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 _____	R 12/17/2025

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, follow-up, and complaint investigation on 12/16/25 - 12/17/25.	D 000	**Responses 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; the plan of correction is Prepared solely as a matter of compliance With State Law.**	
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 ensure medications were administered as ordered for in accordance to the facility's policy for 1 of 5 sampled residents (#3) related to medications prescribed for the treatment of diabetes including a long-acting and a fast-acting insulin. The findings are: Review of Resident #3's current FL-2 dated 11/25/25 revealed: -Diagnoses included Type II diabetes and early onset alzheimer's disease. -She was semi-ambulatory. -She was constantly disoriented. -There was an order for Jardiance 25mg to be administered each day. (Jardiance is a medication used to control blood sugar levels in people with diabetes.)	D 358	**Wilson House shall ensure that the preparation And administration of medications and treatments By staff are followed according to providers orders, Which are maintained in the residents' record, the Facilities policies and procedures, pharmacy Procedures, and rules of section .1004 (a).**	

Jamaal Willis Reviewed and Acknowledged 03/09/26

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D 358	Continued From page 1 a. Review of Resident #3's hospital discharge summary dated 09/02/25 revealed Jardiance 25mg was to be administered each day. Review of Resident #3's Resident Register revealed she was admitted to the facility on 09/22/25. Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -The start date was documented as 10/27/25. -There was documentation Jardiance 25mg was administered each day on 10/28/25 through 10/31/25. Review of Resident #3's November 2025 eMAR revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -There was documentation Jardiance 25mg was administered each day on 11/01/25 through 11/30/25. Review of Resident #3's December 2025 eMAR revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -There was documentation Jardiance 25mg was administered each day on 12/01/25 through 12/16/25. Observation of Resident #3's medications on hand for administration on 12/16/25 at 2:46pm revealed:	D 358	12/18/25 **ED, RCC, & SCC in serviced med aides on false Documentation of medications, med administration, Facility policies & procedures and pharmacy protocols To ensure all medications are in the facility.** ongoing **ED, RCC, & SCC will complete weekly audits of med carts and refrigerators to ensure expired meds are removed and Ordered per pharmacy protocol.**	

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D 358	Continued From page 2 -Medications were dispensed in a multidose pack. -There was no Jardiance available for administration in the pack. Telephone interview with the pharmacist for the facility's contracted pharmacy on 12/17/25 at 8:36am revealed: -They received an order on 09/22/25 for Resident #3 to be administered Jardiance 25mg each day which was profiled on the eMAR but was not dispensed. -They received a request for a refill of Resident #2's Jardiance 25mg on 12/16/25 which was dispensed on 12/16/25. -Resident #3's medications were dispensed in a multidose pack on cycle fill. -The facility should have called when the Jardiance was not sent in the batch for Resident #3 unless the medication was obtained from family or another pharmacy. Telephone interview with Resident #3's primary care provider (PCP) on 12/17/25 at 9:49am revealed: -Resident #3 was ordered Jardiance 25mg each day on admission. -Jardiance was used for blood sugar control and protected the heart and kidneys. -She sent a refill prescription for Jardiance 25mg on 12/16/25. Telephone interview with Resident #3's family member on 12/17/25 at 9:23am revealed: -She transported Resident #3 to the facility on admission. -She did not bring any medications to the facility from the hospital or home. Interview with a medication aide (MA) on 12/16/25 at 3:02pm revealed:	D 358		

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D 358	Continued From page 3 -There was no Jardiance available administration for Resident #3. -She compared the medications in the pack to the computer when administering medications. -She documented that she administered Resident #3's Jardiance while administering medications and did not notice it was not in the multidose pack. -She would have contacted the pharmacy if she knew the medication was not available for administration. Interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am revealed Medication aides should have paid closer attention when administering medications and should have contacted the pharmacy when the Jardiance was not available for Resident #3. Interview with the Administrator on 12/17/25 at 1:43pm revealed: -The MA should have noticed Resident #3's Jardiance was not in the medication pack during medication administration. -The SCC should have found that Resident #3's Jardiance was not in the medication pack during her weekly cart audits. -The MA and the SCC should have followed up with the pharmacy to ensure the medication was available for administration. Refer to interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am. b. Review of the facility's medication storage policy with a revision date of November 2018 revealed: -Multiple dose injectable vials, once opened, require an expiration date shorter than the manufacturer's expiration date to ensure	D 358		

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D 358	Continued From page 4 medication purity and potency. -Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date and, once opened will be good to use until the manufacturer's expiration date is reached unless the medication is a multi-dose injectable vial. -When the original seal of a manufacturer's container or vial is initially broken, the container or vial would be dated. -A "date opened" sticker shall be placed on the medications. -The expiration date of the vial or container will be 30 days unless the manufacturer recommended another date. -The medication administration personnel would check the expiration date of each medication before administering it. -No expired medication will be administered to a resident. -All expired medication will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. Review of Resident #3's hospital discharge summary dated 09/22/25 revealed: -There was an order for lispro injection pen to be administered per sliding scale before meals and at bedtime. -For blood glucose level 70-150, administer 0 units. -For blood glucose level 151-200, administer 1 units. -For blood glucose level 201-250, administer 2 units. -For blood glucose level 251-300, administer 3 units. -For blood glucose level 301-350, administer 4 units. -For blood glucose level 351-400, administer 5	D 358		

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D 358	Continued From page 5 units. Review of Resident #3's physician's order dated 11/18/25 revealed Lispro 4 units was was to be administered three times daily with meals for blood sugar greater than 250. Observation of Resident #3's medications on hand for administration on 12/16/25 at 2:46pm revealed: -There was a partially used Lispro Kwik pen as directed per sliding scale -There was a sticker applied to the injectable pen with documentation the open date was 10/01/25 and the expiration date was 10/29/25. Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Lispro Kwikpen to be administered per sliding scale before meals and at bedtime and scheduled for 8:00am, 11:00am, 4:00pm and 7:30pm for. -There was documentation Lispro Kwikpen was administered correctly each day per sliding scale before meals and at bedtime on 10/01/25 to 10/31/25. Review of Resident #3's November 2025 eMAR revealed: -There was an electronic entry for Lispro Kwikpen to be administered per sliding scale before meals and at bedtime and scheduled for 8:00am, 11:00am, 4:00pm and 7:30pm. -There was documentation Lispro Kwikpen was administered correctly each day per sliding scale before meals and at bedtime on 11/01/25 to 11/20/25. -There was an electronic entry for Lispro Kwikpen 4 units to be administered three times	D 358		

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D 358	Continued From page 6 daily with meals for blood sugar greater than 250 and scheduled for 8:00, 12:00pm and 5:00pm. -There was documentation Lispro Kwikpen 4 units was administered with meals on 11/24/25 at 5:00pm for a blood sugar level of 293 and on 11/28/25 at 8:00am for a blood sugar level of 269. Review of Resident #3's December 2025 eMAR revealed: -There was an electronic entry for Lispro Kwikpen 4 units to be administered three times daily with meals for blood sugar greater than 250 and scheduled for 8:00, 12:00pm and 5:00pm. -There was documentation Lispro Kwikpen 4 units was administered with meals on 12/03/25 at 12:00pm for a blood sugar level of 289 and 5:00pm for a blood sugar level of 278. -There was documentation Lispro Kwikpen 4 units was administered with meals on 12/08/25 at 12:00pm for a blood sugar level of 256. -There was documentation Lispro Kwikpen 4 units was administered with meals and on 12/11/25 at 12:00pm for a blood sugar levels of 251. Telephone interview with the pharmacist for the facility's contracted pharmacy on 12/17/25 at 10:03am revealed: -Lispro insulin pens were dispensed on 11/21/25 and 12/15/25. -Insulin pens could not be guaranteed sterility and effectiveness after 28 or 30 days once opened, based on manufacturers information and should be discarded. Interview with the medication aide (MA) on 12/16/25 at 3:02pm revealed: -She looked at the expiration date printed on the injectable pens by the manufacturer, not the date opened sticker on the pen when administering	D 358		

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D 358	Continued From page 7 medications. -There were other pens available for use but she had used these pens because there was still medication in them. -There were unopened pens available for administration. Interview with the Administrator on 12/17/25 at 1:43pm revealed: -The MA should have checked the opened date of the injectable insulin pens and discarded expired pens. -The SCC should have found that Resident #3's injectable insulin pens were expired during her weekly cart audits. -The MA and the SCC should have discarded the medication appropriately and the medication should not be administered to a resident. Refer to interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am. c. Review of the facility's medication storage policy with a revision date of November 2018 revealed: -Multiple dose injectable vials, once opened, require an expiration date shorter than the manufacturer's expiration date to ensure medication purity and potency. -Drugs dispensed in the manufacturer's original container will carry the manufacturer's expiration date and, once opened will be good to use until the manufacturer's expiration date is reached unless the medication is a multi-dose injectable vial. -When the original seal of a manufacturer's container or vial is initially broken, the container or vial would be dated. -A "date opened" sticker shall be placed on the medications.	D 358		

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D 358	Continued From page 8 -The expiration date of the vial or container will be 30 days unless the manufacturer recommended another date. -The medication administration personnel would check the expiration date of each medication before administering it. -No expired medication will be administered to a resident. -All expired medication will be removed from the active supply and destroyed in the facility, regardless of the amount remaining. Review of Resident #3's hospital discharge summary dated 09/22/25 revealed there was an order for Lantus 20 units to be administered nightly. Review of Resident #3's physician's order dated 11/18/25 revealed Lantus 24 units was to be administered each night at bedtime. Observation of Resident #3's medications on hand for administration on 12/16/25 at 2:46pm revealed: -There was a partially used Lantus injectable pen labeled 20 units to be administered each night at bedtime. -There was a sticker applied to the injectable pen with documentation the open date was 10/01/25 and the expiration date was 10/29/25. Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Lantus 20 units to be administered each night and scheduled for 8:00pm. -There was documentation Lantus was administered each night on 10/01/25 to 10/31/25.	D 358		

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D 358	Continued From page 9 Review of Resident #3's November 2025 eMAR revealed: -There was an electronic entry for Lantus 20 units to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation Lantus 20 units was administered each night on 11/01/25 to 11/20/25. -There was an electronic entry for Lantus 24 units to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation Lantus 24 units was administered each night on 11/21/25 to 11/31/25. Review of Resident #3's December 2025 eMAR revealed: -There was an electronic entry for Lantus 24 units to be administered each night at bedtime and scheduled for 8:00pm. -There was documentation Lantus 24 units was administered each night on 12/01/25 to 12/15/25. Telephone interview with the pharmacist for the facility's contracted pharmacy on 12/17/25 at 10:03am revealed: -Lantus insulin pens were dispensed on 11/21/25 and 12/15/25. -Insulin pens could not be guaranteed sterility and effectiveness after 28 or 30 days once opened, based on manufacturers information and should be discarded. Interview with the medication aide (MA) on 12/16/25 at 3:02pm revealed: -She looked at the expiration date printed on the injectable pens by the manufacturer, not the date opened sticker on the pen when administering medications. -There were other pens available for use but she had used these pens because there was still medication in them.	D 358		

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D 358	Continued From page 10 -There were unopened pens available for administration. Interview with the Administrator on 12/17/25 at 1:43pm revealed: -The MA should have checked the opened date of the injectable insulin pens and discarded expired pens. -The Special Care Unit Coordinator (SCC) should have found that Resident #3's injectable insulin pens were expired during her weekly cart audits. -The MA and the SCC should have discarded the medication appropriately and the medication should not be administered to a resident. Based on observations, interviews and record review, it was determined Resident #3 was not interviewable. Refer to interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am. Interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am revealed: -Resident #3 was admitted from a hospital and brought in by a family member. -She thought Resident #3's family member brought in some medications but there was no process for documenting the receipt of medications. -She was responsible for completing weekly cart audits which included comparing medications on hand to current physician's orders and ensuring there were no expired medications on the medication cart. -It had been a week or two since she last completed a cart audit because she had not had the time to complete the audit. -Medication aides should have paid closer attention when administering medications.	D 358		

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D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure electronic medication administration records (eMARS) accurately reflected medications that were administered for 1 of 5 sampled residents (#3) related to a medication prescribed for the treatment of diabetes. The findings are:	D 367	ongoing **Med aides will complete daily med cart audits to ensure Meds match the mars; meds are correct and on the cart. If changes are needed, they will document call to the pharmacy,** **And RCC or SCC are alerted as to the change and what the changes were.** **RCC & SCC will follow up behind med aids and cart audits to ensure accuracy.**	

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D 367	Continued From page 12 Review of Resident #3's current FL-2 dated 11/25/25 revealed: -Diagnoses included Type II diabetes and early onset alzheimer's disease. -She was semi-ambulatory. -She was contantly disoriented. -There was an order for Jardiance 25mg to be administered each day. (Jardiance is a medication used to control blood sugar levels in people with diabetes.) Review of Resident #3's hospital discharge summary dated 09/02/25 revealed Jardiance 25mg was to be administered each day. Review of Resident #3's Resident Register revealed she was admitted to the facility on 09/22/25. Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -The start date was documented as 10/27/25. -There was documentation Jardiance 25mg was administered each day on 10/28/25 through 10/31/25. Review of Resident #3's November 2025 eMAR revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -There was documentation Jardiance 25mg was administered each day on 11/01/25 through 11/30/25. Review of Resident #3's December 2025 eMAR	D 367	ongoing **RCC & SCC will complete weekly cart audits matching meds to mars to ensure all meds are correct and on the cart. Cart Audits will be turned in the ED after completion.** ongoing **ED, RCC, & SCC will do weekly med pass observations To ensure med aides are following proper protocols And Meds are being given per the mars.**	

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D 367	Continued From page 13 revealed: -There was an electronic entry for Jardiance 25mg to be administered each day and scheduled for 8:00am. -There was documentation Jardiance 25mg was administered each day on 12/01/25 through 12/16/25. Observation of Resident #3's medications on hand for administration on 12/16/25 at 2:46pm revealed: -Medications were dispensed in a multidose pack. -There was no Jardiance available for administration in the pack. Telephone interview with the pharmacist for the facility's contracted pharmacy on 12/17/25 at 8:36am revealed: -An order for Resident #3 to be administered Jardiance 25mg each day was recieved on 09/22/25. -Jardiance was profiled on the eMAR but was not dispensed until a request for a refill prescription was recieved on 12/16/25. Telephone interview with Resident #3's primary care provider (PCP) on 12/17/25 at 9:49am revealed: -Resident #3 was ordered Jardiance 25mg each day on admission. -Jardiance was used for blood sugar control and protected the heart and kidneys. -The staff should not document a medication was administered when it was not. -She assumed medications were administered appropriately because it was ordered to be administered. Telephone interview with Resident #3's family member on 12/17/25 at 9:23am revealed:	D 367		

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 _____	R 12/17/2025

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D 367	Continued From page 14 -She transported Resident #3 to the facility on admission. -She did not bring any medications to the facility from the hospital or home. Interview with a medication aide (MA) on 12/16/25 at 3:02pm revealed: -There was no Jardiance available administration for Resident #3. -She compared the medications in the pack to the computer when administering medications. -She overlooked Resident #3's Jardiance during medication administration. -She did not know Jardiance was not in the multidose pack so she charted administration in error. Interview with the Special Care Unit Coordinator (SCC) on 12/17/25 at 8:55am revealed: -Resident #3 was admitted from a hospital and brought in by a family member. -She thought Resident #3's family member brought in some medications. -Medication aides should have paid closer attention when administering medications and should not have documented Jardiance was administered when it was not. Interview with the Administrator on 12/17/25 at 1:43pm revealed: -The MA should have noticed Resident #3's Jardiance was not in the medication pack during medication administration. -The MAs shoud not document that a medications was administered when it was not. -The eMAR should be accurate to ensure appropriate medications were administered as ordered. Based on observations, interviews and record	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 15 review, it was determined Resident #3 was not interviewable.	D 367		