STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 the Wilson County Department of Social Services conducted an annual survey and complaint investigation on October 10-16, 2018 with an exit conference via telephone on October 17, 2018. The complaint investigation was initiated by the Wilson County Department of Social Services on August 3, 2018.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to assure the walls, ceilings, and floors were kept clean and in good repair in 7 resident rooms, 10 bathrooms and the Special Care Unit (SCU) dining room. The findings are: Observation of the bathroom for room #200 on 10/10/18 at 10:02am revealed: -The grout on the floor tile of the shower, around the base of the toilet, and along all base edges where the tile floor met the tile walls had areas of dark brown and black stains. -The air return vent had a thick coating of dust covering it.	D 074	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10-18-18 Facility Survey Consultant Grout on floor tiles of showers, bathrooms and base edges of walls have been scrubbed and sanitized on the entire 200 hall including rooms: 200, 201, 203, 205, 210/212. Air return vents have been cleaned in all bathrooms of 200 hall including common bathroom and 202/204.	~~10/13/18~~ 10/18/18 10/18/18

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jean Etter — TITLE: Administrator — (X6) DATE: 12/10/2018

Reviewed & Accepted with Revisions

Christopher Cahan USN
Facility Survey Consultant
12/13/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 1 Observation of the shared bathroom for rooms #202 and #204 on 10/10/18 at 10:15am revealed: -The grout around the base of the toilet, and along all base edges where the tile floor met the walls had areas of dark brown and black stains. -The air return vent had a thick coating of dust covering it. -There were two half inch diameter holes in the ceiling next to the air return vent. -The wall across from the toilet had seven areas ranging from four inches to twelve inches in diameter of chipped plaster. -The bottoms of the door frames each had a half inch rusted area where the frames met the floor. Observation of room #204 on 10/10/18 at 10:31am revealed: -There were five holes, one inch each in diameter on the left wall next to the door. -There was a three feet by two feet area of no paint on the left wall next to the door. -There were three areas of chipped paint approximately twelve inches by one inch on the wall behind the bed. -There were six black scuff marks and missing paint on the corner of the wall to the right of the dresser. Observation of the common bathroom on the #200 hall on 10/10/18 at 10:34am revealed: -The grout on the floor tile of the shower, around the base of the toilet, and along all base edges where the tile floor met the tile walls at the door entry had areas of dark brown and black stains. -The air return vent had a thick coating of dust covering it. Observation of room #206 on 10/10/18 at 10:44am revealed: -The wall behind the bed had five areas ranging	D 074	Holes in ceiling next to air vent has been patched and painted in bath-room of 202/204. All holes in walls of 200 hall have been patched and painted including chipped walls and rusted door frames to include rooms and bathrooms of 201, 202, 204, 205, 206, 208, 210, and 212.	11/2/18 12/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 2 from four inches to twelve inches where the plaster was separating from the wall. - The baseboards of the entire room had areas of thickened dark brown and black stains. Observation of the bathroom for room #206 on 10/10/18 at 10:45am revealed: -The grout around the base of the toilet, and along all base edges where the tile floor met the walls had areas of dark brown and black stains. -The wall above the light switch had one area six by six inches and one area six by four inches with chipped plaster. -The air return vent had a thick coating of dust covering it. Observation of room #208 on 10/10/18 at 10:52am revealed there was a five feet by half inch area of chipped and flaking paint on the wall where it met the air conditioner. Observation of room #210 on 10/10/18 at 10:55am revealed: -The wall above the beds had four areas, one inch to six inches in diameter with chipped plaster. -There was an area five feet by one inch missing paint on the corner of the wall to the right of the dresser. -The door to the entry of the room had chipped wood around the handle with ten screws around it holding the broken wood together. Observation of room #212 on 10/10/18 at 10:55am revealed: -The tiled floor had one to two inches of chipped tile over the entire floor. -The closet door had a three by two inch area of wood chipped out of the door.	D 074	Room 206 has been deep cleaned to include baseboard found with dark and black stains. Residents removed from 212 and will not be occupied until floor tile has been replaced.	12/3/18 12/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 3 Observation of the shared bathroom for rooms #212 and #210 on 10/10/18 at 10:59am revealed: -The grout around the base of the toilet, and along all base edges where the tile floor met the walls had areas of heavy thickened material with dark black stains. -The grout on the entire tiled floor had areas of dark black stains. -The bottoms of the door frames each had a half inch rusted area where the frames met the floor. -The air return vent had a thick coating of dust covering it. Based on observations, interviews, and record reviews it was determined that the residents who occupied rooms #200, #202, #204, #206, #208, #210 & #212 were not interviewable. Observation of room #303 on 10/10/18 at 10:29am revealed: -The entire floor had a clear sticky substance and made an audible sound when walked upon. -There were numerous black and brown particles of debris throughout the entire floor. -The wall behind the nightstand was covered in a sticky splatter extending 2-feet high from floor on both sides of the nightstand. -There were several dead bugs, a dust-covered drinking straw and black specks along the baseboard of the wall under the air-conditioner unit. Interview with the resident occupying room #303 on 10/10/18 at 10:45am revealed: -The staff did not adequately mop the floors when they performed housekeeping. -The wheels of her wheelchair were sticky due to rolling along the floor in her room. -She had never seen the walls wiped down by staff.	D 074	Room 303 floor and wall has been cleaned.	11/6/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 4 Interview with a family member of the resident occupying room #303 at 10/12/18 at 2:45pm revealed: -The floors in room #303 were always sticky when he would visit at least twice weekly. -The sticky floors were due to frequent soda spills from the drink cup in the cup holder attached to her wheelchair which spilled when she transferred into and out of the chair. -His family member was not happy with the cleanliness of the floors and walls and she expected daily housekeeping to include mopping. Review of Housekeeping Deep Cleaning Checklist on 10/11/18 revealed: -The name of the housekeeper was assigned to a specific room and date. -The individual duties for each room were listed with a space for the housekeeper to initial. -The schedule for 10/08/18 documented room #200 was deep cleaned. -The schedule for 10/09/18 documented room #201 was deep cleaned. -There was no deep cleaning schedule posted for 10/10/18. Interview with the Administrator on 10/11/18 at 9:30am revealed: -The housekeeping staff reported to her. -She did not know about the issues in the resident rooms and bathrooms. -She completed a walk through weekly of the rooms, but did not go to each room every week. -She met with the housekeepers a week ago to review a deep cleaning schedule for each room; one room per day. Interview with a personal care aide (PCA) on 10/11/18 at 11:50am revealed:	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 5 -Issues for additional cleaning were reported verbally to the Medication Aide (MA). -The MA reported the issues to the Maintenance Supervisor. -Reports for additional cleaning were not documented. Interview with the Maintenance Supervisor on 10/12/18 at 9:00am revealed: -A list of issues/repairs requested and completed were kept in his office. -The staff told him verbally, or put a note in his box on his door, if there was additional cleaning required. -He was informed by the Administrator of the new issues identified on 10/11/18 in the SCU bedrooms and bathrooms, and would be addressing those. Interview with a Special Care Unit (SCU) housekeeper on 10/15/18 at 10:00am revealed: -She cleaned each room and bathroom daily on the SCU, which included mopping the floors. -The bathrooms on the SCU have been in the current condition for "a long time". -She thought that the management team knew the condition of the bathrooms. -She reported repairs only if needed to the maintenance supervisor. Observation of the bathroom for room #201 on 10/10/18 at 10:00am revealed: -There was a brown build up along the edge of the shower floor. -There was a brown build up in the grout lines on the shower floor and shower walls. -There was a scattered brown build up along the entire length of the hand rail in the shower. - There was a brown build up along the edge of the threshold where the bathroom floor met the	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 6 room floor. -There was a brown build up behind the toilet. -There was a one inch by one inch hole in the wall under the power socket. -There was a brown build up on the wall next to the light switch. Observation of resident room #203 on 10/10/18 at 10:05am revealed there was a twelve inch by six inch rip in the wall paper next to the resident's bed that had been secured with clear tape. Observation of the bathroom for room #203 on 10/10/18 at 10:05am revealed: - There was a brown build up along the edge of the threshold where the bathroom floor met the room floor. -There was a brown build up behind the toilet. Observation of the bathroom for room #205 on 10/10/18 at 10:10am revealed: - There was a brown build up along the edge of the threshold where the bathroom floor met the room floor. -There was a brown build up behind the toilet. -There was a three inch by three inch area of missing plaster along the bottom of the bathroom wall closet to the bathroom door. -There was a thin black stain running the entire width of the bottom of bathroom wall. Observation of the bathroom for room #207 on 10/10/18 at 10:15am revealed: - There was a brown build up along the edge of the bathroom floor where the threshold met the room floor. -There was thick dark brown and black stains on the grout around the base of the toilet. Observation of the bathroom for room #212 on	D 074	Room 203 ripped wallpaper has been removed and wall painted.	11/1/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 7 10/10/18 at 10:20am revealed: -There was a brown build up around the entire base of the toilet. -There was a two inch by two inch area of missing plaster on the wall exiting the shower along with multiple areas of chipped paint. Interview with the resident in room #212 revealed that he was unsure when his room was supposed to be cleaned, but thought it was just cleaned. Based on observations and interviews, it was determined that the residents who occupied rooms #201, #203, #205, #207 and #209 were not interviewable. Observation of the dining room on the SCU on 10/10/18 at 10:45am revealed: -There was a build up of a thick black substance on the dining room floor along the front edge of the entire length of the counter. -There were multiple thin brown and thick black substances including food debris throughout out the entire dining room floor. Interview with Personal Care Aide (PCA) on the SCU on 10/12/18 at 3:45pm revealed: -The housekeeping staff only worked from 7am to 3pm. -The housekeeping staff locked the cleaning supplies up when they left and the PCA's did not have to access them. -The PCA's were to clean up the dining room floor on the SCU after dinner. -Housekeeping was responsible for cleaning the cabinet and microwave in the SCU. Interview with the Administrator on 10/12/18 at 3:45pm revealed: -She was did not know of the brown build up on	D 074	Dining room of 200 hall: thick substance has been removed. Room floor has been stripped completely and waxed. Key to housekeeping closet is Maintained on front hall med cart For accessibility after housekeeping Regular hours.	10/29/18 11/15/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 074	Continued From page 8 the bathroom floors and around the toilets on the SCU. -There was housekeeping staff assigned to each hall including the SCU. -There was only housekeeping staff available for the SCU on first shift. -She had recently instructed the housekeeping staff to perform a deep cleaning of the rooms and that the cleaning staff was assigned a room to deep clean daily. -The housekeeping staff was responsible for sweeping and mopping the dining room floor of the SCU after each meal except dinner due to shift ending prior to dinner being served. -The PCA's were responsible for sweeping and mopping the dining room after dinner. -Housekeeping was responsible for clean the cabinets and microwave in the SCU daily. -The "floor man" was in the process of stripping and refinishing the floors in the dining room and hallway of the SCU.	D 074	It is the policy of Wilson Assisted Living that all floors in all resident rooms, bathrooms, common areas and hallways are swept and mopped daily, and as needed, by housekeeping Staff. The dining rooms are to be swept and mopped daily after each meal by housekeeping staff from 7am-3pm and by care staff after dinner. The Administrator or designee will do a weekly walk thru of all areas of the facility and documentation will be maintained in the Administrator's office.	11/19/18
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure furniture in the special care unit was maintained in good repair for resident rooms 202, 203, 205, 209 and 212.. The findings are:	D 076		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 076	Continued From page 9 Observations on the special care unit on 10/10/18 at 10:15am revealed: -In resident room #202 the bedside dresser had six areas one-inch by one-half inch with missing paint and the top drawer handle missing. -In resident room #212, the top left drawer was missing on the dresser and the dresser had three areas that were one to three inches with paint missing. Based on observations, interviews, and record reviews it was determined that the residents who occupied rooms #202 and #212 were not interviewable. Observations on the Special Care Unit (SCU) on 10/10/18 from 10:00am until 10:45am revealed: -There was a missing drawer cover on the lower left side of the built-in drawers in resident room #203. -There was a missing drawer cover on the lower right side of the built-in drawers in resident room #205. -There was a missing drawer on the upper right side of the built-in drawers in resident room #209. -There was a missing drawer on the upper left side of the built-in drawers in room #212. Interview with the Administrator on 10/11/18 at 9:30am revealed: -She did not know of the issues with the furniture. -She completed a walk through weekly of the rooms, but did not go to each room every week. -Any repairs that were needed were to be reported to the maintenance supervisor by the Medication Aide (MA) on duty. Interview with a PCA on 10/11/18 at 11:50am revealed:	D 076	Drawer covers, bedside dresser paint and missing drawer handles have been repaired in rooms 202, 203, 205, 209 And 212.	11/26/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 076	Continued From page 10 -Issues for repairs are reported verbally to the Medication Aide (MA). -The MA reported the issues to the Maintenance Supervisor. -She was not aware of the furniture repairs needed in rooms #202 and #212.	D 076	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10/18/18 Facility Survey Consultant	
	Interview with the Maintenance Supervisor on 10/12/18 at 9:00am revealed: -A list of issues/repairs requested and completed were kept in his office. -The staff told him verbally, or put a note in his box on his door for the request. -He was informed by the Administrator of the new issues identified on 10/11/18 in the SCU bedrooms and bathrooms, and would be addressing those. Observation of the Maintenance Request book on 10/12/18 at 9:00am revealed several requests were completed on 09/06/18 on the SCU for a toilet leak (room 202), and air conditioner adjustments (rooms 208 and 205). Interview with a Special Care Unit (SCU) housekeeper on 10/15/18 at 10:00am revealed: -She reported repairs only if needed to the maintenance supervisor. -She did not know of the furniture repairs needed in rooms #202 and #212.		Maintenance log is ready and available to report any and all maintenance needs and is checked by Administrator weekly. Staff have been in-serviced on how to report maintenance issues.	~~10/12/18~~
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	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 11 hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure the exposed sharp metal edges of two curtain rods and hooks under a mirror, and protruding rusted screws on the base of toilets on the special care unit were not a potential hazard for residents. The findings are: Observation of the bathroom im room #200 on 10/10/18 at 10:02am revealed: -There were two sharp metal hooks protruding one inch from under the mirror above the sink. -There were two rusted screws protruding one inch from each side of the base of the toilet. Observations of resident room #202 10/10/18 at 10:15am revealed there were two metal curtain rods with sharp edges leaning against the wall to the left of the window. Observation of the shared bathroom for rooms #202 and #204 on 10/10/18 at 10:15am revealed: -There was a raised toilet seat above the toilet that had rust covering the front edges of the seat and the two front legs. -There were two rusted screws protruding one inch from each side of the base of the toilet. Observation of the common bathroom on the #200 hall on 10/10/18 at 10:34am revealed there was a metal curtain rod with sharp edges sitting next to the toilet.	D 079	Protruding hooks, screws/bolts protruding from toilets, curtain rods not in proper use, and rusted raised toilet seats have all been removed and bolts sawed down with added covering for safety.	12/7/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 12 Observation of the bathroom in room #206 on 10/10/18 at 10:45am revealed there were two rusted screws protruding one inch from each side of the base of the toilet. Based on observations, interviews, and record reviews it was determined that the residents who occupied rooms #200, #202, #204, and #206 were not interviewable. Observation of the bathroom for room #201 on 10/10/18 at 10:00am revealed there were two rusted screws with a thick black substance build up protruding one inch from each side of the base of the toilet. Observation of the bathroom for room #205 on 10/10/18 at 10:10am revealed: -There was two rusted screws protruding one inch from each side of the base of the toilet. -There was a metal elevated toilet seat positioned above the toilet with rusted areas on both front legs of the lifted toilet seat. Observation of the bathroom for room #207 on 10/10/18 at 10:15am revealed: -There were two rusted screws with a thick black substance build up protruding one inch from each side of the base of the toilet. -There was a metal elevated toilet seat positioned above the toilet with rusted areas on both front legs, along the front and back bars and middle brace of the lifted toilet seat. Based on observations and interviews, it was determined that the residents who occupied rooms #201, #205, and #207 were not interviewable.	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 13 Interview with a Special Care Unit (SCU) housekeeper on 10/15/18 at 10:00am revealed: -She reported repairs only if needed to the maintenance supervisor. -She was not aware of the hazardous issues in the resident rooms and bathrooms. -She had not reported the rusted screws protruding on the bases of the toilets. Interview with the Administrator on 10/11/18 at 9:30am revealed: -She did not know of the hazardous issues in the resident rooms and bathrooms. -She completed a walk through weekly of the rooms, but did not go to each room every week. -Any needed repairs were to be reported to the Medication Aide (MA) who reported them to the maintenance supervisor. Interview with the Administrator on 10/12/18 at 3:45pm revealed: -She did not know of the rusted elevated toilet seats in the bathrooms of resident rooms #205 and #207. -She did not know of the rusted screws protruding from each side of the base of the toilets in the bathrooms of resident rooms #201, #205 and #207. Interview with the Maintenance Supervisor on 10/12/18 at 9:00am revealed: -A list of issues/repairs requested and completed were kept in his office. -The staff told him verbally, or put a note in his box on his door, if there was additional cleaning required. -He was not aware of the hazardous issues in the resident rooms and bathrooms which included sharp metal edges of two curtain rods and hooks under a mirror, and protruding rusted screws on	D 079		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 14 the base of toilets.	D 079		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement interventions to address the current symptoms and assessed needs for 2 of 5 residents sampled (#1, #2) who each had a diagnosis of Alzheimer's. Resident #1, who had a history of attempting to ambulate without assistance and multiple falls with injuries, sustained a fractured hip. Resident #2, who had a history of multiple falls with injuries, was found on the floor and was admitted to the hospital and died eleven days later. The findings are: 1. Review of Resident #2's current FL-2 dated 08/07/18 revealed: -Diagnoses included Alzheimer's, insomnia, dementia, gastroesophageal reflux disease, hypertension, and debilitation. -The resident was non-ambulatory, constantly	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 15 disoriented and incontinent of bowel and bladder. Review of Resident #2's care plan dated 08/09/2018 revealed: -Resident #2 was totally dependent with eating, toileting, ambulation, bathing, dressing, grooming and transfers. -Resident #2 required a two person assistance for ambulation and transfers, and required staff to assist with wheelchair. -There was no documentation of fall prevention interventions or supervision for Resident #2. Review of Resident #2's Licensed Health Professional Support (LHPS) review dated 07/23/18 revealed the resident required assistance with feeding, ambulation and transfers. Review of Resident #2's Accident/Injury report dated 03/09/18 revealed: -The report was completed by a medication aide (MA). -The date and time of the accident was 03/09/18 at 7:00am. -Resident #2 had been in her wheelchair in the dining room propelling her chair back and forth with her feet. -Resident #2 leaned forward and fell out of the wheelchair to the floor. -Resident #2's vital signs were blood pressure 150/95, pulse 51, and respirations 18. -The description of the injury was "no injury". -The "staff action taken" was "keep attention on the resident when in wheelchair because she likes to move around a lot". -The family member was notified at 7:24am. -The physician was left a message at 7:45am. -The MA signed the report and dated it 03/09/18. -The Administrator had not signed the	D 270	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10-18-18 Facility Survey Consultant It is the policy of Wilson Assisted Living to do a minimum of 2 hour checks on every resident and as needed per resident need or physicians order. RCC, Administrator or designee follows up on this documentation weekly. Fall Management policy is in place and staff inserviced. Residents are assessed upon admission by our in house Therapy department. When falls occur, referrals for therapy will be requested. While being assessed by therapy, it will be determined if assistive devices are necessary. Fall prevention meetings are held monthly by Management and interventions put in place.	11/16/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 16 Accident/Injury report. Review of Resident #2's Accident/Injury report dated 05/28/18 revealed: -The report was completed by a medication aide (MA). -The date and time of the accident was 05/28/18 at 4:00pm. -Resident #2 had been assisted by staff to the wheelchair. -Resident #2 had leaned forward and fell out of the wheelchair to the floor. -Resident #2's vital signs were blood pressure 158/70, pulse 70, and respirations 20. -The type of injury was a skin tear. -The resident's level of consciousness was alert, oriented and would arouse when name called. -The resident was taken to the ER but was not hospitalized. -A message was left for the family member/responsible party. -The physician was left a message at 4:20pm. -The MA signed the report and dated it 05/28/18. -The Administrator had not signed the Accident/Injury report. Review of an emergency department (ED) Patient Visit Information report for Resident #2 dated 05/28/18 revealed: -Resident #2 was checked in to the ED at 4:24pm on 05/28/18. -Resident #2 was seen for a fall from ground level, forehead contusion and forehead abrasion. -Resident #2 received wound cleansing, antibiotic ointment and a dressing was applied. -Resident #2 was released from the ED at 5:27pm. Review of facility "Nurses Notes" revealed on 05/29/18 (no time indicated):	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 17 -Resident #2 went to the ED for a fall. -Resident #2 returned back with a forehead contusion and abrasion. -There were no new orders for Resident #2. -Resident #2 had a follow-up appoint with her primary care physician (PCP) on 05/31/18. Review of facility PCP "Encounter Summaries" revealed on 05/31/18, Resident #2 was seen for a follow-up from the 05/28/18 fall. There was a minor abrasion to the right side of the forehead. The staff should "continue to monitor" Resident #2. Review of facility "Nurses Notes" revealed on 05/31/18 (no time indicated) Resident #2 was seen by her PCP. The staff will "keep monitoring her". Review of Resident #2's Accident/Injury report dated 07/09/18 revealed: -The report was completed by a MA. -The date and time of the accident was 07/09/18 at 6:57am. -Resident #2 was found on the floor in the dining room. -Resident #2's vital signs were blood pressure 130/78, pulse 81, and respirations 18. -The description of the injury was "no injury". -The "staff action taken" was "help the resident back in her wheel chair after checking for an injury and vital signs". -The family member was notified at 7:03am. -The physician was left a message at 6:58am. -The MA signed the report and dated it 07/09/18. -The Administrator signed the report and dated it 07/09/18. Review of facility PCP "Encounter Summaries" revealed on 07/31/18, Resident #2 was seen for a	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 18 follow-up to anemia, hypertension and cognitive communication disorder. It was noted to "continue to monitor". Review of facility "Nurses Notes" revealed on 08/03/18 (no time indicated) Resident #2 was seen by her PCP. They would still monitor the resident. Review of facility PCP "Encounter Summaries" revealed on 08/30/18, Resident #2 was seen for a follow-up to insomnia and fall from the wheelchair. It was noted to "continue to monitor". Review of facility "Nurses Notes" revealed on 08/30/18 at 11:00am, the special care coordinator (SCC) documented that Resident #2 had no problems and continue to monitor. Review of Resident #2's Accident/Injury report dated 09/03/18 revealed: -The report was completed by a MA. -The date and time of the accident was 09/03/18 at 3:00am. -The MA came into the room and found the resident lying on the floor on her right side. -Resident #2's vital signs were blood pressure 127/75, pulse 60, and respirations 22. -The type of injury was noted as "swelling" and "knot on head". -The resident's level of consciousness was alert and oriented. -The resident was taken to the ED and was hospitalized. -A message was left for the family member/responsible party at 3:30am. -It was not noted if the physician was notified. -Department of Social Services (DSS) had been notified. -The MA signed the report and dated it 09/03/18.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 19 -The Administrator signed the report and dated it 09/04/18. Review of the Emergency Medical Services (EMS) report dated 09/03/18 revealed: -Upon arrival to the scene at 3:30am, the EMS personnel were met by the facility staff. -Resident #2 was found lying on her right side on the floor of her room. -At 3:35am, Resident's heart rate was 75, and her blood pressure was 148/98. -The resident had a small lump on her head. -The resident was transferred and admitted to the emergency department (ED). Review of the 09/03/18 hospital ED Provider Progress notes for Resident #2 revealed: -Resident #2 was checked in to the ED at 4:07am on 09/03/18. -Resident #2 was diagnosed with a urinary tract infection, had hypothermia (her temperature was 87 degrees Fahrenheit) in the ED upon admission. -Resident #2 began experiencing bradycardia shortly after admission and her heart rate dropped to 28 beats per minute. -Resident #2 then became pulseless and advanced cardiac life support was started with cardio-pulmonary resuscitation. -After about three minutes of resuscitation during which Resident #2 was intubated, she regained a pulse. -Resident #2 had a head CT scan (computed tomography scan) that revealed no intracranial abnormalities but showed her frontal scalp hematoma. -Resident #2 was placed on a ventilator and admitted to the intensive care unit (ICU). -Resident #2 remained on a warming blanket. -Resident #2's prognosis was poor to guarded.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 20 Review of the hospital Provider Progress notes for Resident #2 revealed: -On 09/04/18, Resident #2 remained intubated, in ICU, her prognosis was poor and she was a "do not resuscitate" status. -On 09/05/18, Resident #2's family agreed with comfort measures. Resident #2 was extubated and the plan was to transfer her to a medical/surgical unit. -On 09/06/18, Resident #2 had an order for hospice evaluation. -On 09/07/18, Resident #2 was transferred to the medical floor with comfort measures only. -There were no notes available for 09/08/18-09/10/18. -It was documented for 09/11/18-09/12/18 that Resident #2 was awaiting placement to a Skilled Nursing Facility (SNF). -On 09/13/18 at 11:47am Resident #2 had a bed available at a SNF. -On 09/14/18, Resident #2 was awaiting placement to the SNF. -There were no further progress notes available. Interview with the Special Care Coordinator (SCC) on 10/15/18 at 10:30am revealed: -Resident #2 required total care for all feeding, toileting, ambulation, bathing, dressing, grooming and transfer. -Resident #2 stayed in a wheelchair or in her bed. -Resident #2 did not have a history of falls. -Resident #2 did not have any fall precautions in place. -Resident #2 did not have bed rails, bed alarm, chair alarm or a fall mat. -The facility protocol was to check on each resident every two hours unless there were orders from the primary care physician (PCP) to check on the resident more often.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 21 -Per facility protocol, they did not document resident checks every two hours unless the PCP ordered it specifically for every two hours or more often, or if the staff determined the resident had a lot of falls, they would check on the resident more often and document those checks on a checklist. -Resident #2 was checked on every two hours just like all the other residents. -There was no documentation to show that Resident #2 was checked on every two hours. -She was not working when Resident #2 was found on the floor on 09/03/18 at 3:00am. -She was told the staff were performing rounds and found Resident #2 on the floor. -She came to work on the 1st shift on 09/03/18 and called the hospital at 10:00am and received confirmation that Resident #2 was admitted. Interview on 10/15/18 at 11:45am with a personal care aide (PCA) revealed: -Resident #2 required total care. -Resident #2 always sat in her wheelchair or laid in her bed. -She was not aware if Resident #2 fell often. -Resident #2 was not on any fall precautions. -Resident #2 was checked on every two hours but it was not documented unless the PCP ordered to check on them more often. Interview with the Administrator on 10/15/18 at 11:50am revealed: -Resident #2 was found on the floor of her room on 09/03/18 around 3:00am. -After the PCA found her, another PCA came into the room with the medication aide (MA). -She had been told by staff that Resident #2 "moved around a lot" and had fallen before. -Resident #2 had fallen in July because she moved around a lot in her bed. -The July fall had been reported to the PCP but	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 22 she did not know if any additional orders were received from the PCP for additional precautions. -She knew the staff checked on all residents every two hours and that included Resident #2. -There were no other fall precautions in place for Resident #2 after her previous falls. -She had just found out that the every two hour checks on residents was not documented by the PCAs. -She had thought the staff documented every two hour checks on all residents. -She knew there was a different check sheet for every 15 minute checks but thought the PCAs documented the every two hour checks on the resident daily Personal Care Record. -She would implement a check sheet for every two hour checks on all residents to be signed off by the PCAs. Interview with Resident #2's family member on 10/16/18 at 11:30am revealed: -Resident #2 had experienced several falls in the last year. -After Resident #2 was admitted to the hospital for her fall on 09/03/18, she had asked the Administrator what had been done as a result of Resident #2's falls, and the Administrator told her that the previous administrator had not put anything in place but that she would work on it. -She was not called by the facility about Resident #2's fall on 09/03/18. -After Resident #2 was admitted on 09/03/18 to the hospital, the Administrator told her that the facility would get Resident #2 a lower bed with a fall mat beside the bed. -She had asked to see the video recording of the night Resident #2 was found on the floor, but the Administrator had not yet provided it. -Several PCAs had recently told Resident #2's family member that Resident #2 needed to be	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 23 admitted to a skilled nursing facility (SNF) because she required total care and that they had told the Administrator. Interview with Resident #2's primary care provider (PCP) on 10/16/18 at 12:20pm revealed: -She started working with the facility the end of July 2018. -She did not know about all of Resident #2's falls. -Her expectation was that the facility would report all of Resident #2's falls to her. -She saw Resident #2 on 07/31/18, for a follow-up to anemia, hypertension and cognitive communication disorder. -She saw Resident #2 on 08/30/18, for a follow-up to insomnia and fall from the wheelchair. She noted to continue to monitor the resident. -If she knew that Resident #2 had multiple falls, she would have contacted the family for input regarding the use of a concaved mattress or a floor mat beside the bed; whatever the family prefers she would work with them. -Any resident that had a fall, she would see them for follow-up on her next visit to the facility, if not required sooner. Interview with a MA on 10/17/18 at 10:30am revealed: -She gave medications to Resident #2 when she worked. -Resident #2 required two person assist. -Resident #2 could roll side to side in the bed and sit up on her own. -Resident #2 was not on any type of fall precautions and she had not been told to do anything additional for Resident #2 regarding falls. -When she first started working at the facility in January 2018, she had asked specifically if	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 24 Resident #2 had a floor mat since she rolled around in the bed but could not walk. -She told the SCC that Resident #2 needed a floor mat beside her bed but they never got her one. -A lot of the staff thought Resident #2 needed to be in a SNF facility because she required total care. -She knew that the PCAs were to check on all residents every two hours, and if they were a wanderer, the PCAs should check on them every 15 minutes. -She assumed they checked on Resident #2 every two hours. -She had given Resident #2 her medications crushed in pudding on 09/02/18 at 7:30pm or 8:00pm and Resident #2 was in the bed at that time and "appeared fine". Confidential interview with a staff member revealed: -Resident #2 was a two person assist. -Resident #2 would roll back and forth in her bed. -Resident #2 could sit on the side of her bed but needed assistance. -All residents were to be checked on every two hours but it was not documented. -If a resident was to be checked every 15 minutes it was documented on a checklist. -Resident #2 was supposed to be checked every two hours. -The night Resident #2 was found on the floor (09/03/18), there were three PCAs and one MA working on the SCU. -One of the PCAs working that night recalled seeing Resident #2 at 11:00pm and again at 1:00am and both times she was in her bed. -The PCA assigned to Resident #2 was not seen entering Resident #2's room but "that does not mean the PCA did not check on her".	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 25 -The PCA that found Resident #2 was not assigned to her but was walking by her room at 3:00am looking for another resident and saw Resident #2 laying on the floor. -The PCA that found Resident #2 immediately got the MA to go to Resident #2's room. -The PCA that was assigned to Resident #2 was found in another room sitting in a chair with her head down at the time Resident #2 was found. -The PCA assigned to Resident #2 that night was seen sleeping once or twice that night. -Another PCA working on the SCU that night had also been seen sleeping that night. -The MA working that night (09/03/18) Resident #2 was found on the floor had also been seen sleeping once or twice that night but "maybe not in a deep sleep". -The Administrator had been told several times before that Resident #2 needed more assistance and needed to be in a SNF facility. Interview with a second MA on 10/17/18 at 12:30pm revealed: -She was working as a MA on the night Resident #2 was found on the floor (09/03/18). -Resident #2 was totally dependent for her care and needed two people for transfers. -Resident #2 was assigned to two hour checks. -Resident #2 had falls and she could roll off the bed. -There were no additional measures put in place for Resident #2 with regards to falls prevention. -She had not told the Administrator about her concerns regarding Resident #2 falling because she thought the Administrator knew it. -She had seen Resident #2 in her bed at 11:00pm that night when she did her rounds right after coming on duty and then again at 1:00am she saw her in her bed. -She had not seen Resident #2 anymore that	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 26 night until she was found by a PCA laying in the middle of the floor in her room. -She assumed the PCA assigned to Resident #2 checked on her every two hours that night. -Resident #2's roommate came out of their room and said in the hallway "the baby is on the floor", and that's when the PCA went into their room and found Resident #2 on the floor. -Resident #2 did not appear injured, she was just looking around the room. -She called 911 to have Resident #2 transported to the ED since she was not sure how Resident #2 even got to the middle of the room on the floor. Interview with a family member of another SCU resident on 10/11/18 at 1:15pm revealed: -She often visited the SCU at 3:00am and 4:00am and had seen on several occasions staff sleeping. -She had reported all of the instances to the Administrator. -She felt that the staff on the SCU need more training on how to work with those residents. Refer to interview with the Administrator on 10/16/18 at 10:10am. 2. Review of Resident #1 current FL2 dated 8/7/18 revealed: -Diagnoses that included Alzheimer's, large cerebral infarct, hearing loss, hypertension, seizures, possible cerebral lesion. -Resident #1 was semi ambulatory, constantly disoriented, had wandering behavior and used a walker. Review of Resident #1's care plan dated 08/04/2018 revealed: -Resident #1 needed supervision with toileting, was totally dependent for ambulation, bathing,	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 27 dressing and grooming and needed supervision with transfers. -The resident ambulates himself with supervision. -Resident is on 15min checks for wandering behaviors. -There was no documentation of fall prevention interventions for Resident #1. Review of an Accident/Injury report dated 06/12/18 at 5:45pm revealed: -Resident #1 was getting up from the chair after eating dinner and lost his balance and fell backwards on his bottom. -Type of injury was documented as none present. -Resident #1's blood pressure was 146/88, pulse was 93, and respirations were 17. -Resident #1 was sent to the emergency room via emergency medical service (EMS) for evaluation. Review of Resident #1's emergency room progress note dated 06/12/18 revealed: -Resident #1 was seen for a fall and non traumatic fracture of L4 lumbar vertebra. -Resident #1 was prescribed Tramadol 50mg (used for moderately severe pain) every 8 hours as needed for pain. -Resident #1 was discharged back to the facility. There was no documentation of fall prevention measures implemented for Resident #1 after the fall on 06/12/18. Review of Accident/Injury report dated 08/10/18 at 10:00am revealed: -Resident #1 started to get up and walk from the dining room table and lost his balance and fell forward on the floor hitting his head on the left side. -Type of injury was none present. -Resident #1 was unable to state what happened.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 28 -Resident #1 blood pressure was 132/78, pulse 67 and respirations 16. -Resident #1 was sent to the emergency room via EMS. Review of Resident #1's emergency room progress note dated 08/10/18 revealed: -Resident #1 was seen for a fall and hematoma of right forehead. -Resident #1 had a computed tomography scan (CT scan) of the head that showed no acute intracranial hemorrhage. -Resident #1 had a CT scan of the cervical spine that showed no compression fracture. -Resident #1 was discharged back to the facility. There was no documentation of fall prevention measures implemented for Resident #1 after the fall on 08/10/18. Review of Resident #1's Accident/Injury report dated 09/20/18 revealed: -At 6:30pm Resident #1 was sitting on his bottom by his bed. -Type of injury was documented as none present. -Resident #1's blood pressure was 128/64, pulse was 61, and respiration was 18. -Resident #1 was not sent to the hospital for evaluation. Review of daily communication log dated 09/21/18 third shift (11:00pm-7:00am) revealed, Resident #1 was sent to the emergency room for right hip and leg pain. Review of emergency room provider notes for Resident #1 dated 09/22/18 revealed: -Resident #1 had a fracture of the right hip with rotation. -Resident #1 needed surgical repair of the right	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 29 hip. Attempted interview with Resident #1 revealed, he was not available for interview during the survey. Interview with special care coordinator (SCC) on 10/16/18 at 4:05pm revealed: -There had not been any increase in supervision for Resident #1 due to falls. -Resident #1 was on 15 minute checks for wandering. -The staff knew of the 15 minute checks on Resident #1. -They did not document 15 minute checks on Resident #1. Interview with the primary care provider on 10/16/18 at 12:00pm revealed: -She had been coming to the facility to see residents since the end of July 2018 (not sure of date). -She was aware that Resident #1 was having an increase in falls. -She was not aware of any increase in supervision to prevent falls implemented at the facility for Resident #1. -She had suggested in her visit note dated 08/14/18 that Resident #1 be up-graded to skilled nursing facility (SNF) due to repeated falls, at the current facilities discretion. -She did not remember if she discussed this with the facility management. -She did not indicate a time frame that Resident #1 should be moved to a skilled nursing facility. Review of the facilities Fall Risk Policy provided by the Administrator revealed, Physical and/or Occupational Therapy will assess residents that is determined to be at risk of having fall and when	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 30 a fall occurs. During assessment, it will be determined what assistive devices are necessary to help prevent falls from occurring and minimize the chance of injury from falls that do occur, including but not limited to, low beds, bedside mats, walkers, wheel chairs and cushions and other positioning devices.	D 270		
	Interview with the facilities Physical Therapy provider on 10/16/18 at 11:30am revealed: -Resident #1 had been receiving physical therapy at the facility from 06/28/18 thru 09/21/18, he was discharged because he was not at the facility. -She had not gotten any fall information on Resident #1. Telephone interview with Resident #1's guardian on 10/17/18 at 9:25am revealed: -Resident #1 usually walked with a walker. -Resident #1 fell many times at the facility. -The facility would call him to notify him when Resident #1 fell (can't remember number of falls or dates of falls). -He was concerned about Resident #1 falling so frequently, but he never spoke to anyone at the facility about how the falls could be prevented. -Resident #1 was currently at a rehabilitation facility recovering from hip surgery. Refer to interview with the Administrator on 10/16/18 at 10:10am. Interview with the Administrator on 10/16/18 at 10:10am revealed: -She knew of the facility fall policy. -She realized the fall policy has not been implemented. -She had made implementing the fall risk policy a top priority recently (no date specified). -She realized (no date stated)) that there have			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 270	Continued From page 31 been a lot of falls at the facility. -She started tracking the falls from April 2018 thru July 2018 on a log. -The previous RCC left at the end of August 2018. -The SCC, assistant RCC and Administrator covered the duties of the RCC. -The new RCC is scheduled to start working on 10/22/18. -She would start the fall risk meetings when the new RCC started working at the facility. The facility failed to provide supervision in accordance with the needs for two residents with Alzheimer's, and a history of multiple falls with no increase in supervision, with Resident #1 sustaining multiple injuries including a fractured hip; and Resident #2 found on the floor of her bedroom and was admitted to the hospital with hypothermia. This failure constitutes a Type A1 Violation for serious physical harm and neglect. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/16/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2018.	D 270		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 32 This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 1 of 5 sampled residents (Residents #1) by delaying immediate transport to the emergency department (ED) for Resident #1 who complained of hip pain after a fall that resulted in a fractured hip. The findings are: 1.Review of Resident #1's current FL-2 dated 08/07/18 revealed diagnoses that included Alzheimer's, large cerebral infarct, hearing loss, Hypertension, seizures, possible cerebral lesion. Review of an Accident/Injury report for Resident #1 dated 09/20/18 revealed: -The time of the incident was documented as 6:30pm. -The description of the event was documented as "resident was sitting on his bottom by his bed". -The description of the injury was none. -The residents vital signs were documented as blood pressure was 124/64, temperature was 97.4, pulse was 61, respirations was 18. Interview on 10/15/18 at 3:12pm with the medication aide (MA) that completed the Accident/Injury report for Resident #1 on 9/20/18 at 6:30pm revealed: -Resident #1 was found sitting on the floor in his room next to his bed. -It took two staff to help him up and sit him on his	D 273	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10/18/18 Facility Survey Consultant All orders, follow-up and referrals are to be faxed to Primary care Physicians, Home Health agencies, therapy, specialists, etc. and followed up by RCC. All referrals and follow-ups are to be reported to the Administrator weekly. Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10/18/18 Facility Survey Consultant Administrator and/or RCC are to be notified of all accidents/incidents to determine if Resident needs to be sent to the Emergency Department.	~~10/15/18~~ ~~10/15/18~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 33 bed. -He did not seem to have any pain when they sat him on his bed. -He did not complain of any pain. -The staff did not have him attempt to walk with his walker. -The MA "checked him out" to see if he was injured. -She did not see any bruising or injury. -She did not think Resident #1 hit his head. -She left a message for Resident #1's primary care provider and his family member. -She does not usually document 30 minute checks. -She told the next shift MA about Resident #1's fall, but she was sure she documented it on the shift daily communication log. Review of the Daily Communication Log for 09/20/18 second shift (3:00pm-11:00pm) revealed, there was no documentation on the log that Resident #1 had fallen. Interview with a personal care aide (PCA) on 10/15/18 at 3:50pm who worked on Resident #1's unit on 09/20/18 and 09/21/18 second shift revealed: -Staff usually send a resident out to the hospital to be checked after a fall. -She was not sure why Resident #1 was not "sent out" to be checked. -When she worked on 09/21/18 she saw Resident #1 in a wheelchair. -Another staff told her Resident #1 could not walk. -Resident #1 did not have his own wheelchair. -She was not sure where the wheelchair that Resident #1 was sitting in came from. Telephone interview with the MA 10/17/18 at	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 34 1:39pm who worked the third shift (11:00pm-7:00am) on 09/20/18 revealed: -She did not see any documentation in the Daily Communication Log that Resident #1 had fallen on the previous shift. -No one had verbally reported to her that Resident #1 had fallen on the previous shift. -In the morning on 09/21/18 about 5:30am the PCA came to her and told her Resident #1 was complaining of right leg pain. -She went to talk to Resident #1 between 5:30am-6:00am. -Resident #1 did not talk much and he told her he was "OK". -"It was hard to tell what is going on with him". -She did not remember if she reported his right hip pain to next shift. There was no Daily Communication Log available for the first shift (7:00am-3:00pm) on 09/21/18. Interview on 10/16/18 at 4:30pm with a MA/PCA who worked on 09/21/18 first shift revealed: -She saw Resident #1 sitting in the dining room in the wheelchair at breakfast time in the dining room. -She did not see him walking on 09/21/18 during the first shift. -Resident #1 would usually walk with his walker. -She was not sure if he was having any pain in his right hip. Review of Daily Communication Log for 09/21/18 for the second shift (3:00pm-11:00pm) revealed, there was no documentation about Resident #1 in the log. Interview with on 10/15/18 at 2:40pm with a PCA that worked the second shift (3:00pm-11:00pm) on 09/21/18 revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 35 -She could not remember if she saw Resident #1 walking with his walker or if he was in the wheelchair. -She did not remember if Resident #1 was complaining of pain. Telephone interview on 10/16/18 with a MA that worked the third shift (11:00pm-7:00am) on 09/21/18 revealed: -There was no note in the log about Resident #1 falling. -She did not know that Resident #1 had fallen on 09/20/18 at 6:30pm. -The PCA came to her at about 5:00am to report Resident #1 was complaining of right hip pain when she was changing him. - When she checked Resident #1 he could not move very much. -She did not know that Resident #1 had been using a wheel chair. -Resident #1 usually walked with a walker. -She called the special care coordinator (SCC) on 09/22/18 at 5:30am and reported Resident #1's was having right hip pain and the special care unit coordinator directed her to call 911 and send him to the hospital. Review of the Emergency Room Provider Records dated 09/22/18 at 7:31am revealed: -Resident #1 had a fall out of bed 2 days ago. -Resident #1 had an X-ray today that revealed a fractured right hip. -Resident #1 needed to have surgical repair of his right hip fracture. Attempted interview with Resident #1 revealed he was not available for interview during the survey. Interview with the SCC on 10/12/18 at 10:10am revealed:	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 36 -Resident #1 was using a wheelchair on 09/21/18 because he was having pain in his right leg and hip area. -Resident #1 usually ambulated with a walker. -Resident #1 would sometimes fall when he had a seizure. -Sometimes he was sent to the emergency room (ER) and would be admitted to the hospital. -She was not sure why Resident #1 didn't go to the ER to be checked when he fell on 09/20/18. Interview with the Administrator on 10/15/18 at 3:35pm revealed: -When a resident had a fall the MA should check them out for any pain or injury. -The staff did not send everyone out to the ER when they fall. -She thought any resident that fell should be sent to the hospital for evaluation. -The staff did not always call her when they send a resident to the ER. -She expected the staff to notify her or the residential care coordinator (RCC) when a resident is sent to the ER. -The RCC left at the end of August 2018 and the new RCC starts in a few weeks. -The assistant RCC, SCC and the Administrator were sharing the RCC duties. -It was not reported to her Resident #1 fell on 09/20/18 at 6:30pm. -She was not sure if the assistant RCC or the SCC knew of Resident #1's fall on 09/20/18 at 6:30pm. -She was not aware of the fall until she signed the Accident/Injury report on 09/24/18. Interview with the special SCC on 10/16/18 at 4:05pm revealed: -A resident that has an unwitnessed fall should be sent to the ER for evaluation.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 37 -Resident #1 should have been sent to the ER after the fall on 09/20/18 at 6:30pm. -She was not sure why Resident #1 was not sent to the ER to be evaluated after the fall on 09/20/18 at 6:30pm -The MA did not complete the Accident/Injury report for Resident #1's fall on 09/20/18 until 09/21/18. -Accident/Injury reports should be completed during the shift the incident occured. -She was not sure why the MA didn't complete the report until 09/21/18. Interview with the PCP on 10/16/18 at 12:00pm revealed: -She did not see the Accident/Injury report for Resident #1 because she comes to the facility on Tuesday's and Thursday's to check the residents. -If Resident #1 fell on Thursday (09/20/18 evening she would not be back to the facility until Tuesday. -She was not sure if she got the message left by the MA on 09/20/18 at 6:45pm about Resident #1 falling. -She usually reviewed ER discharge paperwork when she came to the facility on her regular visit days of Tuesdays and Thursdays. -If Resident #1 had a change in condition such as not walking after a fall she would expect the facility to send him to the ER for evaluation. -She was surprised that the facility did not send Resident #1 to the ER for evaluation after the fall on 09/20/18. Telephone interview with Resident #1's guardian on 10/17/18 at 9:25am revealed: -Resident #1 usually ambulated with a walker. -Resident #1 fell many times. -The facility would call him to notify him of Resident #1's falls.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 273	Continued From page 38 -Resident #1 was sent to the hospital for falls in the past but he could not remember the dates of any of the falls or hospital visits. -He could not remember if he was notified of the fall on 09/20/18. -Resident #1 had surgery on his right hip to repair it a few weeks ago (not sure of the date). -Resident #1 is in the Rehabilitation facility recovering. _____ The facility failed to notify the provider for Resident #1 who complained of hip pain after a fall that resulted in a fractured hip, but was not transported to the emergency department until 36 hours later, which resulted in serious physical harm and neglect which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2018.	D 273		
D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure the kitchen area was free of	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 282	Continued From page 39 contamination including chipped and flaking paint at the opening of the convection oven, dark baked on material on the top of the stove around the six burners and inside of all the ovens including the oven hood switch area. The findings are: Observation of the facility kitchen area on 10/10/18 at 3:10pm revealed: -The stove had dried black baked on material around all six burners. -The knobs on the stove and oven were sticky. -The inside of all three ovens had black baked on material. -The inside of the convection oven door had brown baked on material. -The knobs on the front panel of the convection oven were sticky. -Two of the knobs on the convection oven were covered with rust and one of those knobs was missing the protective plastic covering. -The panel across the front top of the convection oven had four 1 ½ inch diameter areas of chipped paint, and the other areas of the panel had paint flaking and cracked. -The panel across the front top of the convection oven was directly above the oven doors where food was put in and taken out of the oven. -The convection oven was in use and had a large covered tray of food being cooked. Interview with the Kitchen Manager on 10/10/18 at 3:50pm revealed: -There was not a written weekly cleaning schedule. -The dietary aides were supposed to wipe down and clean everything in the kitchen daily. -The floors in the kitchen were mopped daily. -Once per week, the kitchen had a deep cleaning.	D 282	Stove and convection oven have Been deep cleaned and a new stove And convection oven have been Ordered for replacement.	12/10/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 282	Continued From page 40 -She was responsible to ensure the cleaning was completed daily and the deep cleaning weekly. -The top of the stove and oven have had the black baked material on it for a long time. -They clean the stove daily but the material cannot be removed. -The paint chipping on the convection oven had been that way for a long time. -She had reported the paint chipping and the buildup of black baked material to the Administrator a few months ago. Interview with the Administrator on 10/11/18 at 10:00am revealed: -She supervised the kitchen staff along with the Kitchen Manager; they both share the role. -The Kitchen Manager should be sure the cleaning was completed by the dietary staff daily and weekly. -She tried to go into the kitchen two times a week to follow-up and check to see if the kitchen was clean. -She did not know of the black baked material on the stove tops. -The two ovens below the stove top were broken. -They planned on purchasing a new oven and stove soon. -She did not know of the paint chipping on the convection front panel. -She took a picture of the paint chipping/convection oven and sent it to the facility owner requesting a replacement. -She understood the chipping paint was a hazard and would work immediately on that issue.	D 282		
D 287	10A NCAC 13F .0904(b)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 287	Continued From page 41 (b) Food Preparation and Service in Adult Care Homes: (2) Table service shall include a napkin and non-disposable place setting consisting of at least a knife, fork, spoon, plate and beverage containers. Exceptions may be made on an individual basis and shall be based on documented needs or preferences of the resident. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure each table service included a non-disposable place setting consisting of a knife, fork, and spoon. The findings are: Observation of the small dining room on the assisted living (AL) side of the facility on 10/11/18 at 8:23am revealed: -There were 5 tables each with 3 sets of dinnerware left from the breakfast meal waiting to be cleared. -Each plate at every table had only a plastic spoon and fork. -There were no knives available on any table. Observation of the main dining room on the AL side of the facility on 10/11/18 at 11:35am revealed: -The dietary aide (DA) had set up the twelve tables each with three plastic utensil bags. -There were no knives in the utensil bags. -All of the spoons were plastic. -Half of the bags had plastic forks and the other half had metal forks.	D 287	It is the policy of Wilson Assisted Living to only use plastic/paper goods only in times of emergency. Any Shortage of tableware is to be reported to the Administrator for replacements. Replacement silverware was purchased to cover entire building and dietary staff have been in-serviced on this policy/regulation requirement. Administrator or designee to Follow up weekly.	~~10/12/18~~

Amended by telephone on 12/13/18 with Administrator.
New Correction Date: 10/18/18
Facility Survey Consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 287	Continued From page 42 Observation of the lunch meal in the main dining on the AL side on 10/11/18 between 11:35am and 12:10pm revealed: -Each resident was served a chicken patty. -All of the residents were holding their chicken patty in place with their forks as they tore the meat with their fingers. -Approximately half of the residents had plastic forks and spoons. -None of the residents had knives. Interview with 3 residents during the lunch meal in the AL main dining room on 10/11/18 at 11:50am revealed: -They received at least one plastic utensil with each meal. -Sometimes they get a metal fork and a plastic spoon. -The knives were in short supply for unknown reasons. -They had been getting mixed plastic and metal utensils at different times over the past year. -They thought that the dishwasher person at the facility did not have time to clean the metal utensils from the previous meal so they received plastic utensils. -They would prefer to receive metal utensils. -They wanted a knife with each meal. -They got used to using their fingers to tear the meat or using the side of a metal fork if they received one. -They could not recall the last time they had a metal spoon. -They had never complained to staff or the Administrator about having plastic utensils. Observation of the special care unit dining room on 10/11/18 at 8:00am revealed: -There were nine residents eating breakfast. -All were served their meal with a plastic fork and	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 287	Continued From page 43 spoon. Observation of the special care unit dining room on 10/11/18 at 12:00pm revealed: -There were thirteen residents seated as the personal care aides (PCAs) set each place setting with a metal fork, plastic spoon and a napkin. -There were no knives given to residents. -Three residents ate their chicken patty holding it with their fork and tore the patty with their fingers. -Ten of the residents ate the chicken patty with their fingers only. Observation of the kitchen pantry on 10/11/18 at 8:31am revealed: -There were two boxes of 1000 count plastic forks, 2 boxes of 1000 count plastic spoons and 2 boxes of 1000 count plastic knives. -One opened box of forks was approximately 25% full. Interview with the dietary aide (DA) on 10/11/18 at 12:30pm revealed: -Utensils were placed in plastic sheath bags for each table setting. -She assembled the utensils in the bags and placed them on the tables. -She acquired the utensils for the bags from the available metal utensils and frequently mixed them with the plastic utensils when the metal ones were not available. -The utensil bags were frequently filled with only a plastic spoon and plastic fork. -A resident could ask for any utensil if there was one missing from the bag. -The facility had metal utensils but plastic utensils were substituted as the supply dwindled . -The facility's metal forks, knives and spoons were often "hoarded" by some of the residents.	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 287	Continued From page 44 -The Dietary Manager was notified when supplies were low including utensils. -The facility had just received new plastic forks, knives and spoons a few days ago. -The facility ordered plastic forks, knives and spoons on a monthly basis for the last few months. -Plastic forks, knives and spoons were ordered every one or two weeks. -The facility occasionally received metal utensils but they gradually ended up missing after resident meals. -Metal knives were in short supply. -She was unaware that non-disposable utensils were to be provided to residents. -She was unaware that a fork, knife and spoon were to be provided to residents at each meal. Attempted interview with the Dietary Manager on 10/11/18 at 12:30pm was unsuccessful. Interview with the Administrator on 10/12/18 at 9:30am revealed: -She was unaware that the residents were being served plastic utensils on a regular basis. -The facility ordered plastic utensils during the recent hurricane but they were for emergency purposes and not for daily usage. -She ordered replacement metal utensil when the Dietary Manager requested them. -She recently ordered metal utensils "a few months ago" and would provide the receipt. -The facility had a couple of "hoarders" who took utensils to their rooms. -She needed to go room to room and reacquire all of the utensils. -She would assess the amount of metal utensils needed after a room to room check for lost utensils. -She would place another order for replacement	D 287		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 287	Continued From page 45 metal utensils. -She would reeducate her staff that all residents should receive a place setting containing a non-disposable fork, knife and spoon at each meal. Review of the most recent receipt from the facility's utensil supplier dated 05/16/18 revealed: -There were five boxes of 12-count stainless steel spoons ordered by the DA. -There were five boxes of 12-count stainless steel knives were ordered the DA. -There were five boxes of 12-count stainless steel forks were ordered the DA.	D 287		
D 306	10A NCAC 13F .0904(d)(3)(H) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (3) Daily menus for regular diets shall include the following: (H) Water and Other Beverages: Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure water was served with meals to all residents. The findings are: Review of the 2018 Menu of Week 2 revealed "beverage of choice" included on the menu for breakfast, lunch and dinner for each day of the week. Observation of the breakfast meal in the assisted	D 306	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10/18/18 Facility Survey Consultant It is the policy of Wilson Assisted Living to serve water with all 3 meals as required by 10A NCAC 13F. 0904 (d)(3)(H). Staff have been in-serviced on this requirement. Administrator or designee to follow up daily.	~~10/12/18~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 306	Continued From page 46 living (AL) dining room on 10/11/18 between 8:00 to 8:30am revealed: -Twenty-three residents were in the main dining room eating breakfast. -There were twelve residents in the small dining room eating breakfast. -Each resident was served milk and juice with their meal. -There was no water served to any of the residents throughout the meal. -There was no water offered to any of the residents throughout the meal. Interview with seven residents in the AL dining room on 10/11/18 between 8:20am to 8:30am revealed: -Water was never served with meals. -The only water they served was with medication administration. -The residents did not request water with meals. -They had never seen water poured for any of the other residents. -They could not recall the last time water was served with any meal. Observation of the lunch meal 10/11/18 between 11:35am and 12:10pm revealed: -Twenty-two residents were in the main dining room eating lunch. -There were twelve residents in the small dining room eating lunch. -Each resident was served tea with their meal. -There was no water served to any of the residents throughout the meal. Interviews with six residents on 10/11/18 between 12:00pm and 12:10pm revealed: -Water was never served with meals unless a resident requested it. -If water was served at each meal, they would	D 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 306	Continued From page 47 drink the water. -They could not recall the last time water was served with any meal. -The residents never requested water to be served with their meal. Interview with the dietary aide on 10/11/18 at 2:45pm revealed: -Water was not served with meals. -She was not told to serve water with meals. -She did not offer water during their meal. -The residents received orange juice, milk and coffee at breakfast but no water. -The residents received tea or another beverage with lunch and dinner but no water. -She did not know that water was supposed to be served with all meals. -She would ensure residents received water with all meals. Attempted interview with the Dietary Manager on 10/11/18 at 12:30pm was unsuccessful. Interview with the Administrator on 10/12/18 at 9:30am revealed: -She supervised the Dietary Manager over the kitchen staff. -She was unaware that water was not being served with meals. -None of the residents had mentioned not receiving water with their meals. -She would educate the dietary staff that all residents are required to be served water with each meal. -She would ensure all residents received water with their meals.	D 306		
D 338	10A NCAC 13F .0909 Resident Rights	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 48 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations, record reviews and interviews, the facility failed to protect 1 of 1 residents (Resident #5) from injury and abuse by who had been assaulted by a family member at the facility, subsequently sent to the hospital, initially diagnosed with a contusion of right knee and later diagnosed with a femoral hip fracture. The findings are: Review of Resident #5's FL-2 dated 04/13/18 revealed: -Diagnoses included senile dementia, diabetes mellitus type 2 (DM2), hypertension (HTN), anemia, esophageal, reflux, phlebitis leg, and hyperlipidemia. -Resident #5 was semi-ambulatory. Review of Resident #5's Resident Register revealed he was admitted to the facility on 07/08/11 and the family member was Resident #5's responsible party. Review of Resident #5's Care Notes dated 07/30/18 revealed:	D 338	Amended by telephone on 12/13/18 with Administrator. New Correction Date: 10/18/18 Facility Survey Consultant All incidences of accident, injury, inappropriate touching and physical assaults are to be documented on the accident/injury report for each person involved and turned in to the Administrator promptly. In the event of inappropriate touching or assault of a Resident, the Administrator is to be contacted immediately by phone if not on premises, as well as, Management on duty. Any allegation of inappropriate touching and/or physical assault, will be reported to the Police Dept., DSS and Resident will be sent to the hospital for evaluation. Management has been in-serviced on this protocol.	~~8/15/18~~

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 49 -Resident #5 was sent to the Emergency Room (ER) complaining of right knee pain. -He returned back to facility with a diagnosis of contusion of right knee. -Resident #5 was to follow-up with his primary care physician (PCP) in 2 days then follow-up with the Orthopedist on 08/01/18. Review of Resident #5's ER Provider Record dated 07/30/18 revealed: -Resident #5 arrived at the ER at 4:44pm with a chief complaint of pain in his right knee. -Resident #5 stated he fell earlier when he argued with his family member and lost his balance. -He was discharged at 7:28pm with a diagnosis of contusion of right knee. Review of Resident #5's Care Notes dated 08/01/18 revealed a diagnosis of fracture of right hip after a follow-up visit with an Orthopedist. Telephone interview with a former personal care aide (PCA) on 08/03/18 at 12:15pm revealed: -Resident #5's family member who was also the responsible party came to the facility after being called by a staff who informed him that Resident #5 was refusing to take his bath. -Resident #5's family member came into the facility into Resident #5's room and "was punching him like he was fighting somebody outside." -The Administrator said "Well, we can't do anything about it because that's his family." Interview with the Administrator on 08/03/18 at 2:45pm revealed: -She "did not know how to push forward with the story she got." -Resident #5 refused to take a shower.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 50 -Resident #5's family member came to the facility that evening or late afternoon before 5:00pm while she was still there. -There was some kind of altercation from what she was told between Resident #5 and his family member. -A personal care aide (PCA) came to her office and said "no, something went on between Resident #5 and his family member because he was refusing to take a shower." -The Administrator asked if Resident #5 hit his head and staff said no. -The Administrator asked if Resident #5 hit his "bottom" and staff said yes. -The Administrator stated she was thinking "ok, so he has fallen." -She understood that the family member was there only to visit. -The story she received was that Resident #5 and his family member had "some type of weird fighting relationship" and she was not told about it prior to this incident. -They could not get Resident #5 to stand up after the incident. -She went to Resident #5's room and observed him sitting in his rollator seat with his foot turned. -The former Resident Care Coordinator (RCC) and another PCA got Resident #5 in the shower when the RCC observed the bruises on Resident #5's leg. -Resident #5 was complaining about his right leg hurting when she went to his room. -The family member was still in Resident #5's room standing in the doorway while the staff had Resident #5 sitting in the hall in his rollator right outside his door. -The Administrator asked Resident #5 what was wrong and Resident #5 said he was hurting. -She asked him if it was his leg and he said yes. -She asked him if it was his knee and he said that	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 51 he had always had problems with that knee. -She asked Resident #5 if he was hurting anywhere else because the RCC had informed her of bruises on Resident #5's left hip or thigh and those were bruises they had never seen before. -She asked Resident #5 what happened and he said he fell. -She asked Resident #5's family member if he hit his head and he said "no, he fell straight back." -The Administrator asked Resident #5's family member what he did to cause Resident #5 to be hurt and the family member did not give a clear answer while shaking his fist. -Resident #5's family member said Resident #5 "backed up like he was going to fight and when [the family member] jumped back at him, [Resident #5] fell." -She did not give a reason why she did not speak to the two PCAs who were working the evening of the assault. -Resident #5's family member said Resident #5 was hurt because he did not want to take a shower. -The Administrator told Resident #5's family member "he's never acted like that here with anyone else." -She had not questioned the two PCAs whom she was told witnessed the event. -Resident #5 did not tell her what happened to him. -The RCC told her that Resident #5 was not going to say anything with his family member present. -Resident #5 was sent to the hospital Monday evening (07/30/18) and he returned with a contusion of the right knee. -She was in her office when Resident #5 was being sent out [to the hospital]. -When she asked why Resident #5 was being	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 52 sent out to the hospital, staff stated Resident #5 fell. -She was out all day Tuesday (07/31/18) and when she returned to the office Wednesday (08/01/18), one of the PCAs told her that they were unable to get Resident #5 out of the bed as he was in pain and would not stand up. -Resident #5 had a follow-up appointment with the orthopedist after the hospital visit. -Resident #5 was sent to the hospital on 08/01/18 by the orthopedist because his hip was broken. -She knew something was not right and questioned what really went on in Resident #5's room between the resident and his family member. -The family member told her Resident #5 fell when he was in the room. -She did not want to confront the family member who reportedly assaulted Resident #5 because she did not see it with her own eyes and she was going off of the information provided to her. -She did not want to falsely accuse anyone and their security cameras were only going to show what went on in the hallways. -She did not call the police as she would not know what to say unless she got a PCA to give a first-hand report. -She could not say if the PCAs witnessed the event first-hand. -The 2nd shift PCA and the former RCC were around when she questioned Resident #5 and his family member, but they did not see what happened. -She did not know if the family member called out for assistance when Resident #5 fell. -She was told was that Resident #5 needed help in the shower and that the family member was called to assist. -She did not know anything about the alleged assault until after Resident #5 had gotten his	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 53 shower and was dressed. -Resident #5 would have needed assistance getting up from the floor but she did not know which staff had assisted Resident #5 in getting up. Interview with the former RCC on 08/03/18 at 3:05 pm revealed: -She was not a witness to the altercation, but was told that Resident #5's family member came to the facility to make him take a shower and fought with Resident #5. -A staff member had informed the former RCC that Resident #5's family member was fighting him. -She was not sure if staff actually witnessed the altercation. -She went to the Administrator's office and told her Resident #5 was sent to the hospital after a fight. -No one told the Administrator there was a witnessed altercation between Resident #5 and his family member. -She told the Administrator that she was going to send Resident #5 out because she was informed that Resident #5 and his family member were fighting. -She asked the Administrator to go to Resident #5's room with her to talk with Resident #5 and his family member. Review of Resident #5's hospital Discharge Summary dated 08/06/18 revealed: -Resident #5 was admitted to the hospital at 12:43pm on 08/01/18. -Resident #5 admitting diagnosis was femoral neck fracture (hip fracture). -A right hip hemiarthroplasty was performed on 08/03/18 due to the right femoral neck fracture. -Resident #5 was discharged on 08/09/18 to a	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 54 skilled nursing home. Interview with Resident #5 on 08/07/18 at 11:25am revealed: -He was in the hospital because he "fell backward bam" and broke his leg and hip bone. -He fell on his visiting family member when the family member came into his room at the facility. -After he fell, his family member jumped up, started laughing and saying "ha ha ha, you fell." -His family member had "stomped" on his foot and would not help him up. -His family member came in arguing with him because he did not want to take a shower. -His family member should be ashamed of himself for knocking him down and coming in his room to fight. -He tried to fight back but he lost his balance and fell. -Staff saw his family member push Resident #5 off him. -He identified the staff who witnessed the altercation but did not know their names. -After the altercation, he said his leg was hurting. Interview with a 1st shift medication aide (MA) on 08/07/18 at 1:45pm revealed: -The family member had been to the facility several times before and said to Resident #5 "oh you going to take a bath today." -The family member was very demanding with Resident #5 and tried to make him take a bath. -The family member had been to the facility on previous occasions to try to make Resident #5 take a bath, but had never put his hands on Resident #5. -The family member never physically fought Resident #5 prior to 07/30/18. -When she returned to work the next day Resident #5 was sitting in his room with his leg	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 55 propped up with a portable cast from the hospital. -Resident #5 said that his family member pushed, kicked and "stomped down" on him. -Resident #5 said his family member slammed him down in a rocking chair "on account of a bath." -Resident #5's roommate told her his family member fought with Resident #5. -She heard about the altercation when she returned to work the next day. -The Administrator did not interview her about the incident. Interview with the former RCC on 08/07/18 at 2:15pm revealed: -A staff came to her office and told the RCC about the altercation between Resident #5 and his family member. -She interviewed Resident #5 about the altercation while he was sitting in his chair. -The staff told her that his family member was in Resident 5's room fighting him. -She went to the Administrator's office and told her "I was not a witness, but it was told to me that Resident #5's family member fought him and jumped on him and you need to come down here with me." -The Administrator went to Resident #5's room and asked him what happened and Resident #5 did not answer. -The Administrator asked what happened again and Resident #5's family member said he fell. -The Administrator asked the family member how Resident #5 fell and he stated he tripped. -She noticed a bruise on Resident #5's left hip when the PCA was getting him ready for his bath. -The RCC asked the PCA to help her give Resident #5 a bath and get him dressed so she could send him to the hospital due to the bruised area that was hurting him.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 56 -She told the Administrator she was sending Resident #5 to the hospital. -The facility's protocol was to call the police if there was an alleged assault that was or was not witnessed. -The Administrator should have called the police when she was told that Resident #5's family member jumped on him. -Other PCAs heard the commotion causing one PCA to inform the RCC that something was going on. -The 1st shift medication aide (MA) told her on 08/01/18 that she saw the entire assault incident. Interview with the 1st shift MA and former RCC on 08/07/18 at 2:45pm revealed: -The 1st shift MA was at the facility the day of incident and witnessed the entire assault. -The 1st shift MA saw Resident #5's family member grab Resident #5, slam him to the floor and kick him. -She did not tell anyone what she saw until two days later when she reported it to the RCC when she found out Resident #5 went to the hospital on 07/30/18 for contusion of the knee and subsequently the orthopedist on 08/01/18. Interview on 08/07/18 at 3:30pm with the Administrator revealed: -The facility's protocol was to call the police, contact DSS and send resident to the emergency department (ED) if the resident had been assaulted. -She didn't automatically think that the report of a fight meant that it was a physical fight. -"Fighting can mean anything including fussing and arguing." -The family member did not seem to be agitated or upset when she went to the room. -She was out of the office 07/31/18, he went to	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 57 the orthopedist on 08/01/18 and she did not hear any more about the incident until DSS came in on 08/03/18. -When she asked the family member on 08/05/18 about the event, the family member told her that Resident #5 lost his balance, stood up too fast and his feet slipped from under him. -The family member told her two different statements within five minutes. Review of the police department's Incident/Investigation Report dated 08/15/18 revealed: -Adult Protective Services (APS) contacted the police department on 08/15/18. -Resident #5's family member picked up Resident #5 from his wheelchair by the collar of his shirt, slamming him to the ground and kicking him. -The family member was arrested on 09/30/18 and charged with felony assault inflicting serious injury. The facility's failure to protect Resident #5 from an aggressive assault by a family member resulted in physical harm in the form of a broken hip and contusion to his knee. The facility's failure resulted in serious physical harm and neglect. This constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/13/18 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2018.	D 338		
D 358	10A NCAC 13F .1004(a) Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 58 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews and record reviews the facility failed to ensure medications were available for administration for 5 of 10 residents sampled (Residents #3, #4, #7, #8, and #9) observed during the medication passes including errors with anxiety medication (#3), a medication to regulate phosphate levels (#4), a blood pressure medication (#7), and a medication for constipation (#8 and #9); and to administer medication as ordered by the prescribing physician for 1 of 5 sampled residents (#6) who did not receive a blood thinner due to the medication being unavailable. The findings are: 1. The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities during the morning medication pass	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 59 on 10/10/18, and 10/11/18. a. Review of Resident #8's current FL2 dated 09/18/18 revealed: -Diagnoses included acute kidney failure, dysphagia, hyperlipidemia, muscle weakness, obstructive uropathy and intestinal obstruction. -Review of Resident #8's current FL2 medication orders dated 09/18/18 revealed, there was an order for Linzess 145 mcg take one daily (used to treat constipation). -Review of the electronic medication record (eMAR) on 10/11/18 at 10:15am revealed, there was an entry for Linzess 145mcg take one daily. Observation of the medication pass on 10/10/18 at 10:15am revealed, there was no Linzess 145mcg capsules on the medication cart to administer to Resident #8. Interview with the medication aide (MA) on 10/10/18 at 10:15am revealed: -She was not sure why the Linzess was not on the cart. -Somebody might have forgotten to order it. -Medication was supposed to be ordered when it was down to a 7 day supply. -She thought that 3rd shift was checking to be sure medications were ordered. -Medications could be reordered on the eMAR. -She would order it right now and it should come in tonight. -She would have reorded it if she gave the last pill. Based on observations interviews and record reviews it was determined Resident #8 was not interviewable.	D 358	It is the policy of Wilson Assisted Living to ensure all prescribed medications are in the facility and available for distribution as prescribed. Medications are to be reordered when down to 7 day supply. Medication Communication Logs are on every Med Cart. A 3rd shift med aide responsibility form has been reviewed and signed by all current and new Med Aide and is kept in their personnel file. These additions include, but are not limited to, Med delivery check-ins, checking med logs, stocking med carts, ordering needed medications, who ordered meds and when, date of arrival and follow-up notes. RCC or Administrators designee to check med logs daily to ensure proper follow-up. Med carts are audited weekly by RCC, Administrator or Administrator's designee.	~~10/11/18~~

Amended by telephone on 12/13/18 with Administrator.
New Correction Date: 10/18/18
Facility Survey Consultant

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 60 Refer to Interview with the Administrator on 10/15/18 at 10:32am b. Review of Resident #7's current FL2 dated 07/16/18 revealed: -Diagnoses included unilateral osteoarthritis of right knee, history of falling, difficulty walking, hypertension and traumatic amputation of left arm. -Review of Resident #7's current FL2 medication orders dated 07/16/18 revealed, there was an order for Amlodipine 5mg daily (used to treat high blood pressure). Review of the eMAR on 10/10/18 at 10:20am revealed an entry for Amlodipine 5mg daily. Observation of the medication pass on 10/10/18 at 10:20am revealed, there was no Amlodipine 5mg tablets on the medication cart to administer to Resident #7. Interview with the medication aide (MA) on 10/10/18 at 10:20am revealed: -She was not sure why the Amlodipine was not on the cart. -When she checked the medication room the Amlodipine was not in the medication room. -The electronic medication record (eMAR) system showed it had been ordered (no date specified). -She was not sure why it did not come in. -She would call the pharmacy and check on it. Based on observation interviews and record reviews it was determined that Resident #7 was not interviewable. Interview with the primary care provider (PCP) on 10/17/18 at 12:00pm revealed: -Resident #7 should receive all his medication as	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 61 ordered. -He might have elevated blood pressure if he missed his Amlodipine. Refer to the interview with the Administrator on 10/15/18 at 10:32am. c. Review of Resident #9's current FL2 dated 10/4/18 revealed: -Diagnoses included dementia, dehydration, metabolic encephalopathy, hypertension, gastroesophageal reflux disease (GERD) and osteoporosis. -Review of Resident #9's current FL2 medication orders dated 10/04/18 revealed there was an order for Miralax 17gm (used to treat constipation) in 8 ounces of water and administer every other day. Review of the eMAR on 10/11/18 at 9:12am revealed the Miralax was due to be administered on 10/11/18 at 8:00am. Observation of the medication pass on 10/11/18 at 9:12am revealed Resident #9 had an empty bottle of Miralax on the medication cart. Interview with the medication aide (MA) on 10/11/18 at 9:15am revealed: -Resident #9's family member usually purchased her Miralax. -She was not sure why someone had not asked the family member to purchase it. -Resident #9's family visited almost every day. -She would ask the family member to pickup the Miralax today. Based on observations, interviews, and record reviews it was determined Resident #9 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 62 Interview with Resident #9's family member on 10/11/18 at 9:20am revealed: -She would buy the Miralax for Resident #9 when the MA told her they needed it. -The MA had not mentioned to her until today that they needed the Miralax. Refer to interview with the Administrator on 10/15/18 at 10:32am. d. Review of Resident #4's current FL2 dated 03/01/18 revealed diagnoses that included hypertension, osteoarthritis, reflux and aortic aneurysm. Review of Resident #4's current medication orders on 10/15/18 revealed there was an order for Auryxia 210mg (used to control phosphate levels in patients with chronic kidney disease) to be given daily written on 10/05/18. Review of the eMAR on 10/10/18 at 10:22am revealed Auryxia was scheduled for administration at 10/10/18 at 8:00am. Observation of the medication pass on 10/10/18 at 10:22am revealed Resident #4 had no Auryxia on the medication cart to administer to Resident #4. Interview with the medication aide (MA) on 10/10/18 at 10:22am revealed: -The order was a new order written on 10/05/18 according to the computer. -The medication should have been on the cart but has not come in yet. -She could not explain why the medication was not on the cart since 10/05/18. -She had not given the medication before to	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 63 Resident #4. -She had been off for a few days and the medication probably came over on the weekend. -Resident #4 paid for her own medications so it probably was not available because she used a 3rd party provider for all of her medications. -She would have to ask the Administrator about the status of Resident #4's Auryxia. Interview with Resident #4 on 10/10/18 at 10:26am revealed: -She ordered her own medications through her pharmacy provider. -She knew her medication regimen. -She did not know that she was prescribed Auryxia on 10/5/18. -She did not know what Auryxia was for and had not taken it in the past. -She thought that Auryxia was a medication her provider must have put her on it recently. -She was not surprised that her medications were not on the cart "because they often run out." -The MAs reminded her to reorder them when her medications were "getting low." -The Administrator was aware that she approved all of her own prescribed medication purchases through her own pharmacy. Interview with the Administrator on 10/10/18 at 1:04pm revealed: -Resident #4 received her medications through another pharmacy and was the only person who could authorize payment and processing of her medications. -Every time Resident #4 was ordered a new medication there was often a delay because Resident #4 had to give a verbal approval by phone to send it because she was the recipient of the medication and her insurance would not let staff order on her behalf.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 64 -She had not ordered Auryxia via the backup pharmacy. -She was not told that there was a new order for Auryxia and that it had not yet arrived since being ordered on 10/05/18. -Since the old resident care coordinator (RCC) left, the medication aides were not checking to ensure that all medications were on the cart. -She would check on Resident #4's Auryxia and with her provider to see if it needed to be ordered from the backup pharmacy. Attempted interview with Resident #4's PCP on 10/16/18 at 9:45am was unsuccessful. Refer to interview with the Administrator on 10/15/18 at 10:32am. e. Review of Resident #3's current FL-2 dated 05/30/18 revealed: -Diagnoses included non-traumatic intracerebral hemorrhage in hemisphere, cortical hemorrhage of cerebrum, unspecified loss of consciousness, dysphagia, oropharyngeal phase, chronic obstructive pulmonary disease, essential hypertension, muscle weakness and hyperlipidemia. -A physician's order for Ativan 0.5mg (used to treat anxiety) three times a day as needed (PRN). -A physician's order for Ativan 0.25mg three times a day for anxiety. Review of Resident #3's electronic medication administration record (eMAR) revealed: -There was an entry for Ativan 0.25mg to be taken three times daily for anxiety at 8:00am, 2:00pm and 8:00pm. -There was an entry for Ativan 0.5mg to be taken PRN for anxiety.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 65 Observation of the medication pass on 10/10/18 at 10:06am revealed: -The 8:00am scheduled administration for Resident #3 appeared on the eMAR as still awaiting to be administered. -The MA removed Resident #3's Ativan 0.25mg card from the medication cart which was empty. -The MA clicked on the eMAR on screen and documented that the medication was not available on the cart and "in route." -The MA removed Resident #3's Ativan 0.5mg PRN card and administered one tablet to Resident #3. -The MA clicked on the PRN administration on screen and input the reason "for anxiety." -The scheduled administration of Ativan 0.25mg was documented "not given" and the Ativan 0.5mg PRN dose was documented as administered. Interview with the medication aide (MA) on 10/10/18 at 10:08am revealed: -The scheduled daily Ativan medication card had been ordered but not yet arrived so she used the PRN Ativan medication card instead. -She did not know when the Ativan refill was ordered. -She was unaware that the scheduled Ativan dosage was 0.25mg and the PRN Ativan dosage was 0.5mg. -She had recently used the PRN card on three occasions this week since the regularly scheduled Ativan card was not available. -She did not get approval to use PRN card in lieu of the schedule Ativan card. -She had not checked to see why the scheduled Ativan had not arrived. Review of Resident #3's electronic medication administration record (eMAR) on the med cart's	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 66 computer screen revealed: -There was an onscreen tab where medications could be refilled by the MA. -The area of the computer screen displaying the status of a refill for Ativan 0.25mg showed that there was no refill request made. -The earliest suggested refill date for Ativan 0.25mg was 10/06/18. -There were 4 PRN administrations recorded for Ativan 0.5mg documented as administerered at 8:00am on 10/06/18, 10/07/18, 10/09/18 and 10/10/18. -Ativan 0.25mg was documented as not given on 10/06/18 at 8:00am and 2:00pm. -Ativan 0.25mg was documented as not given on 10/07/18 at 8:00am, 2:00pm and 8:00pm. -Ativan 0.25mg was documented as not given on 10/08/18 at 2:00pm and 8:00pm. -Ativan 0.25mg was documented as not given on 10/10/18 at 8:00am. -The onscreen reason for Ativan 0.25mg not given as ordered was "med not available" documented by the MA. Interview with the MA on 10/10/18 at 10:16am revealed: -She was supposed to order any medication when they were "down to the last 7 pills." -She did not order the Ativan 0.25mg but was certain it had been previously ordered prior to running out on 10/06/18. -She immediately checked the eMAR system and realized that it was not ordered after checking the order history. -She had not checked to see if a refill of Ativan had previously been ordered prior to 10/10/18. -She immediately placed a refill request at 10:16am for Ativan 0.25mg. -The former resident care coordinator (RCC) always checked to ensure the medications did not	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 67 run out. -Each MA was supposed to order medications on screen when any medication for any resident was low on supply. Interview with the Administrator on 10/10/18 at 10:18am revealed: -She could not explain why there was an empty card of Ativan 0.25mg and there were no other cards available on the cart. -The MAs were expected to read the dosages on the medication labels. -There was no excuse for giving the wrong dosage. -She was unaware that the MAs were using a PRN card of Ativan with a different dosage. -PRN medications were not to be used in lieu of scheduled medications. -MAs were expected to put in an on-screen refill request for any medications for any resident that were "down to the last week." Interview with Resident #3's primary care provider (PCP) on 10/16/18 at 10:55am revealed: -She was aware of Resident #3 and her diagnoses. -She was unaware that Resident #3 received 8 doses of Ativan 0.5mg between 10/06/18 and 10/10/18 instead of the scheduled 0.25mg dose. -She expected the MAs to adhere to the proper dosage and medication card. Interview with the facility's pharmacy provider on 10/16/18 at 10:30pm revealed: -Resident #3's Ativan 0.25mg was filled regularly each month. -The only time Ativan 0.25mg was filled late was on 10/10/18. -The facility should have run out on 10/06/18 based on refill dates.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 68 -The facility was expected to request a refill before Resident #3's Ativan ran out. -Resident #3's Ativan 0.25mg and 0.5mg were only refilled only at the facility's request and not automatically ordered. Based on observation, record review and interview, Resident #3 was unable to be interviewed. Refer to interview with the Administrator on 10/15/18 at 10:32am. 2. Review of Resident #6's current FL-2 dated 10/02/18 revealed: -Diagnoses included diabetes, cerebral infarction, chronic pain, chronic obstructive pulmonary disease (COPD), diabetes mellitus type 2 and hypertension. -Eliquis 5mg (a blood thinner, used to reduce the risk of stroke and systemic embolism) take one table twice a day. Review of Resident #6's October 2018 electronic medication administration record (eMAR) revealed: -There was an entry for Eliquis 5mg take one tablet twice a day scheduled for 8:00am and 8:00pm. -The Eliquis was documented as not administered due to "awaiting med" on 09/03/18 at 8:00pm. -The Eliquis was documented as not administered due to "enroute from pharmacy" on 09/04/18 at 8:00am. -The Eliquis was documented as administered on 10/05/18 at 8:00am. -The Eliquis was documented as not administered due to "awaiting med" on 10/05/18 at 8:00pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 69 -The Eliquis was documented as not administered due to medication being "en route" on 10/06/18 at 8:00am. -The Eliquis was documented as administered on 10/06/18 at 8:00pm. -The Eliquis was documented as not administered due to medication being "en route" on 10/07/18 at 8:00am. -The Eliquis was documented as administered on 10/07/18 at 8:00pm. -The Eliquis was documented as administered on 10/08/18 at 8:00am. -The Eliquis was documented as administered on 10/08/18 at 8:00pm. -The Eliquis was documented as not administered on 10/09/18 at 8:00am and 8:00pm with a reason given as "awaiting arrival of medication". -The Eliquis was documented as administered on 10/10/18 at 8:00am and 8:00pm. -The Eliquis was documented as administered on 10/11/18 at 8:00am and 8:00pm. Review of the control substance sheet dated 10/08/18 for Eliquis 5mg revealed: -Two tablets of Eliquis 5mg were logged in on the control substance log as amount received on 10/08/18. -One tablet was signed out as given on 10/08/18 at 8:00pm. -The last tablet was signed out as given on 10/10/18 at 8:00am. -Resident #6 missed two doses of Eliquis 5mg from 09/03/18 to 09/04/18. -Resident #6 missed five doses of Eliquis 5mg from 10/05/18 to 10/09/18. Review of the control substance sheet dated 10/11/18 for Eliquis 5mg revealed 60 tablets were logged in on the control substance log as amount	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 70 received on 10/11/18. Interview with Resident #6 on 10/15/18 at 2:45pm revealed: -She constantly ran out of medications on the weekends. -The last time she ran out was on 10/06/18. -She was out of her Eliquis for at least 3 days. -It was very important that she took her blood thinners. -She did not want to miss any doses. Interview with the medication aide (MA) on 10/16/18 at 4:00pm revealed: -Eliquis was not available and arrived from the back up pharmacy on 10/08/18. -The MA made the control substance log for the two Eliquis on the cart for 10/08/18. -Awaiting medication in the comment section of the eMAR means no medication was in the building. Telephone interview with a former medication aide (MA) on 10/17/18 at 1:42pm revealed: -Resident #6 was out of Eliquis on 10/06/18 and 10/07/18 for the 8:00pm dose. -Resident #6 was out of Eliquis because the MA that worked the medication cart the previous two days had not reorder the medication like he was supposed to. -The MAs' counted the control medication and the blood thinners. -The MA had called the assistant resident care coordinator (ARCC) on 10/06/18 and informed her that Resident #6 was out of Eliquis. -The ARCC instructed the MA to use another resident's medication and she would handle it when she returned to work on Monday. -The MA reported getting the Eliquis from another resident's supply and giving it to Resident #6.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 71 -The medication should have been ordered prior to Resident #6 running out. -Medications were to be ordered when there were 7 pills remaining. -Medication had not been reordered until Resident #6 was completely out of her medication. -This was not the first time Resident #6 ran out of medication. -Often Resident #6's family member had to get the medication from the back up pharmacy and brought it to the facility. Interview with ARCC on 10/16/18 at 11:05am revealed: -She was not aware Resident #6 ran out of Eliquis on 10/06/18. -MA's were supposed to reorder medications when there were 7 doses left. -When Resident #6 was out of medication, the MAs' would call and get the medication from the back up pharmacy. -The primary care provider (PCP) would write the prescription so that the medication could be picked up from the back up pharmacy. -There was no documentation of when or what medications were called in to the backup pharmacy. Telephone interview with Resident #6's family member on 10/17/18 at 1:55pm revealed: -Resident #6 had only been living at the facility for a little over three months. -Resident #6 frequently ran out of medication, often on the weekends. -She was aware of at least 12 times that Resident #6 had ran out of medications since living at the facility. -The facility staff did not make her aware of when Resident #6 had ran out of medication.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 72 -Resident #6 had informed her when she was out of medication. -On multiple occasions she had to get Resident #6's medication from the back up pharmacy and deliver it to the facility. -The Administrator was made aware of the concerns. -Resident #6's family member addressed the concerns in a letter to the Administrator last week. Telephone interview with the facility's pharmacy provider on 10/16/18 at 9:30am revealed: -Eliquis 5mg was filled on 08/01/18 with 60 tablets dispensed, which would have been a 4 day lapse between refills. -Eliquis 5mg was filled on 09/04/18 with 60 tablets dispensed, which would have been a 5 day lapse between refills. -Eliquis 5mg was filled on 10/10/18 with 60 tablets dispensed. -Resident #6 had missed 18 doses of Eliquis between August 2018 and October 2018 according to the fill history. Interview with the primary care provider (PCP) on 10/16/18 at 12:10pm revealed: -She was not aware of Resident #6 had missed 2 doses of Eliquis between 09/03/18 and 09/04/18, had missed 8 doses of Eliquis in September 2018, had missed 5 doses of Eliquis between 10/05/18 and 10/09/18, had missed 10 doses of Eliquis in October 2018 according to fill dates. -Resident #6 was taking Eliquis due to past history of pulmonary embolism (PE) and stroke. -After 6 missed days of Eliquis, the resident could have "thrown a clot". -She expected for medications to be given as ordered. -She tried to get the MA's to check the medication carts prior to the weekends.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 73 -Residents should not be running out of medications. -She expected to have been notified of Resident #6 running out of Eliquis. -If she would have been notified Resident #6 was out of Eliquis, she would have written a prescription to take to the backup pharmacy over the weekend. Refer to interview with the Administrator on 10/15/18 at 10:32am Interview with the Administrator on 10/15/18 at 10:32am revealed: -The ARCC was expected to perform cart audits weekly to ensure medications were available on the cart and to determine which medications needed to be reordered. -The ARCC and the MAs were expected to follow-up on medications that were reordered to ensure that they arrived at the facility. -When medications for any resident were down to 7 doses, the MAs were expected to reorder. -She was aware the medications were not being reordered when there were 7 or less doses on hand. -The medications arrived and third shift was expected to place the medications on the carts. -She created a new sheet to monitor MA's responsibilities which included reordering of medications and ensuring the medication carts were stocked with medications sent from the pharmacy. -Communication logs were placed on all medication carts as of 10/11/18 to for all MAs to keep up on what medications needed to be ordered as well as to inform other MAs on all shifts of any medication shortages on the carts. -The third shift MA's responsibility was to check-in medications, stock the medication carts,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 74 order needed medications and perform cart audits on a daily basis. -All staff were to follow-up on medication orders if they did not arrive after refill requests before the current supply of a resident's medication ran out. -She would ensure that all cart audits were performed by the designated MAs on a daily basis. -She would perform a weekly cart audit to ensure they were performed properly as of 10/15/18. The facility failured to ensure that medications were available and the proper dosages were administered per provider orders resulting in 25 missed dosesof blood thinner for Resident #6 who had a history of pulmonary embolism (PE) and stroke which increased the risk of blood clots. This failure resulted in substantial risk of serious harm, neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 10/15/18 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED NOVEMBER 16, 2018.	D 358		
D 364	10A NCAC 13F .1004(g) Medication Administration 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by:	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 364	Continued From page 75 Based on observation, interviews and record reviews, the facility failed to assure medications used treat high cholesterol (Resident #8), depression(Resident #3), anxiety (Resident #3), enlarged prostate Resident #8, constipation (Resident #8) and pain (Resident #7) were administered within one hour before or one hour after the scheduled administration time for 3 of 3 residents (Resident #3, #7 and #8) observed during medication pass on 10/10/18 between 10:06am and 10:20am. The findings are: Observation of a medication aide (MA) on 10/10/18 at 10:15am to 10:24am revealed: -The MA was administering medications scheduled for 8:00am on the 100 hall of the facility. -The MA was documenting the administration in the 8:00am area of the electronic medication administration Record (eMAR). Interview with the MA on 10/10/18 at 10:24am revealed: -She was running late with passing out the 8:00am morning medications. -She was usually done with the morning medications pass by 10:00am. -There were a lot of medications to pass in the morning and it was hard to complete them before 9:00am. 1. Review of Resident #8's current FL2 dated 09/18/18 revealed diagnoses of acute kidney failure, hyperlipidemia, muscle weakness, obstructive uropathy and intestinal obstruction. Observation of the Resident #8's medication administration on 10/10/18 at 10:15am revealed	D 364	It is the policy of Wilson Assisted Living to ensure medications are passed in a timely manner by giving meds no more than an hour before or an hour after prescribed times. Adjustment has been made to med pass times to allow Residents to receive medications to required time frames.	10/19/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 364	Continued From page 76 he received aspirin 81 mg (used to help prevent heart disease), atrovastatin 10mg (used to treat high cholesterol levels), tamsulosin 0.4 mg (used to treat enlarged prostate and urinary retention), Senexon-S 8.6-50 mg (used to treat constipation) and Miralax 17gm (used to treat constipation).	D 364		
	Review of Resident #8's eMAR for October 2018 revealed resident revealed: -An entry for of aspirin 81 mg daily at 8:00am. -An entry for atrovastatin 10 mg daily at 8:00am. -An entry for tamsulosin 0.4mg daily at 8:00am give 30 minutes after a meal. -An entry for Senexon-S 8.6-50mg one tablet twice daily at 8:00am and 8:00pm. -An entry for Miralax 17gm mixed in 8 ounces of liquid once daily at 8:00am. Review of medications administered to Resident #8 at 10:15am were initialed by MA on 10/10/18 under 8:00am time. Based on observation, interviews and record review it was determined that Resident #8 was not interviewable. Interview with primary care provider (PCP) on 10/16/18 at 12:00pm revealed: -She expected Resident #8's medications be administered at the prescribed times. -She was not aware that Resident #8's medications were being administered after the prescribed times. Refer to interview with Administrator on 10/11/18 at 10:00am. 2. Review of Resident #7's current FL2 dated 7/16/18 revealed diagnoses included unilateral osteoarthritis of the right knee, history of falling,			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 364	Continued From page 77 difficulty walking, hypertension and traumatic amputation of the left arm. Observation of the Resident #7's medication administration on 10/10/18 at 10:20am revealed themedication aide (MA) administered Percocet 5-325 mg (used to treat moderately to moderately severe pain). The review of Resident #7's eMAR for October 2018 revealed an entry for Percocet 5-325mg twice daily at 8:00am and 8:00pm. Review of medication administered to Resident #7 at 10:20am was initialed by the MA under the 8:00am time. Based on observation, interviews and record reviews it was determined that Resident #7 was not interviewable. Refer to interview with the Administrator on 10/11/18 at 10:00am. 3. Review of Resident #3's current FL2 dated 05/30/18 revealed diagnoses included hypertension, cerebral hemorrhage, dysphagia, chronic obstructive pulmonary disease, history of stroke, and hyperlipidemia. Review of Resident #3's medication administration on 10/10/18 at 10:06am revealed the MA administered buproprion Hcl XL 150mg (used to treat depression), lorazepam 0.5mg (used to treat anxiety), and Nudexta 20-10mg (used to treat outbursts of crying). Review of Resident #3's eMAR for October 2018 revealed: -There was an entry for Buproprion Hcl XL 150mg at 8:00am.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 364	Continued From page 78 -There was an entry for Lorazepam 0.5mg at 8:00am. -There was an entry for Nudexta 20-10mg at 8:00am. Interview with a MA administering medications to Resident #3 on 10/10/18 at 10:08am revealed: -She was late giving Resident #3's 8:00am medications this morning. -Sometimes the MAs ran late when passing medications due to the amount of residents receiving medications at 8:00am. -She knew that the 8:00am medications were supposed to be given between 7:00am and 9:00am. -She usually ran late due to the number of medications scheduled at 8:00am on the 300 hall. -The Administrator knew the 8:00am medications on the 300 hall were frequently given past 10:00am. Review of the eMAR on 10/10/18 at 10:08am revealed the medications administered to Resident #3 at 10:06am were initialed by the MA under the 8:00am time. Based on observation, interviews and record reviews it was determined that Resident #3 was not interviewable. Interview with the PCP on 10/16/18 at 11:35am revealed: -She expected Resident #3 to receive her medications at the scheduled time. -She was unaware that Resident #3 was not receiving her medications at her scheduled times. -She would speak with the Administrator regarding the importance of administering medications at the scheduled times.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 364	Continued From page 79 Refer to interview with the Administrator on 10/11/18 at 10:00am. _____ Interview with the Administrator on 10/11/18 at 10:00am revealed: -The facility's had a previous residential care coordinator (RCC) who left at the end of August 2018. -She hired a new RCC who was scheduled to start in a few weeks. -The RCC usually handled all medication issues. -She was aware of the medications were frequently being given past the hour window. -She had not notified the primary care provider that medications were frequently given late. -She was looking into changing the medication times so they are not all scheduled for 8:00am so they could be given with in the one hour before and after the scheduled time. -She anticipated that the scheduled administrations times would be changed within a week.	D 364		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 451	Continued From page 80 This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the county department of social services of incidents for 2 of 2 sampled Residents (#1 and #2) requiring referral to the emergency department (ED). The findings are: Review of Resident #1's current FL-2 dated 08/07/18 revealed diagnoses included Alzheimer's, large cerebral infarct, hearing loss, Hypertension, seizures, possible cerebral lesion. Review of Accident/Injury report dated 09/20/18 revealed: -The staff completing the report was a medication aide (MA). -The date and time documented on the Accident/Injury report was documented as 09/20/18 at 6:30pm. -Resident #1 was found sitting on his bottom on the floor by his bed. -Type of injury was documented as none. -Level of consciousness was documented as alert and oriented. -Was the resident taken to the emergency room (ER) was documented as no. -The MA signed the report and dated it 09/20/18. -The Administrator signed the Accident/Injury report and dated it on 09/24/18. Attempted interview with Resident #1 revealed, he was not available for interview during the survey. Interview with the MA that completed the Accident/Injury report for Resident #1 dated	D 451	All incidents of accident or injury reports are to be given to the Administrator for review. It is our policy to ensure reports resulting in more than first aid be sent to the county DSS within 48 hours of incidence. It is also the policy to inform family, or responsible party, and physician of any and every incident to resident.	12/5/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 451	Continued From page 81 09/20/18 on 10/15/18 at 3:12pm revealed, after she completed the report she put it on the Special Care Units Coordinator's desk so she could review it when she came in the next day. Interview with the Special Care Coordinator (SCC) on 09/15/18 at 10:10am revealed: -She made a copy of the Accident/Injury report for Resident #1 and put it in her book in her office. -She takes the original report to the Administrators office and puts it on her desk. -It was the Administrators responsibility to fax it to the Department of Social Services (DSS). -She was not sure why the Administrator did not fax the report to DSS. -She was called by the MA aide on 09/22/18 between 5:30am-6:00am when Resident #1 was complaining of right hip pain and she instructed the MA to send him to the ER. Interview with the Administrator on 10/15/18 at 11:30am revealed: -The MA's do the Accident/Injury reports and notify the primary care provider (PCP) and the family members of the incidents. -All falls should have an Accident/Injury report completed even if there is no injury. -She usually reviewed all the Accident/Injury reports daily and signs them off. -Any time a resident is found on the floor it is considered a fall. -She did not see the Accident/Injury report for Resident #1 until she came to work on Monday 09/24/18. -She was responsible for faxing Accident/Injury reports to DSS. -She is not sure why Resident #1's Accident/Injury report dated 09/20/18 did not get faxed to DSS after she signed it.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 451	Continued From page 82 Telephone interview with the county DSS adult home specialist (AHS) on 10/17/18 at 8:30am revealed: -She never received an Accident/Injury report from the facility for Resident #1 dated 09/20/18. -She should receive Accident/Injury reports in 48 hours. 2 .Review of Resident #2's current FL-2 dated 08/07/18 revealed diagnoses included Alzheimer's, insomnia, dementia, gastroesophageal reflux disease, hypertension, and debilitation. Review of Accident/Injury report dated 05/28/18 revealed: -The report was completed by a medication aide (MA). -The date and time of the accident was 05/28/18 at 4:00pm. -Resident #2 had been assisted by staff to the wheelchair. -Resident #2 had leaned forward and fell out of the wheelchair to the floor. -Type of injury was a skin tear. -The resident was taken to the ER but was not hospitalized. -The MA signed the report and dated it 05/28/18. -There was no documentation in the section of the report referring that a regulatory agency had been notified or that Department of Social Services had been notified if treatment was greater than first aide. -The Administrator had not signed the Accident/Injury report. Telephone interview with the county DSS adult home specialist (AHS) on 10/16/18 at 11:00am revealed: -She never received an Accident/Injury report	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 451	Continued From page 83 from the facility for Resident #2 dated 05/28/18. -She should receive Accident/Injury reports in 48 hours. Attempted interview with Resident #2 10/16/18 at 11:30am was unsuccessful. Attempted interview on 10/16/18 at 4:25pm with the MA that completed the Accident/Injury report for Resident #2 dated 05/28/18 was unsuccessful. Interview with the Special Care Coordinator (SCC) on 10/16/18 at 4:26pm revealed: -A copy had been made of the Accident/Injury report for Resident #2 and was in a notebook in her office. -She took the original report to the Administrators office and put it on her desk. -It was the Administrator's responsibility to fax it to the Department of Social Services (DSS). -She was not sure why the Administrator did not fax the report to DSS. -She was aware Resident #2 was sent to the emergency department (ED) on 05/28/18 and treated. Interview with the Administrator on 10/16/18 at 10:10am revealed: -She was not aware that Resident #2 had fallen and an Accident/Injury report dated 05/28/18 was completed and the resident was sent to the ER. -She did not fax the Accident/Injury report to DSS because she did not see the report. -The process was the MA's completed Accident/Injury reports and notified the primary care provider (PCP) and the family members of the incidents. -The SCC would make a copy of the Accident/Injury report and give it to her.	D 451		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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 451	Continued From page 84 -She reviewed all Accident/Injury reports daily and signed them off. -She was the one responsible for faxing DSS all Accident/Injury reports, that resulted in the resident requiring referrral for emergency medical evaluation.	D 451		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to assure every resident had the right to receive care and services which are adequate, appropriate, and in compliance with rules and regulations as related to healthcare referral and follow-up, supervision and medication administration. The findings are: 1. Based on interviews and record reviews, the facility failed to assure referral and follow up for the acute and routine health care needs of 1 of 5 sampled residents (Residents #1) by delaying immediate transport to the emergency department (ED) for Resident #1 who complained of hip pain after a fall that resulted in a fractured hip. [Refer to Tag C0273 10A NCAC 13F .0902(b) Health Care (Type A1 Violation).]	D912	It is the policy of Wilson Assisted Living to provide and promote all of NC Declaration of Resident Rights. All staff have been in-serviced on resident rights. All staff are in-serviced on these rights at hire and yearly thereafter. Amended by telephone on 12/13/18 with Administrator. New Correction Date: 11/16/18 Facility Survey Consultant	12/3/18

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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
D912	Continued From page 85 2. Based on observations, interviews, and record reviews, the facility failed to implement interventions to address the current symptoms and assessed needs for 2 of 5 residents sampled (#1, #2) who each had a diagnosis of Alzheimer's. Resident #1, who had a history of attempting to ambulate without assistance and multiple falls with injuries, sustained a fractured hip. Resident #2, who had a history of multiple falls with injuries, was found on the floor and was admitted to the hospital and died eleven days later. [Refer to Tag C0270 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 3. Based on observations, interviews and record reviews the facility failed to ensure medications were available for administration for 5 of 10 residents sampled (Residents #3, #4, #7, #8, and #9) observed during the medication passes including errors with anxiety medication (#3), a medication to regulate phosphate levels (#4), a blood pressure medication (#7), and a medication for constipation (#8 and #9); and to administer medication as ordered by the prescribing physician for 1 of 5 sampled residents (#6) who did not recieve a blood thinner due to the medication being unavailable. [Refer to Tag C0358 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation).]	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL098027	A. BUILDING: _____ B. WING _____	10/17/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

(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
D914	Continued From page 86 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to assure residents are protected from harm and neglect and in compliance with federal and state laws and rules and regulations related to resident rights. The findings are: 1. Based on observations, record reviews and interviews, the facility failed to protect 1 of 1 residents (Resident #5) from injury and abuse by who had been assaulted by a family member at the facility, subsequently sent to the hospital, initially diagnosed with a contusion of right knee and later diagnosed with a femoral hip fracture. [Refer to Tag C0338 10A NCAC 13F .0909 Resident Rights (Type A1 Violation).]	D914		