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	HAL098023	A. BUILDING: _____ B. WING _____	R 02/07/2024

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 and Wilson County Department of Social Services conducted an annual and follow-up survey on 02/06/24 - 02/07/24.	D 000	Responses to the cited defeciencies 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 defeciencies; 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 special care unit was free of hazards including bleach cleaner, aerosol disinfectant, acetone nail polish remover, nail polish, metal bedframes with sharp edges and an exit door that partially opened while locked. The findings are: Review of the facility's census report dated 02/06/24 revealed there were 22 residents in the special care unit (SCU). Observations during the SCU tour on 02/06/24 from 9:25am until 10:03am revealed: -The last door on the odd numbered rooms on the 400 hall was open and unlocked. -There were two large rooms inside the door with multiple carts, open boxes and storage containers containing craft and decorating supplies.	D 079	The community's management team will ensure it is maintained in an uncluttered, clean and odorless manner, free of all obtructions and hazards. The community's management team will ensure that any room with hazardous items will be removed and maintained in a secured capacity. The management team will check to ensure hazardous items are secured during daily rounds. Any items found unsecured will be immediately moved to a secured storage. Community Executive Director(ED) and on-site management has been in-serviced on rounding community, storage of hazardous materials and proper reporting of any equipment found not functioning properly. Training conducted by Regional Vice Presdient of Operations(RVPO). All community staff has been in-serviced on hazardous materials and proper storage of hazardous materials. Training conducted by the ED.	2/8/24 2/8/24 2/8/24 2/8/24

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Donna Dawson — TITLE: Executive Director — (X6) DATE: 3/14/24

Jamaal Willis Reviewed and Acknowledged 03/22/24

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D 079	Continued From page 1 -There was a 12-inch paper cutter on a shelf in the first room. -There was a full spray bottle of a cleaner with bleach. -The spray cleaner had a label with a warning that the product was a hazard to humans, was an eye and skin irritant, the vapors might irritate, and was harmful if swallowed. -There was an unplugged fan that had a broken stand, and the cover was off exposing the blades. -There was a small plastic basket with nail care supplies including multiple bottles of nail polish, small scissors, nail clippers, acetone nail polish remover and a can of aerosol nail dryer. -Both the acetone nail polish remover and aerosol nail dryer had labels with a warning that ingestion was harmful and to contact poison control if the product was ingested. -There was a large plastic container on the floor approximately half full with personal care products such as shampoo, conditioner and body wash. -There was an aerosol can of disinfectant spray on the desk with a warning on the label that the contents were hazardous to humans and cause eye irritation. -The exit door near the Memory Care Coordinator (MCC's) office opened approximately 6 inches from the bottom half while remaining locked from the top of the door. -There was no sounding device when the bottom half of the door was opened. -There was a metal bed frame on the floor with sharp edges at the end of the frame and a second metal bed frame with sharp edges at the end leaned up against the wall with the feet of the frame projecting outward from the wall in resident room 306 which was an unlocked vacant room. -There were two metal bedframes with sharp edges at the end on the floor in resident room	D 079		

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D 079	Continued From page 2 310 which was an unlocked vacant room. -There was a female resident walking through the halls and into areas with open doors during the tour. Interview with a personal care aide (PCA) on 02/06/24 at 9:46am revealed all residents on the SCU required supervision for wandering behaviors. Interview with a medication aide (MA) on 02/06/24 at 10:05am revealed: -The unlocked room on the 400-hall used to be the activity room. -Staff did not usually go into that room. -The maintenance person was usually the only staff member who went into the former activity room. -She did not know if the door was supposed to be kept locked or not. Interview with the MCC on 02/06/24 at 10:19pm revealed: -The maintenance person had the key to the former activity room. -The door to the former activity room was usually kept locked. -The maintenance person usually checked to make sure doors were locked on the halls, doors to vacant rooms, storage, janitorial and the former activity room. -PCAs also checked all doors on each hall when they rounded every 2 hours. -She did not know there were metal frames stored in unlocked vacant rooms. Interview with the maintenance person on 02/07/24 at 2:09pm revealed: -The door to the former activity room could easily be opened because there was a missing strike	D 079		

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D 079	Continued From page 3 plate for it to latch securely. -He was in the former activity room just before 9:00am on 02/06/24. -He was moving a TV from the former activity room into a resident's room. -His hands were full and he was pulled away to another task before returning to close and secure the door to the former activity room. Second interview with the MCC on 02/07/24 at 1:50pm revealed: -She knew there were hazards the residents could possibly get into in the former activity room. -The door to the former activity room was rarely unlocked. -The maintenance person had the only key to the former activity room. -Normally he went into the former activity room to get items for staff to conduct activities. -The maintenance person was responsible for ensuring the door to the former activity room was kept locked. -Staff on the SCU were responsible for checking doors to vacant rooms and the former activity room were locked every two hours when they rounded. -There were no residents currently with exit seeking behaviors that might go to the exit door near her office. -If a resident went near the broken exit door near her office, the resident would be redirected by her or staff. Interview with the Administrator on 02/07/24 at 3:05pm revealed: -The door to the former activity room on the SCU was supposed to be kept locked. -She knew there were craft supplies but she did not know there were hazards such as a bleach cleaner in the former activity room.	D 079		

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D 079	Continued From page 4 -The maintenance person was responsible for checking that doors to vacant rooms and the former activity room were kept locked. -The maintenance person was responsible to make sure the door was when he went in and out of the former activity room. -The broken exit door near the MCC's office was scheduled for replacement. -No preventative safety measures had been implemented to reduce resident access to the broken area of the exit door.	D 079	Type text here	
D 189	10A NCAC 13F .0604 (e)(2)(A-E) Personal Care And Other Staffing 10A NCAC 13F .0604 Personal Care And Other Staffing (e) Homes with capacity or census of 21 or more shall comply with the following staffing. When the home is staffing to census and the census falls below 21 residents, the staffing requirements for a home with a census of 13-20 shall apply. (2) The following describes the nature of the aide's duties, including allowances and limitations: (A) The job responsibility of the aide is to provide the direct personal assistance and supervision needed by the residents. (B) Any housekeeping performed by an aide between the hours of 7 a.m. and 9 p.m. shall be limited to occasional, non-routine tasks, such as wiping up a water spill to prevent an accident, attending to an individual resident's soiling of his bed, or helping a resident make his bed. Routine bed-making is a permissible aide duty. (C) If the home employs more than the minimum number of aides required, any additional hours of aide duty above the required hours of direct	D 189	Community ED has reviewed all job descriptions for all departments, including Medication Aide, Personal Care Aide and housekeeping. Community ED has hired additional housekeeping staff to ensure that housekeeping duties are performed and that the Personal Care Aides and Medication Aides task are met. Community Dietary and Care Staff has been in-serviced on dietary food service duties and appropriate assistance of care staff during meal services. Community ED conducted training.	2/9/24 2/14/24 2/8/24

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D 189	Continued From page 5 service between 7 a.m. and 9 p.m. may involve the performance of housekeeping tasks. (D) An aide may perform housekeeping duties between the hours of 9 p.m. and 7 a.m. as long as such duties do not hinder the aide's care of residents or immediate response to resident calls, do not disrupt the residents' normal lifestyles and sleeping patterns, and do not take the aide out of view of where the residents are. The aide shall be prepared to care for the residents since that remains his primary duty. (E) Aides shall not be assigned food service duties; however, providing assistance to individual residents who need help with eating and carrying plates, trays or beverages to residents is an appropriate aide duty. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure medication aides and personal care aides were primarily purposed with the care and supervision of residents and not routinely assigned housekeeping, dietary aide, and laundry service duties from 7:00am until 9:00pm daily. The findings are: Review of the facility's census report dated 02/06/24 revealed there were 45 residents in the facility; 23 on the assisted living (AL) side and 22	D 189		

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D 189	Continued From page 6 in the special care unit (SCU). Observation of the lunch meal on the SCU on 02/06/24 from 11:30am until 12:05pm revealed: -At 11:30am two personal care aides (PCAs), a medication aide (MA) and the Memory Care Coordinator (MCC) were serving residents in the large dining room and two residents in the small dining room on the SCU. -There was 1 resident in the small dining room and two residents in the large dining room that required staff assistance to eat lunch. -There were 4 residents who remained in their rooms and there was no staff on the hall. -At 12:05pm, staff cleared and cleaned dining room tables, residents were leaving the dining rooms with staff assistance and two PCAs went to assist two residents in their room who required assistance with eating. Interview with a PCA on 02/06/24 at 9:46am revealed: -All residents on the SCU required supervision for wandering behaviors. -There was one resident currently on the SCU who required two staff for personal care assistance such as transfers, toileting, bathing, and dressing. -There was one resident with a large bruise on her face; she did not know the cause of the bruise. -There were two other residents who experienced falls within the last week or two. -There were 4 to 5 residents who required assistance with eating meals. -PCAs were responsible for checking residents for toileting and incontinence care needs every two hours. Observation of the breakfast meal on the AL side	D 189		

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D 189	Continued From page 7 on 02/07/24 at 7:50am revealed: -The cook was plating food in the kitchen. -A PCA was delivering plates to residents in the dining room. -A MA was delivering beverages to residents in the dining room. -There was no dietary aide assisting with the meal service. Interview with a second PCA on 02/07/24 at 8:10am revealed: -She was responsible for making sure residents on the AL side were clean, dry and in the dining room by 7:40am for breakfast. -She was responsible for serving meals, clearing plates and cleaning tables after each meal. -After breakfast, she checked resident beds. -She stripped beds and washed bed linens for any soiled beds. -She was responsible for washing all female residents' linens on Mondays and male residents' linens on Tuesdays. -She was responsible for 3-4 resident showers spread out through her 12-hour shift. -She was responsible for cleaning residents' clothing on their shower day. -She was responsible for some housekeeping duties in the residents' rooms trash, food and anything she saw needing to be cleaned. Interview with a third PCA on 02/07/24 at 9:54am revealed: -There were two PCAs and a MA working first shift in the SCU on 02/07/24. -PCAs, the MA and the maintenance person were responsible for cleaning the hallways, common area, dining room and resident rooms. -The facility did not have a housekeeper. -PCAs were responsible for cleaning residents' laundry and bed linens on their assigned shower	D 189		

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D 189	Continued From page 8 day and as needed. -Each PCA was usually assigned to 2 to 3 residents -PCAs and the MA were responsible for conducting activities with residents. -PCAs were responsible for getting residents up, dressed/cleaned and to the dining room for meals. -PCAs were responsible for serving plates and beverages, assisting residents as needed, clearing and cleaning tables, and sweeping the dining room floor for each meal. Observation on the SCU on 02/07/24 at 10:11am revealed: -The MA was cleaning and removing trash from the front desk and medication room. -There was one PCA at the center area of the hall. -The second PCA was assisting a resident with a shower. Observation of the facility on 02/07/24 at 10:50am revealed: -The MA was holding a broom as he exited a resident's room. -The MA placed the broom on a housekeeping cart and pushed the cart into another resident's room. Interview with the maintenance person on 02/07/24 at 8:25am revealed: -In December 2023, the facility eliminated the housekeeper position. -One of the housekeepers worked in the kitchen and one worked as a PCA position on the floor. -He was responsible for taking out trash and cleaning the hallways and common areas in the facility. -He sometimes cleaned resident rooms.	D 189		

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D 189	Continued From page 9 -Third shift PCAs were mainly responsible for cleaning resident rooms. -He sometimes came in to work at 4:30am or 5:00am to help with cleaning resident rooms. -The activity director and transportation positions were also eliminated. -The RCC or whoever was available took residents for appointments. -Sometimes, a PCA working on the floor went with residents for their appointments. Interview with the Memory Care Coordinator (MCC) on 02/07/24 at 1:50pm revealed: -PCAs and the MA were responsible for clearing the tables and sweeping the floors in the dining room. -The MA was currently sweeping the dining room floor. -The PCAs were responsible for cleaning the resident rooms they were assigned to. -The PCAs were responsible for the resident and everything in the resident's room including cleaning, laundry, and bed linens. -Second shift PCAs were responsible for mopping resident rooms because that helped the first shift PCAs. -She did not know direct care staff should not be regularly assigned housekeeping, laundry, and dietary aide duties between the hours of 7:00am to 9:00pm. Interview with the Resident Care Coordinator (RCC) on 02/07/24 at 2:34pm revealed: -PCAs on the AL side were responsible for setting tables, serving, clearing, and cleaning the dining room tables for all meals. -The kitchen staff was responsible for cleaning the dining room floor. -PCAs were responsible for residents' laundry on their shower days.	D 189		

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D 189	Continued From page 10 -PCAs were responsible for striping beds and cleaning linens. -The male residents' beds were done on Tuesdays and female residents' bed were done on Mondays. -The maintenance person cleaned the bulk of common areas and resident rooms on the AL side. -PCAs were responsible for picking up and removing trash and cleaning soiled areas and spills. Interview with the Administrator on 02/07/24 at 3:05pm revealed: -Direct care staff were primarily tasked with resident care. -She expected light housekeeping duties from direct care staff like cleaning a toilet if soiled after use. -The maintenance person was responsible for mopping, trash removal and cleaning resident rooms. -She, the MCM and RCC were responsible for regularly cleaning resident bathrooms. -Some staff took on more responsibilities such as cleaning and laundry. -No one assigned laundry, housekeeping, or dietary aide duties to direct care staff.	D 189		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other	D 283	Wilson House shall ensure that sanitary conditions and preparation are held to standard as set forth in .0904 and 18A .1300. The ED in-serviced the dietary manager and dietary staff that plates are to be covered during transfer from the kitchen to the Secured Care Unit(SCU).	2/8/24 2/8/24

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D 283	Continued From page 11 Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure sanitary conditions for refrigerated food storage by storing perishable food in the refrigerator with temperatures at 52 degrees Fahrenheit (F) and for prepared food with a heavy accumulation of grease, grime and food particles on the front, sides, and drip tray of the stove. The findings are: Review of the facility's census report dated 02/06/24 revealed there were 45 residents in the facility. Review of the county environmental inspection of the facility's kitchen dated 07/26/23 revealed: -The facility score was 97 with 3 total deductions. -There was a 1 point deduction for equipment, food and non-food contact surfaces approved, cleanable, properly designed, designed, constructed and used. -There was a 1 point deduction for non-food contact surfaces clean. -There was a 1 point deduction for physical facilities installed, maintained and clean.	D 283	Community managers will randomly check to ensure plates are covered during transfer from the kitchen to the SCU. The ED in-serviced dietary manager and dietary staff that food must remain covered and dated in coolers to ensure sanitary conditions. Management will randomly check during community rounding to ensure proper sanitary conditions. The ED in-serviced the dietary manager to ensure the daily cleaning schedule is being followed daily. Management will ensure signing and cleaing during daily rounds. The ED and DM will ensure temperature checks of coller are checked and recorded daily. Any area of concern will immediately be reported to the maintenance manager for appropriate follow up. The RVPO had a 3 door cooler delivered to the community for use until the new cooler is installed.	2/8/24 2/8/24 2/8/24 2/8/24 2/8/24

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D 283	Continued From page 12 Observations of the facility's kitchen on 02/06/24 at 2:00pm revealed: -There were thick brown drip marks on the side of the fryer and the stove. -There was a heavy accumulation of yellow, brown, and black grease and grime on the top of the stove in and around the drip plate, the front of the stove, knobs, lip of the oven doors and lip of the bottom drawer. -There was a thick accumulation of grease, grime, and food particles on the sides of the stove and fryer and the stove and the convection oven. -There was an open box in the freezer with an open plastic bag containing unsealed and uncovered beef patties. -There were tan and brown spill marks and pieces of frozen potatoes on the walk-in freezer floor underneath the shelving. -There was a clear liquid on the floor in front of the walk-in refrigerator. -The thermometer outside the refrigerator showed a temperature of 50 degrees Fahrenheit (F). -The thermometer inside the refrigerator showed a temperature of 52 degrees F. Review of the Refrigerator Temperature Log posted on the refrigerator revealed: -Temperatures were documented daily for 01/01/24 through 02/06/24. -Documented temperatures ranged from 41 to 46 degrees F. Interview with a dietary aide on 02/06/24 at 2:00pm revealed: -Kitchen staff cleaned the stove surfaces once every week. -The buildup of grease and grime probably came from the cleaning being missed for a while.	D 283		

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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 283	Continued From page 13 -She did not know the last time the stove surfaces had been cleaned. -The cook or the Dietary Manager usually cleaned the stove surfaces. -The open box containing the open bag of beef patties probably just popped open. -Kitchen staff normally folded the bag and closed the box to protect the food in the freezer. -She checked the refrigerator temperature every morning at the start of the day. -She recorded the temperature from the interior thermometer because the exterior thermometer was broken. -The temperature that morning was 46 degrees F. -The refrigerator temperature was probably warmer due to kitchen staff going in and out throughout the day. Interview with the Administrator on 02/06/24 at 2:45pm revealed: -The Dietary Manager was responsible for oversight of the kitchen environment. -She did not know of any issues with the temperature and functioning of the kitchen refrigerator. Observation of the kitchen refrigerator on 02/06/24 at 3:46pm revealed: -The interior thermometer temperature read 52 degrees F. -Contents of the refrigerator included 2 packages of chicken breast, 2 packages of ground beef, multiple packages of sliced ham, 4 and 1/3 packages of sliced cheese, ½ a case of eggs, 1 case of individual milk containers, and 2/3 of case meal supplement shakes. Interview with a cook on 02/06/24 at 3:46pm revealed:	D 283		

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D 283	Continued From page 14 -The refrigerator temperature had been in the 50's for one week. -She did not know what she was supposed to do about the elevated refrigerator temperature. Observation of the kitchen refrigerator on 02/07/24 at 9:09am revealed: -The interior thermometer read 56 degrees F. -Contents of the refrigerator included 2 packages of chicken breast, multiple packages of sliced ham, 4 and 1/3 packages of sliced cheese, ½ a case of eggs, 1 case of individual milk containers, and 2/3 of case meal supplement shakes. Interview with a second cook on 02/07/24 at 9:12am revealed: -The refrigerator had been leaking and not staying cold for several years. -The management would have a repairman come out and work on the refrigerator which made it okay for a couple months before malfunctioning again. -The refrigerator temperature was "like a roller coaster"; if the door stayed shut the temperature went down and if the door was not kept shut, the temperature increased. -Overnight the refrigerator temperature stayed at 40-45 degrees F. -The cook and dietary aide were responsible to "clean as go" during and after preparing, cooking, and serving the meal. -Some kitchen staff did not "clean as go" or clean thoroughly when they worked. -There was no cleaning schedule with assigned tasks, times, and staff responsible. Interview with the Dietary Manager on 02/07/24 at 9:31am revealed: -The exterior thermometer on the refrigerator did not work; the interior thermometer was checked	D 283		

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D 283	Continued From page 15 daily by kitchen staff. -She discarded the ground beef and chicken breast that morning. -She was working with the Administrator for safe storage of the remaining contents in the refrigerator. -Kitchen staff were responsible for letting the maintenance person know when the refrigerator temperature was more than 50 degrees. -The refrigerator had not been working properly for 1 year. -The maintenance person was responsible for notifying the regional maintenance person. -The kitchen was on the corporate list for renovations which included a new walk-in refrigerator. -She was told about the replacement a couple of months ago. -The kitchen staff on duty on 02/06/24 had not been completing weekly deep cleaning of the stove surfaces. -She was recently returning to work and had not checked behind those for a while. -Kitchen staff were responsible for wiping down surfaces daily and deep cleaning every week on the weekend. -There was no cleaning schedule assigning daily and weekend cleaning tasks for accountability. Interview with the maintenance person on 02/07/24 at 9:46am revealed: -He knew of the refrigerator not working properly for approximately 6 to 7 months. -He applied a pad lock and physical pressure and weight on the refrigerator door when staff notified him the temperature inside the refrigerator was high. -He also notified the Regional Maintenance Director previously and again on 02/07/24.	D 283		

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D 283	Continued From page 16 Interview with the Administrator on 02/07/24 at 3:05pm revealed: -She knew the walk-in refrigerator in the kitchen was leaking but she was not told about the higher temperatures inside the refrigerator. -The leaking had been going on for years. -She walked through the kitchen daily during either breakfast or lunch to look around at the environment. -She saw the condition of the kitchen stove prior to 02/06/24. -Kitchen staff knew they were responsible for cleaning the kitchen after each meal and before leaving each evening.	D 283		
D 317	10A NCAC 13F .0905 (d) Activities Program 10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents were provided 14 hours of activities each week. The findings are: Review of the facility's monthly activities calendar on 02/06/24 at 10:00am revealed: -The January 2024 activity calendar was posted on the wall in the facility. -There were 14 hours of scheduled activities weekly.	D 317	Community ED will ensure that 14 hours of Activites are met per week as set forth by State regulation. Community ED will ensure that the scheduled calendar activites are carried out during the reflected time. Scheduled activities will be reviewed daily during stand up. Community ED will monitor and ensure that all resident's are offered scheduled activites throughout the week.	2/8/24 2/8/24 2/8/24

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D 317	Continued From page 17 Review of the facility's monthly activities calendar on 02/06/24 at 2:00pm revealed: -The February 2024 activities calendar was posted on the wall in the facility. -There were 14 hours of scheduled activities weekly. -There were two activities scheduled for 02/06/24, chair exercise from 10:00am to 11:00am and group talk from 1:00pm to 2:00pm. -There were two activities scheduled for 02/07/24, chair exercise from 10:00am to 11:00am and guessing game from 1:00pm to 2:00pm. Observation of activities on 02/06/24 at 10:15am, there was no chair exercise observed. Observation of activities on 02/06/24 at 1:30pm, there was no group talk observed. Observation of activities on 02/07/24 at 10:30am, there was no chair exercise observed. Observation of activities on 02/07/24 at 1:30pm, there was no guessing game observed. Interview with a resident on 02/06/24 at 9:25am revealed: -The facility had not been providing many activities. -Most of the activities listed on the activity calendar were not offered to the residents. -The facility offered coloring pages for residents. Interview with a second resident on 02/06/24 at 9:40am revealed: -The facility has not been offering activities since the last Activity Director (AD) left. -The facility took residents out to the store regularly. -He would participate in activities if they offered	D 317		

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D 317	Continued From page 18 more. Interview with a third resident on 02/06/24 at 2:10pm revealed: -The facility did not offer her any activities on 02/06/24. -Coloring pages were the only activity provided. -She would participate in activities if they offered more. Interview with a fourth resident on 02/06/24 at 2:15pm revealed: -The facility had an activity calendar, but they did not offer residents activities. -The facility had not been providing enough activities. -He would participate in activities if they offered any that interested him. Interview with a personal care aide (PCA) on 02/06/24 at 2:20pm revealed: -The facility had not been offering activities to the residents recently. -The only activities the residents were doing was coloring in their rooms. Interview with a second PCA on 02/06/24 at 1:10pm revealed: -The Administrator was the AD. -The facility was not offering many activities to the residents. Interview with a third PCA on 02/06/24 at 3:30pm revealed: -The facility had not been offering activities to residents. -The facility gave the residents coloring sheets to do. -The AD did about two hours of activities each week.	D 317		

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D 317	Continued From page 19 Interview with the Administrator on 02/07/23 at 9:40am revealed: -She was responsible for completing the activities calendar and making sure activities were offered to residents. -She had coloring pages and word finds for residents available to residents at all times. -Coloring pages and word finds were not considered activities due to lack of interaction with residents.	D 317		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 residents (#4) observed during the medication pass including a medication used to treat muscle pain and spasms and a medication used to treat chronic obstructive pulmonary disease. The findings are: 1. The medication error rate was 7% as evidenced by 2 errors out of 27 opportunities during the 8:00am medication pass on 02/06/24.	D 358	Wilson House shall ensure that the preparation and administration of medications and treatments by staff are according to Provider orders, which are maintained in the Resident's record; the Facilities policies and procedures; and rules of Section .1004(a). ED and Care Coordinator will in-service Med Aides on Medication Administration to include the 6 rights of Med Administration. ED conducted in-service with the Med techs. The ED and CC will observe random Med Pass observations to verify compliance of with giving meds correctly.	2/8/24 2/8/24 2/8/24

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D 358	Continued From page 20 Review of Resident #4's current FL2 dated 06/23/23 revealed diagnoses included hemiplegia and/or hemiparesis following stroke, pulmonary emphysema, pulmonary hypertension, essential hypertension, congestive heart failure, and primary adenocarcinoma of colon. a. Review of Resident #4's current FL2 dated 06/23/23 revealed there was an order for Baclofen 5mg (Baclofen is a medication used to treat muscle pain and spasms) take one tablet by mouth three times daily at 8:00am, 2:00pm, and 8:00pm. Observation of the 8:00am medication pass on 02/06/24 from 9:23am to 9:45am revealed: -The medication aide (MA) prepared Resident #4's medications and entered Resident #4's room at 9:28am. -Resident #4 began taking his oral medications at 9:30am, which included Baclofen 5mg. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Baclofen 5mg take one tablet by mouth three times daily at 8:00am, 2:00pm, and 8:00pm. -Baclofen 5mg was documented as administered at 8:00am on 02/06/24. Interview with Resident #4 on 02/07/24 at 9:47am revealed: -His 8:00am medications were often administered around 9:00am or later. -He had not noticed an increase in drowsiness when he received his 8:00am dose of Baclofen 5mg late and then took the next dose at 2:00pm.	D 358		

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D 358	Continued From page 21 Interview with the Resident Care Coordinator (RCC) on 02/07/24 at 1:48pm revealed: -MAs had an hour before and an hour after the medication was scheduled to administer the medication. -If MAs were going to be late with medication administration, they should notify her for assistance. -She notified the residents' primary care provider (PCP) if medications were going to be late and let the PCP determine if medications should be administered. Interview with the Administrator on 02/07/24 at 1:36pm revealed: -MAs had an hour before and an hour after the medication was scheduled to administer the medication. -If MAs were going to be late administering medications, they should notify the RCC or Memory Care Director (MCD). -MAs should ask the RCC or MCD for assistance with administering medications so medications would not be administered late. -She was aware that medications not administered on schedule could cause side effects. Interview with Resident #4's primary care provider (PCP) on 02/07/24 at 9:59am revealed: -Baclofen 5mg should be administered in the designated time frame and on schedule. -Taking two doses of Baclofen too close together could contribute to increased drowsiness. Attempted telephone interview with the MA on 02/07/24 at 9:59am was unsuccessful. b. Review of Resident #4's current FL2 dated 06/23/23 revealed there was an order for Breo	D 358		

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D 358	Continued From page 22 Ellipta 100-25mcg (Breo Ellipta is an inhaled medication used to treat chronic obstructive pulmonary disease) inhale one puff by mouth once daily, rinse mouth after use. According to the manufacturer, a potential side effect of this medication is the risk of developing thrush (a fungal infection of the mouth or throat) and rinsing the mouth with water without swallowing after using Breo Ellipta can help reduce the chance of getting thrush. Observation of the 8:00am medication pass on 02/06/24 from 9:23am to 9:45am revealed: -The medication aide (MA) entered Resident #4's room at 9:28am and handed Resident #4 his medications and one cup of water. -Resident #4 inhaled one puff of the Breo Ellipta inhaler but was not prompted by the MA to rinse his mouth or offered additional water by the MA to use to rinse his mouth after using the Breo Ellipta inhaler. -Resident #4 started taking his oral medications immediately after using the Breo Ellipta inhaler. Review of Resident #4's February 2024 electronic medication administration record (eMAR) revealed: -There was an entry for Breo Ellipta 100-25mcg inhale one puff by mouth once daily, rinse mouth after use. -Breo Ellipta 100-25mcg was documented as administered at 8:00am on 02/06/24. Interview with Resident #4 on 02/07/24 at 9:47am revealed: -He was not aware that he was supposed to rinse his mouth after using Breo Ellipta. -None of the MAs had instructed him to rinse his mouth after using Breo Ellipta or provided him with extra water to rinse his mouth.	D 358		

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D 358	Continued From page 23 -He was not aware that rinsing his mouth after using Breo Ellipta could reduce the risk of developing thrush. -He did not recall having any recent mouth or throat irritation. Interview with the RCC on 02/07/24 at 1:48pm revealed MAs should follow the directions on the eMAR when administering medications. Attempted telephone interview with the MA on 02/07/24 at 9:58am was unsuccessful.	D 358		Type text here
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 record reviews and interviews the facility failed to report an injury of unknown origin to the Health Care Personnel Registry (HCPR) for 1 of 1 residents (#1). The findings are: Review of Resident #1's current FL2 dated 09/30/23 revealed diagnoses included dementia, cognitive communication deficit and altered mental status. Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 02/25/22.	D 438	RVPO in-serviced the ED and CC's on the appropriate reporting procedures to the Health Care Personnel Registry. The ED and CC's will review all Incident Reports and electronic reports daily in stand up and will identify any areas that require immediate follow up, documentation and reporting to ensure appropriate reporting procedures are completed. ED and CC's in-serviced all staff on the importance of immediately reporting any concerns of abuse or injuries of unknown origin so that appropriate follow up can occur. ED will ensure accurate and timely completion of 24/5 day report of all allegations and will ensure that reporting occurs within the appropriate timeframe.	2/8/24 2/8/24 2/8/24 2/8/24

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D 438	Continued From page 24 Review of Accident/Incident Report dated 02/02/24 at 3:20pm revealed: -Resident #1 had a skin related issue, bruise over right eye. -Location of the incident was in the hallway. -First aide was not administered. -Resident was not sent to the emergency room. Observation of Resident #1 on 02/06/24 at 3:20pm revealed bruising over the right eye. Interview with a personal care aide (PCA) on 02/06/24 at 1:30pm revealed: -She did not know how Resident #1 got a bruise on her face. -The medication aide was the first person to notice the bruise. -The medication aide (MA) filled out an incident report. Interview with MA on 02/06/24 at 1:35pm revealed: -She was the first person to notice the bruise on Resident #1's face 02/02/24. -She did not know how the resident's face got bruised. -She completed an incident report on 02/02/24 at 3:30pm. Interview with the Memory Care Coordinator (MCC) on 02/07/24 at 1:45pm revealed: -She did not know how the resident's face was bruised. -The MA first saw the bruise and completed an incident report on 02/02/24. -She reviewed the incident report and gave it to the Administrator. -She called the resident's family and notified the primary care provider (PCP) of the bruise on	D 438		

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D 438	Continued From page 25 Resident #1's face. -The Administrator was responsible for all investigations after an incident report was filed. Interview with the Administrator on 02/07/24 at 2:00 pm revealed: -She was aware that Resident #1 had a bruise on her face of unknown origin. -She reviewed the incident report for Resident #1. -She discussed the incident with the MCC and they came to the conclusion that the injury was self-inflicted. -She did not conduct a formal investigation. -Resident #1 regularly ran into doors and walls, staff was constantly redirecting her. -The residents' PCP and family member were notified of the bruise on Resident #1's face. -She did not notify Healthcare Personnel Registry (HCPR) because the incident report was documented as skin related and not an injury of unknown origin. -She should have reported the incident to HCPR. Interview with Resident #1's responsible person/family member on 02/07/24 at 2:15pm revealed: -He was aware that Resident #1 had a bruise on her face. -The MCC called him and made him aware of the bruise. -He believed it was likely the bruise was self-inflicted because he has witnessed her running into doors and furniture. -He believed that the facility was taking precautions to keep Resident #1 safe. -He has no concerns about the care Resident #1 was receiving at the facility. Based on observations, interviews, and record reviews it was determined Resident #1 was not	D 438		

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D 438	Continued From page 26 interviewable.	D 438		