statement of Deficiencies or Corrective Action Report; the plan of correction is prepared solely as a manner of compliance with state law.	
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 16 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: TYPE B VIOLATION Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 6 residents (#8, #9) observed during the medication pass and 3 of 7 residents (#4, #5, #7) sampled for review including errors with medications used to treat dialysis residents, diabetes, blood thinning, constipation, anxiety, and psychosis. The findings are: 1. The medication error rate was 10% as evidenced by the observation of 3 errors out of 28 opportunities during the 8:00 am and 11:00 am medication passes on 11/5/15. A. Review of Resident #9's current FL-2 dated 7/9/15 revealed: -Diagnoses included Alzheimer's, cerebrovascular accident, diabetes mellitus, dementia, hyperlipidemia, history of cervical cancer, gastroesophageal reflux disease, anemia and chronic renal insufficiency. Review of physician's order for Resident #9 dated 7/28/15 revealed: -Finger stick blood sugar (FSBS) three times a day.	D 358	It is the policy of Wilson House to assure that the preparation and administration of medication, prescriptions and non-prescriptions and treatments by staff in accordance with the orders by a licensed prescribing Practitioner. This will be maintained in the residents' records. The facility will review staff procedures on Medication Administration. The pharmacy manual and medication disposition will be reveiwed with medication staff by the ED and RCC. Documentation of audits will be located in the QA binder. In-service on Medication Adminstration of insulin will be given to all medication aides. All Medication Aides will be revalidated. Nurse will in-service on "six rights of medication of administration". Physicians and or designee will clarify physicians orders as residents are admitted, readmitted or new orders are written by physician.	12/21/15 12/21/15 12/21/15 12/21/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 17 -If blood sugar was less than 40 call primary care provider and emergency medical services. -If blood sugar was 40-60, hold insulin and give 1 cup of juice. -If blood sugar was 61-80, give ½ cup of juice and hold insulin. -If blood sugar was 81-99, give no juice and hold insulin. -If blood sugar was greater than 451, call the primary care provider. Review of physician's order for Resident #9 dated 9/29/15 revealed an order to increase Humalog from 5 to 8 units 3 times a day. (Humalog is a rapid-acting insulin used to lower blood sugar. The manufacturer recommends Humalog be taken within 15 minutes before eating a meal). Review of the November 2015 medication administration record (MAR) revealed: -An entry for Humalog, inject 8 units 3 times a day. -Humalog was scheduled to be administered at 9:00 am, 1:00 pm and 6:30 pm. -FSBS were scheduled before meals at 8:00 am, 11:00 am and 6:00 pm. -The FSBS's ranged from 136-459. Observation during the medication pass on 11/5/15 at 11:15 am revealed: -The medication aide checked Resident #8's blood sugar and it was 459. -The medication aide did not administer any insulin. -The medication aide recorded the blood sugar on the MAR. Interview with the Medication Aide on 11/5/15 at 11:15 am revealed: -She had to call the primary care provider	D 358	The ED or designee will conduct a random audit weekly for a month; then monthly to ensure that physicians orders as residents are admitted, readmitted or new orders are written by physician are being clarified. Documentation of audits will be located in the QA binder. Medication Administration passes will be monitored by the RCC and ED for the next 60 days. Documentation will be available in the QA binder. All staff will be in-serviced regarding residents that are diabetic and insulin dependent. These residents will be served first. All diabetics that are insulin dependent will be marked for the first meal tray.	1/20/16 1/20/16 1/20/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 18 because the blood sugar was over 451. -She would wait to see if the primary care provider was going to increase the amount of insulin she would administer. Interview with Resident #9 on 11/5/15 at 12:22 pm revealed: - She "felt alright for an old lady" . -She denied any current symptoms of high blood sugar. -She was getting ready to eat lunch. Observation of Resident #9 on 11/5/15 revealed she was served lunch at 12:25 pm. Interview with the Medication Aide on 11/5/15 at 12:45 pm revealed: -Resident #9 was scheduled to receive 8 units of Humalog. -She was still waiting to hear back from the primary care provider before she gave any insulin. -She thought the primary care physician would want to increase the dose. Interview with the Memory Care Coordinator (MCC) on 11/5/15 at 1:05 pm revealed she had spoken with the primary care provider and he ordered 12 units of Humalog to be administered now and recheck the blood sugar in 1 hour. Observation of the Medication Aide on 11/5/15 at 1:11 pm revealed she administered 12 units of Humalog to Resident #9. Interview with the MCC on 11/5/15 at 1:15 pm revealed: -She was trained to give insulin with meals. -She was not sure what the facility policy was for administering insulin.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 19 -Resident #9's blood sugar was checked before she eats. -The electronic medication administration (eMAR) record notified the medication aide of when to check the blood sugar. -The medication aide must check the blood sugar when the eMAR prompts her to because it would cause a late entry if she waited. -The insulin dosage does not prompt in the eMAR until later. -Resident #9 was to get insulin only after she had eaten. -The staff administers insulin after the residents eat so the residents' blood sugars would not drop. -Resident #9 had an order for Humalog 8 units to be given as a scheduled dose 3 times a day. -The medication aide should have given the scheduled 8 units of Humalog and not have waited to hear back from the primary care providers. Review of care notes dated 11/5/15 (no documented time) revealed: -The MCC spoke with the primary care provider. -The primary care provider ordered to give Humalog 12 units, recheck blood sugar in 1 hour and notify him of results. -Primary care provider was notified of recheck of blood sugar was 168. Telephone interview with the Physician Assistant at the primary care physicians' office on 11/6/15 at 3:00 pm revealed: -The facility followed the order to call the primary care provider if the blood sugar was over 451. -The facility did not follow the order to administer the 8 units of Humalog. -The medication aide should have given the scheduled dose of Humalog and not waited to hear from primary care provider's office.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 20 -He would clarify the order. Review of physician's order dated 11/5/15 at 3:00 pm revealed: -Give Humalog 8 units every day after meals. -If blood sugar was 81-100, hold insulin. -If blood sugar was 61-80, hold insulin and give ½ cup of juice. -If blood sugar was 41-60, hold insulin and give 1 cup of juice. -If blood sugar was less than 40, call emergency medical services. -If blood sugar was greater than 451, give scheduled insulin and call primary care provider. B. Review of Resident #8's current FL-2 dated 9/15/15 revealed: -Diagnoses included hypertension, obesity and abdominal disease, bipolar disorder, history of cervical surgery, history of hepatitis, renal failure, cirrhosis of the liver and muscular degeneration. -There was an order for Xarelto 20 mg daily. (Xarelto is a blood thinner that helps prevent the formation of blood clots). Review of a physician's order dated 9/28/15 revealed: -There was a discontinue order for Xarelto. -There was an order for Eliquis 2.5 mg twice a daily. (Eliquis is a blood thinner that helps prevent the formation of blood clots). Review of the pharmacy dispensing records from 9/28/15 - 11/5/15 revealed: -There was 60 tablets of Eliquis 2.5 mg dispensed on 9/28/15. -There was 2 tablets of Eliquis 2.5 mg dispensed on 10/27/15. Observation of the medication pass on 11/5/15 at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 21 8:58 am revealed: -The medication aide (MA) pulled out an empty medication dose pack with the label for Eliquis 2.5 mg twice a day. -The medication was dispensed on 10/27/15 for 2 tablets. -She said she did not have any Eliquis. - No Eliquis was administered to the resident Review of the October 2015 medication administration record (MAR) revealed: -Eliquis was scheduled to be administered twice a day at 8:00 am and 8:00 pm. -Eliquis was documented as being administered twice a day from 10/1/15 - 10/29/15. -On 10/30/15 the MA documented that Eliquis "med administered new order could not click" for the 8:00 am and 8:00 pm dose. -On 10/31/15 the MA documented "awaiting med from pharmacy" for the 8:00 am and 8:00 pm dose of Eliquis. Review of the November 2015 MAR revealed Eliquis had not been administered from 11/1/15 - 11/5/15 due to "awaiting med from pharmacy" . Review of care notes for Resident #8 revealed: -There was a note written by the Resident Care Coordinator (RCC) on 11/5/15. -The note on 11/5/15 (time unknown) documented the RCC had called the primary care physicians office and left message on the voicemail regarding a prior authorization of medication. -The next note on 11/5/15 at 1:15 pm documented the RCC had called the primary care physician's office and spoke to office staff to get the prior authorization paper work completed. -The next note on 11/5/15 at 2:15 pm documented the RCC had spoken with the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 22 primary care physician and he would fax over a new order. -There was no documentation regarding the of resident's Eliquis prior to 11/5/15 Interview with Resident #8 on 11/5/15 at 1:20 pm revealed he was unsure of the kinds of medications he takes. Interview with MA on 11/5/15 at 1:45 pm revealed: -Eliquis had been out of stock "for a while". -The RCC had called the pharmacy (time unknown) and found out the medication required a prior authorization. Interview with a second MA on 11/6/15 at 4:00 pm revealed: -She was not aware that Resident #8 was on Eliquis. -Medications could be ordered by fax or by clicking medication in the computer. -The computer would tell you if the medication could not be ordered. -If the computer rejected the refill of the medication, the MA was supposed to write in the care notes section of the chart. -If the medication required a prior authorization, she was to report this information to the RCC. Interview with the RCC on 11/5/15 at 1:42 pm revealed: -The MAs reorder medication when it gets to the "blue strip" on the pill package. -The MAs can reorder medications through the computer or by faxing a request. -The PCP's office had been sent the paper work on the prior authorization for the Eliquis for Resident #8 on 10/28/15. -The pharmacy sent the PCP's office and the facility a copy of the prior authorization.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 23 -She was unsure of why Resident #8 was on a blood thinner. -She had ordered a few pills to last resident until the prior authorization went through. -The resident would pay cash price for the few pills. -She had not discussed payment for the pills with the resident or his responsible party. -She would contact the primary physician's office about the Eliquis. Review of physician's order dated and faxed to the facility on 11/5/15 revealed a discontinue order for Eliquis. Interview with the Executive Director (ED) on 11/5/15 at 4:45 pm revealed she was not aware that Resident #8 was on a blood thinner and had not been receiving it. Telephone interview with the Physician Assistant at the primary care physician's office on 11/6/15 at 3:00 pm revealed: -He had been Resident #8's PCP for over 1 year. -He was unsure at that time of why the resident was on a blood thinner. -When he took over care of Resident #8 he prescribed Xarelto. -He switched Resident #8 from Xarelto to Eliquis due to less side effects. -He was not aware the resident had not received the Eliquis in 6 days. -He was not aware the Eliquis required a prior authorization. -He would have liked to have been notified by the facility. -He did not discontinue the Eliquis on 11/5/15. -He was not aware that the primary physician in his office had discontinued the Eliquis on 11/5/15. -He would contact the facility and order Aspirin 81	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 24 mg daily until the resident could be further evaluated. (Aspirin helps prevent the formation of blood clots). Telephone interview with the facility's primary pharmacy on 11/6/15 at 2:45 pm revealed: -The pharmacy received a refill request for the Eliquis on 10/28/15. -The Eliquis required prior authorization. -There were 2 tablets of Eliquis delivered to the facility on 10/28/15. -The prior authorization was initiated by the pharmacy on 10/28/15. -The pharmacy always faxes a copy of the prior authorization to the facility and to the primary care provider's office. -The pharmacy representative always follows up with the facility or the primary care provider in 3-5 days. -The pharmacy representative had spoken with the RCC on 11/5/15 during her 5 day follow up call. -The pharmacy representative ensured the RCC had the prior authorization form sent on 10/28/15. -The RCC had the form and would speak with the Physician Assistant regarding the prior authorization. -The prior authorization paper work had not been completed as of 11/5/15 at 2:45 pm. Interview with the ED on 11/6/15 at 4:10 pm revealed: -The pharmacy sent a copy of the prior authorization to the doctor and to the facility. -The RCC was responsible for following up with prior authorizations. C. Review of Resident #8's current FL-2 dated 9/15/15 revealed diagnoses of hypertension, obesity and abdominal disease, bipolar disorder,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 25 history of cervical surgery, history of hepatitis, renal failure, cirrhosis of the liver and muscular degeneration. Review of physician's order dated 10/19/15 revealed Miralax 17 gm in 8oz of favorite liquid every day, hold if diarrhea occurs. (Miralax is a laxative used to help with constipation). Observation of the medication pass on 11/5/15 at 8:58 am revealed the MA did not offer or administer Miralax to Resident #8 when the resident was administered his other medications scheduled for 8:00 am. Review of the October 2015 medication administration record (MAR) revealed: -Miralax was ordered to be given daily at 8:00 am. -Miralax was documented as being administered from 10/1/15 - 10/31/15. Review of the November 2015 MAR revealed: -Miralax was ordered to be given daily at 8:00 am. -Miralax was documented as being administered from 11/1/15 - 11/5/15. Interview with the MA on 11/5/15 at 1:45 pm revealed: -Miralax was to be given to Resident #8 in the afternoon or when needed. -After seeing the scheduled time of 8:00 am on the MAR, the MA stated she gave Miralax to Resident #8 on 11/5/15 before breakfast. -She documented as giving the Miralax at 8:59 am. -She did not give the Miralax at 8:59 am, she gave it earlier before breakfast. -She "normally" documented the Miralax when she gave it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 26 Review of the label on the Miralax bottle on 11/5/15 at 1:45 pm revealed: -The date it was dispensed at the pharmacy was 6/3/15. -The quantity was a 527 gm bottle. -A 527 gm bottle was a 31 day supply. Review of the pharmacy dispensing records from 12/28/14 - 6/3/15 revealed: -Miralax was dispensed on 12/28/14 for a 527 gm bottle. -Miralax was dispensed on 2/20/15 for a 527 gm bottle. -Miralax was dispensed on 6/3/15 for a 527 gm bottle. Interview with Resident #8 on 11/5/15 at 1:20 pm revealed: -He used to get a "powder" in his water to help his "bowels". -He had not received any medication for his "bowels" in a while (time unknown). -He had not received the medication for his "bowel" this morning 11/5/15. -He was not aware why the staff had stopped giving him the medication. -He was not having any problems with constipation currently. Telephone interview with the Physician Assistant at the primary care physician's office on 11/6/15 at 3:00 pm revealed: -He was aware Resident #8 was prescribed Miralax 17 gm daily. -He would have expected the facility to administer the Miralax daily. -He was not aware the resident had not received the Miralax daily. Interview with the Resident Care Coordinator	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 27 (RCC) on 11/5/15 at 3:30 pm revealed: -She was not aware the Miralax had not been refilled since 6/3/15. -She was not aware the Miralax bottle from 6/3/15 should have only lasted 31 days. Interview with the Executive Director (ED) on 11/6/15 at 4:10 pm revealed she was not aware of any specific orders or directions of Miralax for Resident #8. 2. Review of Resident #7's current FL-2 dated 07/29/15 revealed: - The resident's diagnoses included congestive heart failure and see history and physical (on hospital forms). Review of hospital admission and discharge form dated 07/29/15 revealed: - Resident #7 was admitted to the hospital on 07/22/15 with left sided chest pain, congestive cardiac failure, and hyponatremia. - Other diagnoses included prolonged QT interval, elevated troponin, chronic kidney disease stage 5 on hemodialysis, diabetes mellitus, hypertension, and history of non-compliance. A. Review of Resident #7's current FL-2 dated 07/29/15 included an order for Sensipar 60mg daily with breakfast. (Sensipar is used to treat hyperparathyroidism and lowers parathyroid hormone, calcium, and phosphorus in people on kidney dialysis. The manufacturer recommends Sensipar be taken with food or shortly after a meal.) Review of a subsequent physician's order dated 10/12/15 revealed: - An order for Sensipar 60mg once daily with the evening meal.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 28 Review of the October 2015 and November 2015 medication administration records (MARs) revealed: - The order to change Sensipar to the evening meal on 10/12/15 was never changed on the October or November 2015 MARs. - The computer printed entry for October and November 2015 was for Sensipar every morning with breakfast. - Sensipar was documented as administered daily at 8:00 a.m. instead of in the evening as ordered on 10/12/15. Review of the medication on hand for Resident #7 revealed: - One supply of Sensipar 60mg dispensed on 10/09/15. - The directions on the label were to take 1 tablet in the morning with breakfast. Interview with the medication aide on 11/06/15 at 4:15 p.m. revealed: - She did not usually administer the Sensipar to the resident on second shift because it was scheduled on the MAR at 8:00 a.m. - She was unaware of an order to administer the Sensipar with the evening meal. Interview with the Resident Care Coordinator (RCC) on 11/06/15 at 4:55 p.m. revealed: - The medication aide on duty at the time an order is received or the RCC was responsible for implementing new orders and faxing them to the pharmacy. - The pharmacy will enter the new orders in the computer for the electronic MARs and facility staff have to review and accept the orders on the electronic MARs. - She was not sure if the order dated 10/12/15	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 29 had been faxed to the pharmacy. - She would contact the pharmacy to find out. Attempts to contact the pharmacy on the afternoon of 11/06/15 were unsuccessful. Review of labwork faxed from the dialysis center on 11/06/15 revealed: - Resident #7's most recent phosphorus level was 3.8 (reference range 2.5 - 5.0) on 11/03/15. - The most recent calcium level was 8.2 (reference range 8.6 - 10.2) on 11/03/15. B. Review of Resident #7's physician's orders revealed an order dated 09/22/15 for Renvela 800mg take 3 tablets with meals and 2 tablets with snacks. (Renvela is used to lower phosphorus levels in those receiving dialysis. According to the manufacturer, Renvela should be taken with meals.) Review of the October and November 2015 medication administration records (MARs) revealed: - The mealtime doses for Renvela were scheduled at 8:00 a.m., 12:00 noon, and 5:00 p.m. - The mealtime doses for Renvela were documented as administered daily in October and November 2015. Interview on 11/06/15 at 9:48 a.m. with a medication aide (MA) revealed: - If a resident was out of the facility (OOF) when the medication was listed to be administered, for example at 12:00 p.m. with meals, the medication would be held for one hour after the listed time for administration. - Residents who would be at dialysis or otherwise OOF and were to have Renvela administered	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 30 with meals did not receive it with their lunch when returning if the time was beyond the one hour before and one hour after rule. - If the medication was not administered, it should be circled and explained on the MAR notes. - Medcations to be taken with food meant the medication could be administered before the meal or after finishing the meal. - The MA was not aware the order written to be taken with meals meant after starting to eat. - The night shift gave the Renvela before 6 a.m. when the resident left for dialysis three times per week. Interview on 11/06/15 at 10:02 a.m. with another medication aide revealed: - The Renvela medication for Resident #7 would be able to be administered one hour before and one hour after the time listed for administration on the MAR. - If the resident did not arrive back at the facility by the time the one hour after administration time listed rule, the medication would not be administered unless it was just a few minutes past the one hour limit. - If the resident was not back in time for the administration, the MA documented OOF as reason for not administering the Renvela. Interview on 11/06/15 at 10:15 a.m. with the Resident Care Coordinator (RCC) revealed: - The RCC was not aware the Renvela was not being administered to residents who go to dialysis and return after the scheduled administration time on the MAR. - The RCC was not aware the Renvela was being administered on an empty stomach before dialysis. - Residents were given a sandwich to eat at	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 31 dialysis. - Facility policy was that most medications were to be held to the administration time of one hour before and up to one hour after the listed administration time. - Since Renvela was listed to be administered with meals it could wait for the resident to return and be administered with the lunch meal when served. - If the medication was not administered, the MA was to give reason as OOF but if the resident ate anything when came back to the facility it should have been administered. Interview with Resident #7 on 11/06/15 at 4:10 p.m. revealed - The resident did not eat breakfast on dialysis days before leaving at 6 a.m. for dialysis. - The resident took all of the scheduled morning medications from the medication aide on a empty stomach before she left for dialysis including the "big pills" (Renvela). - Renvela was not given if they were late getting back from dialysis around lunch time. - The sandwiches provided by the facility in the morning as the resident left for dialysis were not usually eaten until retuning to the facility just before or at lunch time. 3. Review of the current FL-2 for Resident #4 revealed: - Diagnoses included End Stage Renal Failure, Heart failure, Hypertension, Diabetes Mellitus, Anemia, Colostomy. - There was a medication order for Renvela 800mg 2 tablets with meals three times erday and 1 tablet with snacks. (Renvela is used to lower phosphorus levels in those receiving dialysis. According to the manufacturer, Renvela should be taken with meals.)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 32 Review of the September 2015, October 2015 and November 215 Medication Administration Records for Resident #4 revealed: - Renvela 800mg 2 tablets was listed for administration with meals at 7:00 a.m., 12:00 p.m. and 5:00 p.m. - Renvela 1 tablet with only one snack per day at 10 a.m. was listed. Review of the September 2015 MAR revealed: - For the 7 a.m. administration time on 9/17/15, a note written at 6:10 a.m. indicated the resident was not administered Renvela for being OOF. (dialysis day). - On 9/05/15 at the 12:00 p.m. lunch meal time, a note was written at 1:33 p.m. Renvela was not administered due to resident being OOF. - On 9/17/15 at the 12:00 p.m. lunch meal time, the Renvela was not administered at 11:01 a.m. due to the resident OOF (dialysis day). - No snack time administration information for Renvela was listed for the 2:00 p.m. snack nor the evening snack. Review of the October 2015 MAR revealed: - On 10/03/15 at 12:17 p.m., and 10/29/15 at 12:36 p.m., (dialysis days) exception notes for Resident #4 were written related to the Renvela not being administered due to the resident being OOF. - There was no documentationof administration of Renvela when the resident returned to the facility and ate his lunch. - No snack time administration documentation for Renvela was listed for the 2:00 p.m. snack or the evening snack. Review of the November 2015 MAR revealed: - On 11/05/15 (dialysis day) at 6:10 a.m. an	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 33 exception note was written on the MAR indicating Renvela 800mg was not administered, OOF. - On dialysis day 11/03/15 at the 10:00 a.m. snack time the administration block was initialed. - There was no snack time administration documentation for Renvela administration for the 2:00 p.m. snack nor the evening snack. Interview on 11/06/15 at 9:48 a.m. with a medication aide (MA) revealed: - When Resident #4 was out of the facility (OOF) when medications were listed to be administered at 12:00 p.m. with meals or with the snack, the medication would be held for one hour after the listed time for administration per facility policy. - Residents, who would be at dialysis or otherwise OOF, who were to have Renvela administered with meals may not have receive it. - If residents did not return during the lunch time and it was one hour beyond the allowed time 12 p.m. for adminisntration they would not administer the Renvella. - The MA would initial the time for administration and circle it with an explanation on the MAR notes. - Renvela was not sent to dialysis with the resident. - Medcations to be taken with food meant the medication could be administered before the meal or after finishing the meal. - The MA was not aware the order written to be taken with meals meant after starting to eat. - The night shift gave the Renvela before 6 a.m. because the resident left at 6 a.m. for dialysis three times per week. Interview on 11/06/15 at 10:02 a.m. with another medication aide revealed: - The Renvela medication for Resident #4 could	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 34 be administered one hour before and one hour after the time listed for administration on the MAR. - If the resident did not arrive back at the facility by the time the one hour after administration time listed rule, the medication would not be administered unless it was just a few minutes passed the one hour limit. - If the resident was not back in time for the administration, the MA documented OOF as reason for not administering the Renvela. Interview on 11/06/15 at 10:15 a.m. with the Resident Care Coordinator (RCC) revealed: - The RCC was not aware the Renvela was not being administered to residents who go to dialysis and return after the time listed for administration on the MAR. - Those residents should receive the Renvela with their meals and snacks. - Resident #4 usually returned before 12:00 p.m. lunch meal and should have received Renvela with the lunch meals. - Facility policy was that most medications were to be held to the administration time of one hour before and up to one hour after the listed administration time. - Since the Renvela was listed to be administered with meals it could wait for the resident to return and be administered with the lunch meal when served. - The RCC was not aware the MAR only listed one snack time for administration. - The RCC was not aware some of the 6 a.m. doses of Renvela were being administered without a meal in the morning before residents left for dialysis. - If the medication was not administered, the MA was to give reason as OOF but if the resident ate anything when they came back to the facility it	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 35 should have been administered with the food served. Interview with Resident #4 on 11/05/15 at 4:12 p.m. revealed: - The resident ate breakfast (a sandwich) on dialysis days before leaving the facility at 6:00 a.m. or while waiting to start dialysis after leaving the facility. - The resident received medications before leaving at 6 a.m. on dialysis days. - The resident said he does not receive medications with his lunch when retuning from dialysis. - The resident said sometimes in the mornings when in the facility he gets medications about 10 a.m. and may or may not have eaten a snack. - There were snacks provided in the afternoon and evening but he did not receive the Renvela at those times. 4. Review of current FL2 dated 8/18/15 for Resident #5 revealed: -The Resident ' s diagnosis was schizoaffective disorder bipolar type. -There were medication orders for Ativan 0.5mg by mouth at bedtime and Seroquel 100mg daily in the morning. Review of the Resident Register for Resident #5, revealed he was admitted to the facility on 4/27/15. Review of subsequent orders for Resident #5 revealed there was an order for Seroquel 50mg daily in morning dated 10/7/15. Review of a discharge summary following a hospital stay for Resident #5 dated 10/22/15 through 10/26/15 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 36 -A heading listed change how you take these medications in large bold letters. -There was a physician order for Seroquel 100mg daily in morning. -In bold large letters were physician instructions to stop taking Ativan, Review of the October 2015 Medication Administration Record (MAR) for Resident #5 revealed: -Seroquel 50 mg had been administered at 8:00am on 10/26/15, 10/27/15, 10/28/15, 10/29/15, 10/30/15 and 10/31/15. -Ativan 0.5mg had been administered at 8:00pm on 10/27/15, 10/28/15, 10/29/15, 10/30/15 and 10/31/15. Review of the November 2015 Medication Administration Record (MAR) for Resident #5 revealed: -Seroquel 50 mg had been administered at 8:00am on 11/1/15, 11/2/ 11/3/15 and 11/4/15. -Ativan 0.5mg had been administered at 8:00pm on 11/1/15, 11/2/15 and 11/3/15. Observation of the medication on hand for Resident #5 on 11/4/15 at 3:00pm revealed: -Seroquel 50mg tablets were on the medication cart. -Ativan 0.5mg tablets were on the medication cart. Interview with the medication aide on 11/4/15 at 3:00pm revealed: -Resident #5 had been receiving the Seroquel 50 mg every morning. -He had also been receiving Ativan 0.5mg every night. -There had not been any recent medication changes.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 37 -Resident #5 had been in the hospital recently, but there had not been any changes to his medications. -The RCC was responsible for checking discharge orders and FL-2 and physician orders for medication changes. Interview with the RCC on 11/4/15 at 3:15pm revealed: -She was responsible for implementing changes in physician orders. -When new physician orders for medication changes came in, they were to be faxed over to the pharmacy. -When pharmacy put the medication changes into the system an alert would show on the screen and flag the medication that was changed, -The RCC and medication aide would have to verify the alert. -She saw the physician changes on the discharge summary for Resident #5's hospitalization dated 10/22/15 through 10/26/15. -The new physician order was for Seroquel 100mg to be given to resident #5 daily in the morning. -The new physician order to stop the Ativan order for Resident #5. -She received these orders upon Resident #5's return from the hospital on 10/26/15 at around 5:00pm. -She called over to the pharmacy to alert the pharmacy technician she was faxing new orders. -She faxed the orders to pharmacy that evening and then she went to a training. -When she went back to the fax machine after the training she put the papers in her mail box and went home. -She did not realized the order change did not pop up on the MAR to be verified. -She could not find the fax confirmation.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 38 Review of care note for Resident #5 dated 11/4/15 at 3:30pm revealed: -The RCC called the mental health team and informed them the new orders Resident received on 10/26/15 were never entered into the quick MAR. -There was no answer and a message was left on the machine. -An entry was added to the bottom of the same note documenting a return call from the mental health team informing the RCC she received the message and would update the chart for Resident #5. Review of Resident #5 ' s care notes dated 10/26/15 revealed documentation that he returned from the hospital with new orders. Interview with the pharmacy representative on 11/4/15 at 3:35 pm revealed: -When medication orders were received from the facility, the medication changes were put into the system the same day. -She had not received a fax from the facility for changes to Resident #5's Ativan since 8/31/15. -The current order in the system was Ativan 0.5mg at bedtime. - She had not received a fax from the facility for changes to Resident #5's Seroquel since 10/7/15. -The current order in the system was Seroquel 50mg daily in the morning. -She did not recall speaking with the RCC on 10/26/15 and there had not been any notation of a conversation on that date. Interview with the Executive Director on 11/5/15 at 1:45pm revealed: -When medication orders and discharge summaries are received at the facility, the policy	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 358	Continued From page 39 is the RCC would fax the order to the pharmacy. -The new order would be flagged on the electronic MAR and the MA and the RCC would have to verify the medication in the system. -The new orders would then go in a notebook so Resident #5's mental health provider could sign them. -The Resident ' s mental health provider was to follow up in 5 days at the facility. -The Ativan was stopped for Resident #5 on 11/4/15 and the Seroquel order was changed to 100mg in the morning on 11/5/15. Interview with Resident #5 on 11/6/15 at 9:30am revealed he was not familiar with his medications, because his orders change a lot.. The Plan of Protection received from the facility on 11/6/15 revealed: - Starting 11/6/15 the facility staff shall administer all medications and treatments as ordered by the practitioner and document accordingly. - The facility medication aided will be in-serviced regarding medications and validated for diabetic administration. - The facility will have all admissions, readmits and FI-2 orders clarified and reconciled with the physician and pharmacy. - The facility will perform medication cart audits every shift randomly by management. - The facility medication aides will be revalidated for all medication administration includes orders, MARs, and medications on hand. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED DECEMBER 21, 2015.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 40	D 438		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to report to the North Carolina Healthcare Registry allegations of abuse of a resident (#10) by a staff member. The findings are: Review of the current FL2 dated 10/26/15 for Resident #10 revealed: -Diagnoses included depression with anxiety, sleep disturbance, schizophrenia and shortness of breath. -She was admitted to the facility on 11/24/2011. Interview with Resident #10's responsible party on 4/6/15 at 12:30pm revealed: -Resident #10 has a split personality, but one day about 6 months ago she called her and told her an employee working at the facility slapped her across the face. -The staff member was a MA that worked in the 100 hallway. -She called the MA and told the MA, she knew what she (the MA) did, and the MA said " she knew she was wrong " and "I know" The MA was also "fussed out by the administrator". -Another time the MA told Resident #10 she did not slap her.	D 438	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusion set forth in the statement of Deficiencies or Corrective Action Report; the plan of correction is prepared solely as a matter of compliance with state law. It is the policy of Wilson House that all incidents involving a resident and staff a 24 hour report will be submitted for all allegations followed by a 5 day report.	12/15/15

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 41 -"They get along better now though", (Resident #10 and the MA). -She spoke with the RCC, and the RCC told the responsible party, Resident #10 had told her something different. -She spoke with the Executive Director about the incident and the Executive Director told her Resident #10 says things that are not true. She told the Executive Director, the MA admitted her wrong doing to her. -"I will let" Resident #10 "tell you what happened now she will tell you, go ahead tell them". Interview with Resident #10 on 4/6/2015 at 12:30pm revealed: -One day when she was in the hallway at the medication cart, she was having an anxiety attack and a MA snapped at her, and got in her face and slapped her face. -Resident #10 had said something to the MA that worked in the women's hallway on 2nd shift, but does not remember what it was she said. -After the incident she went back to her room. -She did not remember what she had said to the MA. -There were no witnesses to the incident. -She reported the incident to the RCC. -On another occasion weeks later on a different day she went up to the medication cart again and the MA said "she needed to apologize to her" and after that staff never bothered her again, she was nice to her after that. -There was another staff member at the facility that was mean to her too, a PCA that worked 2nd shift. -She felt afraid of the PCA and she was always around her following her around. -The women are not allowed to go to the men's hallway after 7:00pm. -She did not allow Resident #10 to go down the	D 438	All staff will be retrained and in-serviced on Abuse and Neglect. Abuse and Neglect training will be completed; and ongoing at every staff meeting. Documentation will be completed by all staff and will be available in the QA binder.	1/15/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 42 men's hallway to say goodnight to her boyfriend before 7:00pm, before she went to bed. -When she would attempt to go down the men's hallway the PCA would tell her they are getting ready for bed and would not allow her to enter into the hallway. -There was a soda machine located at the end of the men's hallway also and the PCA would not let her go down the hallway to the vending machine to get a soda. -The Executive Director had also said things to her she did not like, so she did not tell her about the PCA she was afraid of. -She had said "I come in there every day complaining" and it is not true, so she does not say much to the Executive Director. -She liked the RCC, she had always been nice to her. -No other employee of the facility had ever hit her again. Record review of Resident #10's care notes dated 1/23/2015 at 7:00pm revealed: -The notation was signed by the Medication Aide (MA), documented as follows: -Resident #10 was given an as needed (PRN) medication for agitation. -She was very disrespectful and used unacceptable language. -Resident #10 threw her medication in the trash and said she was not going to take any medication. Record review of Resident #10 ' s care notes dated 1/23/2015 at 7:19pm-8:45pm revealed The notation was signed by the RCC, documented as follows: -Resident #10 was asked to leave the medication cart because she was reaching for things and agitated as the medication aide (MA) tried to	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 43 administer her medications. -Resident #10 refused her medications knocking them away from her and accused the MA of hitting her. -The Resident Care Coordinator (RCC) and another staff member conferenced with Resident #10. -Resident #10 told the RCC and the other staff member she overreacted and apologized for her behavior. -During the conference with the RCC, Resident #10 and other staff member, the RCC stepped out and asked other residents had they seen any physical behavior between Resident #10 and the MA. -The other residents that had been present at the medication cart said Resident #10 had been disrespectful to the MA, but they had not seen any physical behavior between the MA and Resident #10. -After speaking with Resident #10 the RCC returned to the staff and resident and Resident #10 apologized again to the RCC for her behavior and she took her medication for the RCC and promised she wouldn't display that type of behavior again. -The RCC stayed and monitored Resident #10 for 30 minutes, Resident went to bed with no further behavioral problems. Review of Resident #10 care Notes dated 7/15/2015 revealed: -At 5:52pm Resident was agitated and using unacceptable language for no known reason. -Resident was stating a personal care aide (PCA) hit her. -The medication aide spoke with other residents and the residents said they did not see any physical contact between the PCA and Resident #10.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 44 -The responsible party was informed and staff will continue to monitor Resident #10. Interview with a Medication Aide on 11/6/2015 at 4:05pm revealed: -Resident #10 was standing at the medication cart on January 23, 2015 fussing her out about not wanting to take her medication. -Resident #10 had called her responsible party to pick her up and she could not pick her up so Resident #10 had an episode, as she usually would when her family could not pick her up when she requested. -When Resident #10 acts out the MA had been instructed to contact the RCC or the responsible party. -She called the RCC and Resident #10 accused her of calling the RCC on her and she got further upset and began to act out even more. -The RCC came into the facility that evening and helped to diffuse the situation. -Resident #10 told the RCC she (MA) "struck her in the face, she did not hit" the resident. -There was a line of residents in the hallway at the time Resident #10 alleged she hit her. -She came back 30 minutes later and hugged everyone apologizing saying don't tell her responsible party about her behavior that evening. -Resident #10 apologized to her for accusing her of hitting her. -The executive Director met with her to ensure she had done what she was supposed to do. -She was working at the facility as a medication aide on the evening July 5, 2015 when Resident #10 got upset and had another outburst. -This time she accused a PCA of hitting her. -She spoke with the other residents that were around and they all said they had not seen any physical contact between the PCA and Resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 45 #10. -She reported the allegation to the RCC and Resident #10's responsible party. Interview with the RCC on 11/6/2015 at 4:20pm revealed: -During medication administration in January, Resident #10accused the MA of hitting her in the face. -The RCC had gone home that evening and was called back to the facility by the MA. -When she got to the facility, she met with Resident #10 and the activity director. -Resident #10 told the RCC and the activity director she was hit in the face by the MA. -By the end of the conversation, Resident #10 had recanted her allegation of being hit in the face. -Resident #10 had been refusing to take her Clonazepam (a drug used to treat panic disorders). -She eventually decided to take her medication to help her calm down. -The Executive Director had been aware of the allegation. -Resident #10 " had made allegations on many occasions that were not true." -She would accuse staff or residents of incidents that never happened. -Sometime in July Resident #10 alleged a personal care aide hit her. -She did not remember who the staff member was that Resident #10 alleged hit her in July. -She did not remember if she had reported the allegation to the Executive Director or not. -She had not reported either allegation to the North Carolina Healthcare Personnel Registry. Interview with the Executive Director on 11/6/15 at 4:50pm revealed:	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 46 -Back in January when Resident #10 alleged she was slapped in the face by an employee at the facility, she was aware of the accusation and she knew the incident did not happen. -She had witnessed the outburst by Resident #10 in the hallway outside of the nursing station during medication administration. -The MA was administering medications and there was a line of residents and other staff there in the hallway also. -Resident #10 was in a tirade that day, she did that a lot. -She was there that day and knew nothing happened to Resident #10. She later learned that Resident #10 had alleged the MA had hit her during that episode she was having. -She had previously instructed staff, when Resident #10 was "raging" do not say or do anything to her, contact the RCC or her responsible party. -Resident #10 would often accuse people of hitting her. -Resident #10's responsible party had called her on many occasions even on weekends. -Resident #10 would accuse the men in the men's hallway of looking at her, touching, and hitting her. For that reason, staff had been instructed by her not to allow Resident #10 to go onto the men's hallway. -She had also witnessed residents passing by Resident #10 in the hallway and Resident #10 would later accuse the male resident of touching her or looking at her funny. -The next thing she would do was to call her responsible party and tell her the same thing. -She would not allow anyone to hurt any resident in the facility. -If her responsible party thought someone had hit Resident #10 she would have called her and she would have called the police.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 47 -She had not been informed of an accusation of a staff member hitting Resident #10 in July of 2015. -She did send a report regarding the allegation in January 2015 to the North Carolina Healthcare Personnel Registry, because she had witnessed the incident and knew no one had hit Resident #10. Based on interviews and record reviews, the facility failed to report to the North Carolina Healthcare Registry allegations of abuse of a resident (#10) by a staff member. The findings are: Review of the current FL2 dated 10/26/15 for Resident #10 revealed: -Diagnoses included depression with anxiety, sleep disturbance, schizophrenia and shortness of breath. -She was admitted to the facility on 11/24/2011. Interview with Resident #10's responsible party on 4/6/15 at 12:30pm revealed: -Resident #10 has a split personality, but one day about 6 months ago she called her and told her an employee working at the facility slapped her across the face. -The staff member was a MA that worked in the 100 hallway. -She called the MA and told the MA, she knew what she (the MA) did, and the MA said "she knew she was wrong" and "I know" The MA was also "fussed out by the administrator". -Another time the MA told Resident #10 she did not slap her. -"They get along better now though", (Resident #10 and the MA). -She spoke with the RCC, and the RCC told the responsible party, Resident #10 had told her something different. -She spoke with the Executive Director about the	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 48 incident and the Executive Director told her Resident #10 says things that are not true. She told the Executive Director, the MA admitted her wrong doing to her. -"I will let" Resident #10 "tell you what happened now she will tell you, go ahead tell them". Interview with Resident #10 on 4/6/2015 at 12:30pm revealed: -One day when she was in the hallway at the medication cart, she was having an anxiety attack and a MA snapped at her, and got in her face and slapped her face. -Resident #10 had said something to the MA that worked in the women's hallway on 2nd shift, but does not remember what it was she said. -After the incident she went back to her room. -She did not remember what she had said to the MA. -There were no witnesses to the incident. -She reported the incident to the RCC. -On another occasion weeks later on a different day she went up to the medication cart again and the MA said "she needed to apologize to her" and after that staff never bothered her again, she was nice to her after that. -There was another staff member at the facility that was mean to her too, a PCA that worked 2nd shift. -She felt afraid of the PCA and she was always around her following her around. -The women are not allowed to go to the men's hallway after 7:00pm. -She did not allow Resident #10 to go down the men's hallway to say goodnight to her boyfriend before 7:00pm, before she went to bed. -When she would attempt to go down the men's hallway the PCA would tell her they are getting ready for bed and would not allow her to enter into the hallway.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 49 -There was a soda machine located at the end of the men's hallway also and the PCA would not let her go down the hallway to the vending machine to get a soda. -The Executive Director had also said things to her she did not like, so she did not tell her about the PCA she was afraid of. -She had said "I come in there every day complaining" and it is not true, so she does not say much to the Executive Director. -She liked the RCC, she had always been nice to her. -No other employee of the facility had ever hit her again. Record review of Resident #10's care notes dated 1/23/2015 at 7:00pm revealed: -The notation was signed by the Medication Aide (MA), documented as follows: -Resident #10 was given an as needed (PRN) medication for agitation. -She was very disrespectful and used unacceptable language. -Resident #10 threw her medication in the trash and said she was not going to take any medication. Record review of Resident #10's care notes dated 1/23/2015 at 7:19pm-8:45pm revealed The notation was signed by the RCC, documented as follows: -Resident #10 was asked to leave the medication cart because she was reaching for things and agitated as the medication aide (MA) tried to administer her medications. -Resident #10 refused her medications knocking them away from her and accused the MA of hitting her. -The Resident Care Coordinator (RCC) and another staff member conferenced with Resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 50 #10. -Resident #10 told the RCC and the other staff member she overreacted and apologized for her behavior. -During the conference with the RCC, Resident #10 and other staff member, the RCC stepped out and asked other residents had they seen any physical behavior between Resident #10 and the MA. -The other residents that had been present at the medication cart said Resident #10 had been disrespectful to the MA, but they had not seen any physical behavior between the MA and Resident #10. -After speaking with Resident #10 the RCC returned to the staff and resident and Resident #10 apologized again to the RCC for her behavior and she took her medication for the RCC and promised she wouldn't display that type of behavior again. -The RCC stayed and monitored Resident #10 for 30 minutes, Resident went to bed with no further behavioral problems. Review of Resident #10 care Notes dated 7/15/2015 revealed: -At 5:52pm Resident was agitated and using unacceptable language for no known reason. -Resident was stating a personal care aide (PCA) hit her. -The medication aide spoke with other residents and the residents said they did not see any physical contact between the PCA and Resident #10. -The responsible party was informed and staff will continue to monitor Resident #10. Interview with a Medication Aide on 11/6/2015 at 4:05pm revealed: -Resident #10 was standing at the medication	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 51 cart on January 23, 2015 fussing her out about not wanting to take her medication. -Resident #10 had called her responsible party to pick her up and she could not pick her up so Resident #10 had an episode, as she usually would when her family could not pick her up when she requested. -When Resident #10 acts out the MA had been instructed to contact the RCC or the responsible party. -She called the RCC and Resident #10 accused her of calling the RCC on her and she got further upset and began to act out even more. -The RCC came into the facility that evening and helped to diffuse the situation. -Resident #10 told the RCC she (MA) "struck her in the face, she did not hit" the resident. -There was a line of residents in the hallway at the time Resident #10 alleged she hit her. -She came back 30 minutes later and hugged everyone apologizing saying don't tell her responsible party about her behavior that evening. -Resident #10 apologized to her for accusing her of hitting her. -The executive Director met with her to ensure she had done what she was supposed to do. -She was working at the facility as a medication aide on the evening July 5, 2015 when Resident #10 got upset and had another outburst. -This time she accused a PCA of hitting her. -She spoke with the other residents that were around and they all said they had not seen any physical contact between the PCA and Resident #10. -She reported the allegation to the RCC and Resident #10's responsible party. Interview with the RCC on 11/6/2015 at 4:20pm revealed:	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 52 -During medication administration in January, Resident #10accused the MA of hitting her in the face. -The RCC had gone home that evening and was called back to the facility by the MA. -When she got to the facility, she met with Resident #10 and the activity director. -Resident #10 told the RCC and the activity director she was hit in the face by the MA. -By the end of the conversation, Resident #10 had recanted her allegation of being hit in the face. -Resident #10 had been refusing to take her Clonazepam (a drug used to treat panic disorders). -She eventually decided to take her medication to help her calm down. -The Executive Director had been aware of the allegation. -Resident #10 " had made allegations on many occasions that were not true." -She would accuse staff or residents of incidents that never happened. -Sometime in July Resident #10 alleged a personal care aide hit her. -She did not remember who the staff member was that Resident #10 alleged hit her in July. -She did not remember if she had reported the allegation to the Executive Director or not. -She had not reported either allegation to the North Carolina Healthcare Personnel Registry. Interview with the Executive Director on 11/6/15 at 4:50pm revealed: -Back in January when Resident #10 alleged she was slapped in the face by an employee at the facility, she was aware of the accusation and she knew the incident did not happen. -She had witnessed the outburst by Resident #10 in the hallway outside of the nursing station	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 53 during medication administration. -The MA was administering medications and there was a line of residents and other staff there in the hallway also. -Resident #10 was in a tirade that day, she did that a lot. -She was there that day and knew nothing happened to Resident #10. She later learned that Resident #10 had alleged the MA had hit her during that episode she was having. -She had previously instructed staff, when Resident #10 was "raging" do not say or do anything to her, contact the RCC or her responsible party. -Resident #10 would often accuse people of hitting her. -Resident #10's responsible party had called her on many occasions even on weekends. -Resident #10 would accuse the men in the men's hallway of looking at her, touching, and hitting her. For that reason, staff had been instructed by her not to allow Resident #10 to go onto the men's hallway. -She had also witnessed residents passing by Resident #10 in the hallway and Resident #10 would later accuse the male resident of touching her or looking at her funny. -The next thing she would do was to call her responsible party and tell her the same thing. -She would not allow anyone to hurt any resident in the facility. -If her responsible party thought someone had hit Resident #10 she would have called her and she would have called the police. -She had not been informed of an accusation of a staff member hitting Resident #10 in July of 2015. -She did send a report regarding the allegation in January 2015 to the North Carolina Healthcare Personnel Registry, because she had witnessed the incident and knew no one had hit Resident	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098023	A. BUILDING: _____ B. WING _____	C 11/06/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

(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 438	Continued From page 54 #10.	D 438		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to medication administration. The findings are: Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner and in accordance with the facility's policies and procedures for 2 of 6 residents (#8, #9) observed during the medication pass and 3 of 7 residents (#4, #5, #7) sampled for review including errors with medications used to treat dialysis residents, diabetes, blood thinning, constipation, anxiety, and psychosis. [Refer to Tag D358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation).]	D912		