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
	NA1e98025	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1900 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 a complaint investigation on 11/02/21 - 11/04/21. The complaint investigations were initiated by the Wilson County Department of Social Services on 09/22/21 and 10/22/21.	D 000	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.	
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 observations and interviews, the facility failed to ensure the facility was free of hazards including personal care hygiene products being stored unlocked in the common shower room on 400 hall and six residents' rooms (305, 307, 402, 404, 410, 416) and air freshener being stored unlocked in a resident's bathroom (410) resulting in hazardous substances and chemicals being unattended and accessible to the 21 residents residing in the special care unit (SCU). The findings are: Review of the facility's current license effective 01/01/21 revealed the facility was licensed for 136 capacity which included a special care unit (SCU) with a capacity of 64 beds. Review of the facility's census report dated 11/02/21 revealed:	D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings Med Tech's/ Lead Supervisor in Charge will round SCU every 2 hours looking in each resident's room and shower rooms for hazardous substances making sure they are placed in cabinet's in shower room's with pad locks locked on cabinet doors. A tracking Log is in place to be checked off for monitoring correct placement of hazardous chemicals, by Med Tech/ Lead Supervisor in Charge and monitored by SCU manager weekly. All staff in-serviced 11/30/21 by RN on hazardous substances and their possible effects on a body.	11/30/21 11/30/21

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

Signature Edwards — Executive Director — 12-14-21

STATE FORM — MFM211 — Reviewed and Acknowledged mm,rn 12/16/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL068033	A. BUILDING: _____ B. WING _____	11/04/2021

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
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-The facility's total in-house census for assisted living (AL) and SCU was 54 residents.
-There were 15 residents currently in-house residing on the 400 hall in the SCU.
-There were 6 residents currently in-house residing on the 300 hall in the SCU.

Observation of resident room #307 on the 300 hall in the SCU on 11/02/21 at 9:15am revealed
-The resident was sitting in a chair asleep with his head down in front of the television sitting on the chest of drawers.
-There was a container of lotion sitting on the chest of drawers to the left side of the television.
-There was a container of 3-in-1 body wash, shampoo and conditioner sitting on the sink countertop in the bedroom.
-There was a can of shave cream sitting on the sink countertop in the bedroom
-The door to the room was open and accessible to residents in the SCU.
-The warning label on the lotion instructed the user to avoid eyes, nose, and mouth contact.
-The warning label on the shave cream instructed the user to keep out of the reach of children

Observation of resident room #305 on the 300 hall in the SCU on 11/02/21 at 9:20am revealed.
-The door to the room was open and accessible to residents on the SCU.
-The resident was lying in bed but awake.
-There was a can of shave cream sitting on the sink countertop in the room.
-The warning label on the can instructed the user to keep out of the reach of children.
Observation of the MA on 11/02/21 at 9:26am revealed her removing the personal care items in rooms #307 and #305 on the 300 hall in the SCU to the storage cabinet in the common bathroom and locking the cabinet door after being prompted

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	56A188031X	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1000 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	D 079		

by the surveyor.

Observation of resident room #402 on the 400 hall in the SCU on 11/02/21 at 9:35am revealed:
-The door to the room was open and accessible to residents in the SCU.
-There was a bottle of hair conditioner in an unlocked closet in the bedroom.
-The label on the bottle instructed the user to avoid eye contact and rinse immediately with water if the product encountered the eyes.

Observation of resident room #404 on the 400 hall in the SCU on 11/02/21 at 9:37am revealed:
-The door to the room was closed but unlocked
-The resident was sitting on the bed.
-A bottle of whitening mouthwash was lying on the bed beside the resident.
-The label on the container instructed the user not to swallow and in case of ingestion contact the poison control center right away or seek professional assistance.

Interview with the medication aide (MA) / supervisor in the SCU on 11/02/21 at 9:25am revealed:
-Personal care items were supposed to be kept in the common bathroom on the 300 hall in a storage cabinet that has a padlock attached..
-The MAs had a key to the padlock attached to the storage cabinet.
-The MAs unlocked the padlock on the storage cabinet door for the personal care aides (PCAs) to gather the personal care items for resident care.
-The PCAs were responsible for locking the padlock attached to the storage cabinet after gathering the personal care items for resident care.
-The PCAs notified the MA when the padlock

(X1) STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X2) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X3) MULTIPLE CONSTRUCTION	(X4) DATE SURVEY COMPLETED
	NAL088023	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1806 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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attached to the storage cabinet needed to be unlocked for them to return the personal care items to the storage cabinet.
-The PCAs was responsible for locking the padlock attached to the storage cabinet after returning the personal care items to the storage cabinet.

Observation of the Memory Care Manager (MCM) on 11/02/21 at 9:40am revealed her removing the personal care items in rooms #402 and #404 on the 400 hall in the SCU after being prompted by the surveyor.

Interview with the MCM in the SCU on 11/02/21 at 9:45am revealed:
-Personal care items were supposed to be padlocked in a cabinet in the common bathroom on the 300 and 400 halls.
-The MAs unlocked the padlock attached to the storage cabinet for the PCA to gather personal care items for resident care.
-The PCAs were responsible for padlocking the cabinet when the personal care items were removed and/or returned to the cabinet.
-The MAs and the MCM were responsible for ensuring the cabinets on the 300 and 400 halls were always padlocked.

Observation of resident room #416 on the 400 hall in the SCU on 11/02/21 at 9:13am revealed:
-The door to the room was open and accessible to residents in the SCU.
-There was an 18 ounce (oz) bottle of 2-in-1 shower gel / shampoo on the countertop beside the sink in the bedroom.
-Warnings for the 2-in-1 shower gel / shampoo included: for external use only, avoid contact with eyes; if contact occurs, rinse eyes with water.

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	NAL098823	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1808 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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Based on observations and interviews, it was determined the resident residing in resident room #418 was not interviewable.

Observation of resident room #418 on the 400 hall in the SCU on 11/02/21 at 9:33am revealed.
-The door to the room was closed but unlocked and accessible to residents in the SCU.
-There was a 13.5 oz pump bottle of rose, water, and aloe hand soap on the countertop beside the sink in the bedroom.
-Warnings for the hand soap included: for external use only; avoid contact with eyes. if contact occurs, rinse eyes with water.
-There was a white basket on the right side of the countertop beside the sink in the bedroom.
-The white basket contained a 12 oz bottle of conditioner, a 12.5 oz bottle of shampoo, an 18 oz bottle of shampoo, a 15 oz bottle of baby lotion, and a 14 oz bottle of skin therapy lotion.
-Warnings for the shampoos and conditioner included: for external use only; avoid contact with eyes; irritating to eyes.
-Warnings for the baby lotion included keep out of reach of children.
-Warnings for the skin therapy lotion included: keep out of reach of children; for external use only; avoid contact with eyes; if swallowed get medical help or contact a poison control center immediately.
-There was a second white basket on the left side of the countertop beside the sink in the bedroom.
-The second white basket contained one 2.3 oz and two 2.6 oz containers of deodorant / antiperspirant.
-Warnings for the deodorant/antiperspirants included: for external use only; avoid contact with broken skin; keep out of reach of children

Based on observations and interviews, it was

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	NA1658023	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1600 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
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determined the resident residing in room #410 was not interviewable.

Second interview with the MA / supervisor in the SCU on 11/02/21 at 10:10am revealed:
-Sometimes residents' family members brought personal care products and left them in the residents' rooms.
-Personal care items left in residents' room should be locked in the closet.
-There should not be any personal care items left unlocked in the rooms of the SCU residents.

Observation of the common shower room on the 400 hall in the SCU on 11/02/21 at 9:50am revealed:
-The door to the common shower room was open and accessible to residents in the SCU.
-There were no staff or residents in the bathroom.
-There was a beige metal cabinet on the wall behind the entrance door to the bathroom.
-The metal cabinet had a key hole lock but it was not locked.
-The metal cabinet contained: an opened bag of pink disposable razors; a 6 oz tube of toothpaste; a 25 oz bottle of hair conditioner; a 7 oz tube of shave gel for men; an 8 oz bottle of perineal/skin cleanser; and a 7.4 oz can of sterile saline wound wash.
-Warnings for the toothpaste included: keep out of reach of children under 6 years of age, if more than used for brushing is accidentally swallowed get medical help or contact a poison control center right away.
-Warnings for the hair conditioner included: keep out of reach of children; causes serious eye irritation; if in eyes rinse cautiously with water for several minutes.
-Warnings for the shave gel included: for adult use only; for external use only; avoid contact with

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	HAL998023	A. BUILDING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1999 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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eyes; keep out of reach of children.
-Warnings for the perineal/skin cleanser included: for external use only, may cause eye irritation, rinse eyes with water if contact should occur.
-Warnings for the sterile saline wound wash included: for external use only; for single patient use only; keep out of reach of children.
-There was a plastic gray free-standing cabinet in the right corner of the common shower room.
-The gray cabinet had two doors and there was an unlocked metal padlock lying on top of the handle of the right cabinet door.
-The cabinet contained several clear plastic containers labeled with residents' names.
-The unlocked gray cabinet contained: a 22.5 oz bottle of hair conditioner sitting on a shelf, a 12 oz jar of hair conditioner gel; a 12 oz bottle of hair conditioner; a 12.6 oz bottle of shampoo, a 14 oz bottle of skin therapy lotion with aloe; a 13.5 oz pump bottle of rose, water, and aloe hand soap; an 18 oz bottle of 2-in-1 shower gel / shampoo; and 4 containers with toothpaste and toothbrushes.
-Warnings for the hair conditioner included: avoid contact with eyes; in case of contact with eyes, rinse immediately.
-Warnings for the hair conditioner gel included for external use only; avoid eye contact.
-Warnings for the shampoo and conditioner included: for external use only; avoid contact with eyes; irritating to eyes.
-Warnings for the skin therapy lotion included: keep out of reach of children; for external use only; avoid contact with eyes; if swallowed get medical help or contact a poison control center immediately.
-Warnings for the hand soap included: for external use only, avoid contact with eyes; if contact occurs, rinse eyes with water.
-Warnings for the 2-in-1 shower gel / shampoo

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	NAL998021	A. BUILDING: _____ B. WING _____	11/04/2021

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WILSON HOUSE	1800 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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D 079	Continued From page 7	D 079		

Included: for external use only; avoid contact with eyes; if contact occurs, rinse eyes with water.
-Warnings for the toothpastes included: keep out of reach of children under 6 years of age; if more than used for brushing is accidentally swallowed get medical help or contact a poison control center right away.

Second interview with the MCM in the SCU on 11/02/21 at 10:38am revealed:
-The common bathroom on the 400 hall in the SCU had a cabinet with plastic storage bins labeled with the residents' names to keep their personal care products.
-All residents in the SCU were assisted with bathing so the PCAs should make sure the personal care products were locked in the cabinet after providing personal care to each resident.
-The residents' family members sometimes brought personal products to the residents.
-She tried to check residents' rooms for personal care products every 2 weeks.
-The resident in room #410 just moved to the SCU from the AL side about a week ago and they had not made her a personal bin in the common bathroom cabinet to store the resident's items yet.

Second observation of the common shower room on the 400 hall in the SCU on 11/02/21 at 2:42pm revealed:
-The door to the shower room was open and accessible to residents in the SCU.
-There were no staff or residents in the bathroom.
-The padlock for the plastic gray free-standing cabinet in the right corner of the common shower room was unlocked.
-The gray cabinet still contained a 22.5 oz bottle of hair conditioner sitting on a shelf; a 12 oz jar of hair conditioner gel; a 12 oz bottle of hair

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	NAL098023	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1806 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

D00 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)	D00 COMPLETE DATE
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conditioner; a 12.6-oz bottle of shampoo; a 14 oz bottle of skin therapy lotion with aloe; a 13.5 oz pump bottle of lotion, water, and aloe hand soap; an 18 oz bottle of 2-in-1 shower gel / shampoo; and 4 containers with toothpaste and toothbrushes.
-The gray cabinet now contained the items that were previously stored unlocked in the metal cabinet on the wall in the common shower room including an opened bag of pink disposable razors; a 6 oz tube of toothpaste; a 25 oz bottle of hair conditioner; a 7 oz tube of shave gel for men; an 8 oz bottle of perineal/skin cleanser; and a 7.4 oz can of sterile saline wound wash.

Third interview with the MA / supervisor in the SCU on 11/02/21 at 2:44pm revealed:
-She did not know why the gray cabinet in the common shower room was unlocked.
-She would lock the cabinet.

Second observation of resident room #410 on 11/02/21 at 2:52pm revealed:
-There was metal storage rack beside the toilet that contained an 8.8 oz spray can of air freshener; a gel air freshener; and a 10 oz tube of aloe body lotion.
-Warnings for the spray can of air freshener included: keep out of reach of children and pets; do not spray toward the face; if eye contact occurs, rinse well with water.
-Warnings for the gel air freshener included: keep out of reach of children and pets; eye irritant; avoid contact with eyes.
-Warnings for the body lotion included: for external use only; avoid contact with eyes; keep out of reach of children.

Fourth interview with the MA / supervisor in the SCU on 11/02/21 at 3:07pm revealed:

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WILSON HOUSE	1806 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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-The gray cabinet in the shower room on 400 hall in the SCU was probably unlocked because of staff giving baths to the resident that morning -it should have been locked back after showers were finished that morning.
-The items in the bathroom in resident room #410 should not be in there so she would remove them.

Third interview with the MDM on 11/02/21 at 3:12pm revealed:
-She locked the padlock on the gray cabinet in the common shower room on the 400 hall that morning on 11/02/21 after it was found unlocked with personal care products by the surveyor.
-She was not aware it was unlocked again this afternoon.
-It may have been left unlocked while staff was collecting items from residents' rooms to store in the cabinet.
-The cabinet should not have been unlocked if no staff were in the bathroom.

Interview with the Administrator on 11/02/21 at 3:16pm revealed the cabinet in the common shower room on the 400 hall in the SCU should have been locked unless staff were in the bathroom.

Third observation of the common shower room on the 400 hall in the SCU on 11/03/21 at 10:25am revealed:
-The door to the common shower room was open and accessible to residents in the SCU.
-There were no staff or residents in the bathroom.
-The gray cabinet used to store personal care products was locked.
-There was an 18 oz bottle of shampoo stored on top of the gray cabinet and accessible to residents.

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1200 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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D 079	Continued From page 10 -Warnings for the shampoo included: for external use only; avoid contact with eyes; irritating to eyes. Fifth interview with the MA / supervisor in the SCU on 11/03/21 at 10:33am revealed: -The bottle of shampoo should have been locked inside the gray cabinet. -She was not sure how long it had been left unlocked but she would remove the items from the resident's bathroom.	D 079		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the rights of residents were guaranteed for 2 of 8 sampled residents (#5, #6) as evidenced by a resident residing on the special care unit (SCU) not being treated with dignity and respect (#5); and the facility failing to notify a resident's guardian prior to the administration of the COVID-19 vaccine (#6). The findings are: 1. Review of Resident #5's current FL-2 dated 08/03/21 revealed: -Diagnoses included Alzheimer, Parkinson's Disease, heart disease, anxiety, and adult failure to thrive. -He was intermittently disoriented.	D 338	10A NCAC 13F .0909 Residents Rights Residents with behaviors will always be addressed in a calm low tone manor and assistance will be given to the resident in an undemanding manor. Residents will be treated with dignity no matter their diagnosis. This will be monitored by USC/MCM/RCC/ED during rounds in the of the entire community All staff in-serviced on Resident Rights, dignity, tone and approach. By ED, RCC, MCM All staff will be in-serviced by Ombudsman on Sensitivity when working with the elderly and residents with dementia.	11/30/201 11/30/21 12/15/21

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	NAL096023	A. BUILDING: _____ B. WING _____	11/04/2021

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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 338	Continued From page 11 -He had wandering behaviors -He was ambulatory. -He was incontinent to bowel and bladder. -He needed personal care assistance with dressing and toileting Review of Resident #5's personal care plan dated 10/11/21 revealed: -He required extensive assistance with day to day tasks such as toileting and dressing. -There was a history of mental illness -The resident received medications for mental illness/behavior. -He received mental health services. -He had behaviors that included disrobing and hollering down the hall. Review of Resident #5's progress notes revealed: -On 09/03/21 at 3:04pm, the facility contacted Resident #5's representative/facility member to inform him the resident had behaviors that included disrobing and yelling in the hallway. -On 09/09/21 at 2:14pm, the mental health provider (MHP) was notified to inform her Resident #5 had behaviors that included disrobing and yelling in the hallway -On 09/23/21 at 4:14pm, the facility contacted Resident #5's MHP to inform her the resident was still having behaviors that included disrobing and yelling in the hallway. Review of Resident #5's Accident/Incident Report dated 10/27/21 revealed: -There was an incident regarding intimidation and verbal abuse by a staff member towards Resident #5 that occurred on 10/25/21 at 3:58pm. -The incident occurred on the 400 hall of the special care unit -The incident was witnessed by the Divisional Maintenance Director (DMD) on 10/25/21.	D 338	10A NCAC 13F .0909 Residents Rights A list of residents with a guardian or an RP will be addressed in our QA meeting weekly and updated as needed for accuracy. By ED, RCC, MCM, and BOM RCC, MCM, BOM, and ED will review residents with guardian or RP list when consent for treatment is needed i.e Flu, Covid vaccine, to insure that appropriate consent is obtained from guardian or RP. By ED, RCC, MCM, and BOM	11/30/21 11/30/21

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL099023	A. WING _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1000 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 338	Continued From page 12	D 338		

-There was no injury noted.
-The resident was monitored for 72 hours.
-The facility notified the primary care provider (PCP) on 10/25/21 at 6:26pm regarding the incident.
-The facility notified Resident #6's representative/family member on 10/25/21 at 6:26pm regarding the incident.
-This report was completed by the Administrator on 10/27/21 at 3:25pm.

Review of the facility's Resident Abuse, Neglect and Exploitation policy on 11/04/21 revealed:
-In the event of verbal abuse or allegations of verbal abuse of the resident by community staff, the community completed the Health Care Personnel Registry (HCPR) 24-hour report (Initial Report).
-Upon the notification of verbal abuse allegations, the community began an investigation and documented findings on the HCPR 5-day report and was submitted to the HCPR.
-The facility's investigation process included immediate suspension of the accused staff member pending investigation, completed the HCPR 24-hour report within 24 hours of the discovery or knowledge of alleged abuse, and the community management began the investigation to substantiate or unsubstantiate the allegation for reporting on the HCPR 5-day working report.
-The management interviewed all staff present during the allegation.
-The management completed and submitted the 5-day working report either substantiated or unsubstantiated.
-If the allegation was substantiated, the employee received disciplinary action up to and including termination.
-Resident Rights training was scheduled and

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	HA1884033	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1906 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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D 938	Continued From page 13 conducted with the local Ombudsman and or Licensed Professional. -Community Management reviewed Resident Rights training with all staff and all staff re-signed the Declaration of Resident Rights. -Community Management followed up with Primary Care Physician (PCP) for any resident needs regarding the abuse. Review of the facility's HCPR 24-hour report (initial) on 11/04/21 revealed: -The Administrator completed the report on 10/26/21. -The allegation was resident abuse. -A staff member allegedly witnessed another staff member yelling at Resident #6 to pull his pants up while acting in an intimidating manner. -No physical or mental injury/harm was noted. -The incident occurred on 10/25/21 at 3:30pm and the facility became aware of the incident on 10/25/21 at 4:00pm. Review of the facility's HCPR 5-day report on 11/04/21 revealed: -The Administrator completed the report on 11/01/21. -The allegation was resident abuse. -The incident occurred on 10/25/21 at 3:30pm and the facility became aware of the incident on 10/25/21 at 4:00pm. -A staff member witnessed another staff member yelling at a resident to pull his pants up while acting in an intimidating manner. -There was no physical injury/harm or mental anguish observed. -The accused staff member was interviewed at the time of the incident but denied the allegation. -The staff member that witnessed the incident was interviewed. -It was concluded that resident abuse did occur	D 938		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098823	A. BUILDING: _____ B. WING _____	11/04/2021

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 338	Continued From page 14	D 338		

and the allegation was substantiated.
-The accused individual was terminated on 10/30/21 due to the allegation.
-All staff were in-serviced on resident rights and caring for a resident with advanced dementia.

Interview with the DMD on 11/02/21 at 12:21pm revealed:
-He was working on the 400 hall in the SCU on 10/25/21 on second shift around 4:00pm.
-He witnessed verbal abuse and intimidation of Resident #5 by a staff member who he believed was a personal care aide (PCA).
-He heard the staff member tell Resident #5 to pull his pants up in a loud voice.
-He turned around and observed Resident #5 standing in the hallway near the medication cart with his jogging pants pulled down to his ankles.
- He observed the staff member clenching her right hand into a fist while holding a cell phone in her left hand and flinching like lifted hand upward like she was going to hit the resident and in a loud voice said, " Pull up your pants!"
-Resident #5 just stood there with no response and did not appear to look threatened or to understand what was happening.
-He intervened and told the staff member it was her job to help the resident.
-The staff member turned to another staff member who had come into the hallway and commented, "Don't I talk with my hands?"
-The staff member continued to talk to the other staff member but the other staff member did not engage.
-He immediately went to the Administrator's office to report the incident.
-The staff member was subsequently removed from the building pending investigation.
-He did not know what the results of the

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	HAL066023	A. BUILDING: _____ B. WING _____	11/04/2021

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

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D 338	Continued From page 15	D 338		

Investigation was but he had not seen the staff member in the building since the incident.
-He had no concerns with the staff member prior to this incident.
-Resident #5 did not usually communicate verbally but he did not observe any signs that the resident felt threatened or had behavioral changes related to the incident.
-When he went back to the 400 hall after reporting the incident to the Administrator another staff member was taking care of Resident #5's needs.

Interview with the Administrator on 11/04/21 at 5:20pm revealed:
-The alleged verbal abuse towards Resident #5 occurred on the 400 hall of the SCU on 10/25/21.
-The DMD came to her office and informed her of the incident immediately after it occurred.
-The DMD reported to her that he observed a staff member yelling and "flinching" her arms and hands in an aggressive manner towards Resident #5 telling him to pull his pants up.
-The DMD intervened and told the staff member she could not work at this facility anymore and we were not going to put up with that kind of behavior and the staff member had to leave.
-The staff member attempted to leave by the side door but the medication aide (MA) told her she had to leave through the front door and escorted her down the hall towards the front entrance where the administrator's office was located.
-The Administrator observed the staff still yelling and waving her arms and hands coming down the hall towards her commenting, "You know I talk with my hands."
-The accused staff member denied the allegation of resident abuse when questioned.
-The Administrator told the staff member she had to leave the facility pending an investigation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL294021	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1806 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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D 338	Continued From page 16 -The Administrator ensured Resident #5 had no injuries and was fine. -The PCP and the resident's representative/family member were notified on 10/25/21. -The Administrator interviewed other staff who were working on the 400 hall in the SCU at the time of the alleged resident abuse, but they did not know what happened because they did not witness the incident. -The DMD followed protocol when he intervened to ensure the immediate safety of the resident. -She completed the HCPR 24-hour report on 10/26/21 and the HCPR 5-day report on 11/01/21 and submitted them to the HCPR. -The allegation of resident abuse was substantiated and the staff member was terminated on 10/30/21. -The Administrator held an in-service at the facility's regularly scheduled meeting on the last day of the month (October 2021) and re-educated staff regarding tone of voice, body language and residents' rights. Interview with Resident #5's representative/family member on 11/04/21 at 4:40pm revealed: -The facility informed him of the alleged verbal abuse of Resident #5 on 10/25/21. -The facility was in constant communication with him regarding the resident's care. -He had no concerns regarding the resident's care at the facility. Interview with the PCP on 11/04/21 at 4:30pm revealed she was not aware of the incident because she had just started at the facility this week. Based on observations, interviews, and record review, it was determined Resident #5 was not interviewable.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	NAL066023	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1600 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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2. Review of Resident #6's current FL-2 dated 03/03/21 revealed:
-Diagnoses included dementia, cerebrovascular accident (CVA), depressive disorder, nicotine abuse, history of drug abuse, cerebellar ataxia and diabetes mellitus.
-Resident #6 was intermittently disoriented.

Review of Resident #6's Resident Register revealed the Department of Social Services (DSS) was his guardian.

Review of a COVID Vaccine Intake Consent Form for Resident #6 revealed:
-Resident #6 received a 1st dose of the COVID-19 vaccine on 01/07/21.
-Resident #6 signed the consent form to receive the COVID-19 vaccination but did not document the date.
-There was no documentation of a guardian's signature.

Review of a 2nd COVID Vaccine Intake Consent Form for Resident #6 revealed:
-Resident #6 received a 2nd dose of the COVID-19 vaccine on 02/04/21.
-Resident #6 signed the consent form to receive the COVID-19 vaccination on 01/25/21.
-There was no documentation of a guardian's signature.

Interview with Resident #6's Guardian on 11/02/21 at 2:31pm revealed:
-The Social Worker with DSS had contacted the facility to speak with Resident #6's primary care provider (PCP) to determine if he should get the COVID-19 vaccine.
-The Social Worker was advised by the staff that Resident #6 had already received two doses of the COVID-19 vaccine.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	MAL098621	A. BUILDING: _____ B. WING _____	11/04/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON HOUSE	1900 MARTIN LUTHER KING JR. PARKWAY WILSON, NC 27893

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-The facility had not contacted DSS prior to administering Resident #8's COVID vaccines.

Interview with the Administrator on 11/04/21 at 11:56am revealed
-She was not aware that Resident #8's responsible party had not been notified prior to the administration of the COVID-19 vaccination.
-It was the responsibility of the Resident Care Coordinator (RCC) to obtain consent from residents or guardians prior to administration of the COVID-19 vaccine
-The RCC that assisted with obtaining COVID-19 consents was no longer employed with the facility.

Based on observations, record reviews and interviews it was determined that Resident #8 was not interviewable.