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 _____	R-C 07/16/2019

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 Wilson County Department of Social Services conducted a follow up survey and complaint investigation from July 10-12 and July 15-16, 2019. The Wilson County Department of Social Services initiated the complaint on 04/10/19.	D 000		
D 227	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The notices of discharge and appeal rights as required in Paragraph (e) of this Rule shall be made by the facility at least 30 days before the resident is discharged except that notices may be made as soon as practicable when: (1) the resident's health or safety is endangered and the resident's urgent medical needs cannot be met in the facility under Subparagraph (b)(1) of this Rule; or (2) reasons under Subparagraphs (b)(2), (b)(3), and (b)(4) of this Rule exist. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure the Adult Care Home Notice of Discharge form and Adult Care Home Hearing Request form was sent certified mail to the guardian for 1 of 1 sampled resident (#11) who was discharged from the facility 10 days after a medical evaluation by the Nurse Practitioner for skilled nursing care. The findings are: Review of Resident #11's current FL-2 dated 06/24/19 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, insomnia, depression and	D 227		

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D 227	Continued From page 1	D 227		

schizophrenia.

Review of Resident #11's Resident Register on 07/11/19 at 11:34am revealed:
-Resident #11 was admitted to the facility on 01/25/19.
-There was no documentation under the section "Discharge/Transfer Information".

Review of Resident #11's Resident Register on 07/12/19 at 3:36pm revealed:
-There was documentation a discharge was initiated on 06/17/19 by Resident #11's primary care provider (PCP).
-There was documentation Resident #11 was discharged on 06/30/19 due to PCP orders for skilled nursing care.
-There was no documentation the Adult Care Home (ACH) Notice of Discharge was given to Resident #11's guardian.
-Resident #11's guardian had not signed under the section "Discharge/Transfer Information".

Telephone interview with Resident #11's guardian on 07/13/19 at 2:52pm revealed:
-Resident #11 left the facility two weeks ago.
-He was told "at the last minute" about moving Resident #11 to a nursing home; the Administrator called him the Thursday before Resident #11 left the facility (06/27/19).
-The Administrator called to ask him to fill out paperwork without any prior notice.
-He was told Resident #11 was being discharged so there would be staff better able to care for Resident #11.

Telephone interview with Resident #11's family member on 07/15/19 at 6:35pm revealed:
-The facility gave Resident #11's family member a week notice before "they kicked her (Resident

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D 227	Continued From page 2	D 227		

#11) out."
-The family member did not want Resident #11 to go to the nursing home the facility planned to discharge the resident to.
-The family member had a previous bad experience with another family member at nursing home.
-The Administrator told the family member the family could find another facility once Resident #11 was discharged to the nursing home because no other facility would take Resident #11.
-The Administrator had contacted her one week before Resident #11 was discharged (06/30/19).

Interview with a representative of the County Department of Social Services (DSS) on 07/16/19 at 8:41am revealed DSS had not been notified of the planned discharge for Resident #11 to a skilled nursing facility (SNF) prior to the discharge on 06/30/19.

Telephone interview with Resident #11's PCP on 07/15/19 at 11:13am revealed:
-She was concerned and spoke with the Administrator regarding Resident #11 needing skilled nursing care because the resident's needs were more than assisted living could provide.
-She could not remember the exact date she spoke with the Administrator, but thought it was the end of May 2019.
-The facility staff was looking for a SNF, but there were none that wanted to take Resident #11 due to her behaviors.
-Staff had reported Resident #11 was putting herself on the floor and was verbally aggressive.
-She thought Resident #11's guardian was notified of the resident's need to go to a SNF sometime in early June 2019.
-Resident #11 told the PCP her guardian was looking for another facility for her.

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 227	Continued From page 3 Review of PCP visit notes dated 05/02/19 through 06/27/19 revealed: -There was documentation on 06/20/19 that a meeting had occurred between the Administrator and Resident #11 about placement in a nursing home due to the resident being totally dependent with activities of daily living (ADLs). -There was documentation of discharge to a named facility due to increased immobility and requiring total assistance by staff. -There was no documentation of evaluation for skilled nursing care prior to 06/20/19. Interview with the Administrator on 07/12/19 at 11:30am revealed: -Resident #11's behaviors were the reason the PCP "leveled her up" to skilled nursing care. -Resident #11 had mental health issues, required two to three staff to help get her up off the floor and the resident "really could not do much for herself." -Resident #11's needs were beyond the scope of assisted living. Second interview with the Administrator on 07/15/19 at 12:49pm revealed: -There were concerns about the staffs' ability to care for Resident #11 and the Resident Care Coordinator (RCC) discussed the concerns with PCP. -Resident #11's guardian lived out of state. -The RCC contacted Resident #11's guardian by phone two or three weeks prior to the resident being discharged on 06/30/19. -The SNF contacted Resident #11's guardian via email to complete the resident admission paperwork. -She did not think a 30-day discharge notice, ACH Notice of Discharge and ACH Hearing	D 227		

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D 227	Continued From page 4	D 227		

Request form was required when a resident was discharged for medical needs.

Interview with the RCC on 07/15/19 at 5:11pm revealed:
-When the current facility PCP started at the facility, the PCP assessed Resident #11 and said she needed a higher level of care which was either the end of May 2019 or beginning of June 2019.
-The PCP contacted the SNF on 06/17/19 and the RCC contacted Resident #11's guardian the same day and he was at work.
-She contacted Resident #11's guardian again on 06/21/19 but got his voicemail.
-She did not speak with Resident #11's guardian until 06/26/19 regarding the discharge of Resident #11 to the SNF.
-She had not documented any of the contacts or attempted contacts with Resident #11's guardian.
-Resident #11 needed a higher level of care because she was verbally aggressive with staff, had a multiple personality disorder, threw herself on the floor and two to three staff were needed to get her up from the floor.

Second telephone interview with Resident #11's guardian on 07/16/19 at 10:37am revealed:
-He had not received an ACH Notice of Discharge or ACH Hearing Request form.
-He had not been given contact information for the Ombudsman.
-He did not want Resident #11 to go to the nursing home and was not given any time to find another facility.
-The only paperwork he received regarding Resident #11's discharge was from the nursing home.

Third interview with the Administrator on 07/16/19

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 _____	R-C 07/16/2019

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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D 227	Continued From page 5 at 3:35pm revealed: -She did know the ACH Notice of Discharge, ACH Hearing Request form and contact information for the Ombudsman needed to be sent to the guardian when a resident was "skilled up". -Resident #11 had become a two-three person assist with transfers and getting her up from the floor; the resident needed an hydraulic lift, but the facility did not have an hydraulic lift. -The PCP "skilled up" Resident #11; facility staff did not make that decision. -She had not notified DSS Resident #11 was being discharged to a SNF.	D 227		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to assure 1 of 1 sampled resident (#11) received assistance with transfers, mobility and toileting according to the resident's care plan and identified need of assistance from staff.	D 269		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 6 The findings are: Review of Resident #11's current FL-2 dated 06/24/19 revealed: -Diagnoses included hypertension, chronic obstructive pulmonary disease, insomnia, depression and schizophrenia. -There was documentation Resident #11 was intermittently confused and was semi ambulatory. -There was documentation Resident #11 was incontinent of bowel and bladder and needed assistance with bathing, dressing and eating. Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 01/25/19 and discharged on 06/30/19. Review of Resident #11's previous FL-2 dated 01/18/19 revealed: -There was documentation Resident #11 was intermittently confused and was semi ambulatory. -There was documentation Resident #11 was incontinent of bowel and bladder and needed assistance with bathing and dressing. Review of Resident #11's current care plan dated 01/29/19 revealed: -Resident #11 was ambulatory with a wheelchair, had limited upper extremity strength, occasional bowel and bladder incontinence and was sometimes disoriented and forgetful. -Resident #11 needed extensive assistance with eating, toileting, ambulation, bathing, dressing, grooming and transfers. Telephone interview with Resident #11's guardian on 07/13/19 at 2:52pm revealed: -The nursing staff at the facility was "terrible" because they never attended to the residents. -Resident #11 would call him crying often	D 269		

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D 269	Continued From page 7	D 269		

because the staff would not help her.
-Resident #11 had asked for assistance to go to the bathroom when she was sitting outside on the patio and staff did not help her; he could not remember when this happened.
-Resident #11 was incontinent of stool outside on the patio because staff did not help her.
-The staff left Resident #11 outside for 30 minutes sitting in stool before they changed her.
-"No one would call and make up scenarios when they were being mistreated."
-Resident #11 was in a group home prior to the facility and had never called him crying before she was admitted to the facility.
-Resident #11 was not able to stand for long and would end up falling because she tried to do things like get up and use the bathroom by herself.
-Resident #11 would ask staff for help, but she would have to wait a long time before the staff would come and help her.
-Resident #11 fell a lot trying to pick things up from the floor; the staff needed to keep Resident #11's things up higher where she could reach them.
-Resident #11 was able to pick things up from the table.

Telephone interview with Resident #11's family member on 07/15/19 at 6:35pm revealed:
-She received calls from staff approximately three times per week saying Resident #11 had fallen.
-Staff calling to report Resident #11 had fallen started right around the the time the resident was admitted to the facility (01/25/19).
-She left multiple messages over the last couple of months for the Administrator to find out what was going on, but never received a call back.
-Resident #11 said most of the personal care aides (PCAs) ignored her.

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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D 269	Continued From page 8 -Resident #11 would put her call light on for help frequently, staff would not come so Resident #11 would try and do it herself, and fall. -Resident #11 was incontinent and the staff would leave her sitting in urine and stool so the resident would try to take herself to the bathroom and end up falling. Review of Accident/Incident Reports and emergency room (ER) visit summaries for Resident #11 dated 04/05/19 through 06/28/19 revealed: -There were 21 incidents documented with Resident #11 being found on the floor. -There was documentation 11 of the 21 incidents were related to the resident reaching for something and two were from rolling out of the bed. -On 04/06/19, there was ER documentation Resident #11 wanted to go outside, no staff responded, the resident slid out of bed trying to get to her wheelchair, could not reach the call bell and slept on the floor. -On 04/07/19, there was documentation on an accident/incident report another resident found Resident #11 on the floor. -On 04/12/19, there was ER documentation Resident #11 fell from her wheelchair reaching for a drink and sustained a laceration above her left eye. -On 05/06/19, there was ER documentation Resident #11 slipped and fell getting out of bed. -On 05/10/19, there was documentation on an accident/incident report Resident #11 fell on the patio without injury. -There were three accident/incident reports for Resident #11 dated 06/26/19; the resident fell reaching down twice and third time trying to get "stuff" out of her drawer. -There were three falls on 06/28/18; at 2:50pm	D 269		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 9	D 269		

trying to pick up a snack off the floor, at 7:30pm trying to pick toothpaste up off the floor and at 11:26pm the resident was found on the floor and taken to the ER with multiple abrasions.

Review of primary care provider (PCP) visit notes for Resident #11 dated 04/10/19 through 06/27/19 revealed:
-On 04/10/19, there was documentation Resident #11 reported falling when she tried to pick up things and there was an order for a reaching/grabbing tool.
-On 04/24/19, there was documentation Resident #11 was seen for follow up after a fall on 04/22/19 and the resident reported refusing to go to the ER because she was not hurt.
-On 05/29/19, there was documentation Resident #11 was wheelchair bound for most of the day and had areas of excoriation (red and raw skin) on both buttocks.
-On 06/27/19, there was documentation Resident #11 had a fall two days in a row and sustained a contusion and strain of the left hip.

Confidential interview with a staff revealed:
-Staff would have to pull Resident #11 up and back in her wheelchair to keep her from sliding out.
-Staff would have to help reposition Resident #11 whenever she was near the edge of her bed.
-Resident #11 needed two staff to assist with transfers and repositioning.

Interview with a PCA on 07/15/19 at 4:26pm revealed:
-Resident #11 needed a lot of help with getting out of bed, dressing and eating.
-Resident #11 slid out of her wheelchair a lot.
-Resident #11 "would get stiff and just slid out of the chair."

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 10	D 269		

-Resident #11's legs would get stiff and her legs would hang off the bed.
-When she saw Resident #11 "get stiff" she would pull the resident up in her chair or move her away from the edge of the bed.
-Resident #11 needed help with her wheelchair because her hands would get stiff.

Interview with the Dietary Manager (DM) on 07/15/19 at 1:50pm revealed:
-Resident #11 had good days and bad days; the resident needed help with eating her meals.
-Resident #11 used a special spoon; the resident said she could eat better with the plastic spoon.
-Resident #11 needed help with eating because of the trouble with her hands.
-Residents #11's hands looked as if she had a stroke.
-She would help Resident #11 with eating, she "did not mind" helping Resident #11.

Interview with a medication aide (MA) on 07/12/19 at 11:35am revealed:
-Resident #11 only wanted certain PCAs to help her.
-Resident #11 needed to staff to assist her with transfers and toileting.
-Resident #11 would "take and roll herself out of the bed onto the floor."
-The PCAs would put Resident #11 in the bed closest to the wall and Resident #11 would "wiggle" to the side of the bed and then onto the floor.
-She did not witness any of Resident #11's falls.
-"Basically all of the PCAs" said Resident #11 would "throw herself on the floor."
-If the PCAs were busy helping other residents, Resident #11 would get angry and throw herself on the floor.
-Resident #11 needed staff outside with her at all

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 11	D 269		

times because she could not hold a cigarette and would drop it, bend over while seated in the wheelchair to pick up the cigarette and end up falling out of the wheelchair.
-She did not know what other staff did, but she supervised Resident #11 when she could while the resident was outside on the patio.
-There was not enough staff to be outside with resident all of the time.
-Both of Resident #11's hands were contracted as if she had a stroke.
-Staff needed to be with Resident #11 when she was smoking because if she dropped the cigarette on her shirt or her lap, she was not fast enough to get it.
-Resident #11 was able to stand; she had walked by the resident's room at night and seen the resident standing by her wheelchair getting into bed.
-Resident #11 was not able to dress herself.
-Resident #11 required two staff for assistance.
-Resident #11 was "not really" able to propel her wheelchair unassisted; it took the resident 30 minutes to get down the hall.
-Resident #11 would only ask certain PCAs for help with getting things from off the floor.

Interview with a second MA on 07/12/19 at 2:45pm revealed:
-Resident #11 could not walk and needed two staff for transfer and toileting assistance.
-Resident #11 could not propel her own wheelchair and would ask staff for assistance with going outside.
-If Resident #11 asked for something, she wanted it right then.
-Resident #11 did not want staff "disrespecting her or being rough" with her.
-She was unable to clarify what was being disrespectful and rough.

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 269	Continued From page 12 Telephone interview with a third MA on 07/13/19 at 9:24pm revealed: -If staff gave Resident #11 a snack, the resident would drop the snack on the floor and then fall from her chair trying to pick it up. -Sometimes Resident #11 fell from her bed trying to turn around. -Resident #11 needed one to two staff for assistance with transfers and toileting; if the staff was big and strong, they could help Resident #11 by themselves. -If Resident #11 wanted to go outside and smoke a cigarette when staff went into assist the resident with toileting and incontinence care, she would cuss at staff. -Resident #11 was not able to stand or walk on her own; the resident was able to stand with assistance. -Resident #11 was not able to hold things in her hands firmly; that was why the resident dropped things. -It took Resident #11 a long time to propel her wheelchair. -Staff tried to keep the resident close to staff in the hallway near the front desk so staff could see what she was doing. -Staff tried to keep the resident clean and try so she would not try to get up on her own. -Resident #11 had a bedside table and staff would keep the table close to the resident. -Staff would put Resident #11's drinks, snacks and cigarettes on the bedside table. -The Resident Care Coordinator (RCC) and Administrator were aware of Resident #11's falls because each time the resident fell, the MA completed an incident/accident report which went to the RCC and then the Administrator. Telephone interview with a fourth MA on 07/15/19	D 269		

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 _____	R-C 07/16/2019

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

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D 269	Continued From page 13 at 7:06pm revealed: -Resident #11 slid out of her chair a lot trying to pick something up off the floor. -Resident #11 needed a lot of help from staff. -Resident #11 was not able to stand and needed a lot of staff to transfer her because of the problems with the resident's legs. -Resident #11's legs would get stiff and then the resident would not be able to put weight on her leg. -The pain in Resident #11's legs had gotten worse and made it hard for the resident to stand. -Resident #11 needed toileting and incontinence care assistance; she was able to eat unassisted. -Resident #11 was able to pick things up if it was on a table. -She did not know why Resident #11 fell frequently from picking items up from the floor; "maybe she dropped it, threw it or knocked it down." -Staff tried to keep Resident #11 where they could see the resident; she did not let the resident go outside alone because Resident #11 was a fall risk. Interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 07/15/19 at 10:41am revealed: -She saw Resident #11 lean forward in her chair and slide to the floor; Resident #11 told her she was trying to reach for a cup. -Resident #11 was able to use her feet to propel her wheelchair. -Resident #11 needed two to three staff to get her up when she fell. -Resident #11 needed two staff for assistance when she was admitted to the facility (01/25/19), but then she needed three staff for assistance. -Resident #11 needed staff assistance with toileting, incontinence care, bathing and dressing.	D 269		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 269	Continued From page 14 Telephone interview with Resident #11's Physical Therapist (PT) on 07/16/19 at 11:55am revealed: -Resident #11 had weakness in both upper extremities with one arm being worse than the other. -Resident #11 had decreased strength and range of motion in both arms. -Resident #11 required maximum assistance with transfer with two staff for safety. -He would "not trust" Resident #11 to bend over and pick something up from the floor while seated in her wheelchair. -Resident #11 had poor center or sitting balance and it would be a fall risk for the resident to lean forward and pick something up from the floor. -He did not recall whether Resident #11 had a reaching/grabbing tool. Telephone interview with Resident #11's PCP on 07/15/19 at 11:13am revealed: -Resident #11 was totally dependent on staff with transfers. -Staff reported Resident #11 was putting herself on the floor and was verbally aggressive. -She saw Resident #11 transfer from her wheelchair to her bed; the resident had bad lower extremity weakness and needed two staff for assistance. -Resident #11 needed staff assistance with toileting, incontinence care and personal hygiene. -Resident #11 was able to feed herself. -Resident #11 did not have any deformities of her hands; the resident apparently had some weakness or neuropathy in her hands which was why she dropped things. Interview with the RCC on 07/15/19 at 5:11pm revealed: -Resident #11 needed a higher level of care	D 269		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 269	Continued From page 15 because she was verbally aggressive with staff, had mental health issues, threw herself on the floor and two to three staff were needed to get her up from the floor. -It was difficult for staff to assist Resident #11 with transfers, toileting and incontinence care. -It took two to three staff to assist with transferring Resident #11; two to three staff were not always available at the same time. -It was difficult for staff to manage Resident #11's falls because of her behaviors. -Resident #11 did have problems with holding things in her hands. -Some of Resident #11's fall were from the resident trying to pick things up from the floor. -Resident #11 did not get the grabbing reaching tool because it was not covered by her insurance and she did not have the money to pay for it. Interview with the Administrator on 07/12/19 at 11:30am revealed: -The staff were not always able to provide assistance with transfers, toileting and incontinence care for Resident #11. -Resident #11 had mental health issues, required two to three staff to help get her up off the floor and the resident "really could not do much for herself."	D 269		
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.	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 _____	R-C 07/16/2019

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

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D 270	Continued From page 16	D 270		

This Rule is not met as evidenced by:
TYPE A2 VIOLATION

Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 7 sampled residents (#4, #5, and #10) including a resident (#4) who left the facility by climbing over the special care unit secured fence two times unsupervised, and two residents (#4, and #10) who sustained multiple falls in 6 months resulting in injuries and visits to the emergency room.

The findings are:

1. Review of Resident #5's current FL-2 dated 5/21/19 revealed:
-Diagnoses included Alzheimer's, glaucoma/bullious kerapathy, hypertension and malnutrition.
-The resident was constantly disoriented and wandered.
-The resident was ambulatory.
-The resident's current level of care was domicillary/special care unit.

Review of Resident #5's care plan dated 5/10/19 revealed;
-The resident had significant memory loss and wandered.
-The resident required supervision with ambulation.

Review of an Accident/Incident Report Resident

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 270	Continued From page 17	D 270		

#5 dated 06/30/19 revealed:
-At 6:30 p.m., Resident #5 wandered away from the facility, was found and sent to the emergency room (ER) for evaluation due to dementia, confusing behavior.
-The resident was observed by staff after dinner sitting in the secured back patio area.
-The Resident #5 was alone.
-At 6:00 p.m., emergency medical services (EMS) transported Resident #5 to the hospital.
-Resident #5's Primary Care Provider (PCP) notified by way of the nurse line at 8:56 a.m.
-Resident #5 had swelling on his right knee.

Confidential staff interview revealed:
-Resident #5 had tried to leave the facility two times prior to the 6/30/10 incident.
-Resident #5 had tried to jump over the fence on the secured patio and he walked out the front door to the special care unit (SCU).
-The staff could not remember when Resident #5 tried to leave the SCU before, but knew it happened on 1st or 2nd shift during the first week of May 2019.

Interview with a 2nd shift medication aide (MA) on 07/12/19 at 11:26 a.m. revealed:
-At dinner on 06/30/19, Resident #5 seemed agitated and was mumbling he was "ready to go" and he "gotta go."
-Dinner was served "a little after 5:00 p.m."
-Resident #5 went outside and sat on the patio (outside secured area) alone after he finished eating.
-She was passing medications and saw Resident #5 sitting alone on the patio with a bath cloth over his head.
-The last time she saw Resident #5 was at approximately 5:30 p.m.
-She thought Resident #5 came back in because

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	D 270		

he was not on the patio.
-At 6:00 p.m., his 6 p.m. medication popped up on the medication administration record (MAR), but she did not give it to him.
-She did not look for him because she was helping with other residents.
-Another MA asked her where Resident #5 was because she just got a call from the local police department informing her Resident #5 was being transported to the hospital because the resident had walked away from the facility, through the woods and was found by a citizen who lived in a nearby subdivision in a park (about 7/10 of a mile away from the facility).
-Resident #5 "had a busted knee" when he returned from the hospital.

Confidential staff interview on 07/12/19 revealed:
-06/30/19 was not the first time Resident #5 got out of the facility unsupervised.
-About a month ago, Resident #5 was agitated and went out the double door exit but he was brought back in by a staff.
-Resident #5's room was close to the double door exit (leading to the assisted living unit) but was later moved because he followed a family and went out the double doors in May 2019.
-The staff did not know how long the resident was out of the SCU.
The resident remained on 30 minute checks.
-On Monday, July 1, 2019, Resident #5's room was changed to a room in a location because of the June 30, 2019 incident.
-Resident #5 was on 15 minute checks after the 6/30/19 elopement, but management took him off 15 minutes checks on July 11, 2019 and put him back to 30 minute checks.
-Resident #5 continued to be checked every 30 minutes when he was in bed.
-Facility staff did not know Resident #5 had

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 _____	R-C 07/16/2019

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

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D 270	Continued From page 19	D 270		

eloped on 06/30/19 until the police called and asked if Resident #5 was a resident at the facility.

Interview with Administrator on 07/11/2019 at 4:00p.m. revealed:
-She was "unsure" if there is a system in place to make sure staff were following whatever the facility's policy and practice was about checking residents.
-Staff checked residents every 2 hours and the 2 hour checks were documented.
-Supervisory checks were done more frequently with different residents in the SCU.
-Some Residents were placed on 15 minute checks since that 06/30/19 incident and that was continuous.
-Overall, staff check residents every 2 hours, but the special care coordinator changed it to every 30 minutes after the 06/30/elopement by Resident #5.
-Resident #5 was on 2 hour checks like everyone else prior to the 06/30/2019 incident.
-The Administrator was unaware of an earlier incident when Resident #5 attempted to elope.
-The Administrator was only aware of the incident on 6/30/19 when the resident walked out the double door behind someone.
-Because of that incident, his room was moved to a more central part of the hallway a few days later where the MA was usually located and was put on 15 minute checks.
-The day Resident #5 went over the fence, she changed the policy about residents going outdoors. If any resident wanted to go outside, they had to be accompanied by staff.

Interview with the special care coordinator (SCC) on 07/15/19 at 12:38pm revealed:
-She did not work the weekend of 06/30/2019 but was called and informed around 5:00 - 5:15 p.m.

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 _____	R-C 07/16/2019

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

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D 270	Continued From page 20	D 270		

that Resident #5 was missing.
- Th local police department called and asked if Resident #5 was a resident of the facility .
-Resident #5 had climbed over the fence, was found, and taken to the ER.
-Resident #5 had never wandered off before.
-Resident #5 had followed a visitor out of the double door exit (into the AL unit) in May 2019 but a staff sitting at the front hall nurses' station saw him and took him back in the SCU.
-Resident #5 was on 2 hour check (when in his room in bed asleep) and 30 minute check when awake or out of his room.
-After the 06/30/2019 incident, his room was moved to a central location on the SCU and he was put on a 15 minute check and was still on that now.
-Before 06/30/2019, residents could go outside alone, but residents could not go outside alone now.

Interview with Resident #5's family member on 07/15/2019 at 12:46 p.m. revealed:
-06/30/19 was not the first time Resident #5 eloped from the facility, this was the first time the staff did not know he was gone.
-Sometime in April 2019, Resident #5 was on the patio, stood on a chair and jumped over the fence.
-Staff reported that a staff was outside with him and had "just turned her back for a moment."
-On 06/30/2019, staff reported that Resident #5 was "outside alone, climbed over the fence, went through the woods and ran up on a man fishing in a pond."
-Staff called the family member at 7:45 p.m. and informed her that Resident #5 had been gone about thirty-five (35) minutes and they did not know where he was.
-Staff reported to the family that the police took

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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	D 270		

Resident #5 to the ER.
-The family member was told by the Administrator that Resident #5 pressed the door's security code and went out the door.
-Before Resident #5's family consented to admit him to the facility, they discussed their concerns with the Administrator about him having wandering behaviors and she assured Resident #5's family that the facility could accommodate his needs.
-It was hot on 06/30/2019 and Resident #5 could barely see and was legally blind in his left eye.
-Resident #5 hurt his knee while he was wandering outside of the facility.
-The facility moved his room so they could see him and they were supposed to be checking on him every 15 minutes after the elopement on 6/30/19.

Review of the local online weather report revealed the outside temperature on 06/30/2019 at the time of Resident #5's elopement was 97 degrees Fahrenheit.

Review of the 911 Communications Event History report dated 06/30/2019 for the Person Check Welfare revealed:
-At 6:07 p.m., caller advised 911 that "an elderly male came from behind his house from the woods saying he is lost."
-EMS arrived at the residence at 6:18 p.m.
-Police arrived at the residence at 6:28 p.m.
-EMS transported Resident #5 to the hospital at 6:32 p.m.
-At 6:34 p.m., police went to the facility to let the staff know the resident got out of their facility
-At 6:35 p.m., the facility was informed their resident was being transported to the hospital and the officer learned the "subject got out of the secure unit of the facility."

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 _____	R-C 07/16/2019

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 Review of the county EMS report dated 06/30/2019 revealed: -Resident #5 wandered to a residence located in the neighborhood behind the facility (about 1/4 of a mile). -911 received a call at 6:07 p.m. and dispatched an ambulance at 6:08 p.m. -EMS was dispatched for a welfare check on a person who was found wandering in woods behind a bystander's residence. -The ambulance arrived at the residence at 6:18 p.m. -Resident #5 was sitting in a chair in the driveway and two bystanders were standing near the resident. -Resident #5 was able to state his name and birthday, but was confused about location, day and where he walked from. -Resident #5 believed he was in another city. -Resident #5 was unable to walk without assistance. -Resident #5 was found to be a resident of the facility, but was transported to the hospital due to unknown time he was lost. Telephone interview with the local police officer on 07/17/19 at 8:00 p.m. revealed: -The facility did not know Resident #5 was missing until he went to the facility at approximately 6:32 pm on 6/30/19 and told staff that he had located their resident. -911 had just gotten off the phone with staff from the facility when he arrived at the facility and staff told him they were checking for the resident right then and that was when they realized that he was gone. -Resident #5 "walked through the thick of the woods where there's usually a little creek, but luckily it was dried up due to the heat.	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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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	D 270		

-The man who called 911 said Resident #5 kept falling down. He would walk a little ways and fall, walk a little ways and fall.
-The man also stated that the resident was very confused when he walked out of the wooded area.
-The resident was able to tell the police officer his name and that he was from another local city.
-EMS arrived, checked the resident's blood sugar (which was okay), and transported the resident to the local hospital.
-The officer contacted 911 and told them to call the facility located behind the neighborhood to find out if they had anyone missing.
-When the officer arrived at the facility, the staff had just hung up with someone from 911 and told him they did not know how Resident #5 could have gotten out of their locked facility.

Review of the hospital emergency room (ER) Summary Report dated 06/30/2019 revealed:
-Resident #5 arrived at the ER at 6:38 p.m.
-Resident #5 was a resident of the facility who wandered off from the facility.
-The family at the house he wandered to called 911 because the resident was confused.
-It was later discovered that Resident #5 had Alzheimer's and wandered away from the facility.
-Resident #5 was discharged from the hospital at 9:31 p.m.

Review of documentation of Resident #5's 15 minute check sheet dated 06/30/2019 revealed:
-Resident #5 returned from the ER at 10 p.m.
-There were no 15 minute checks were documented for 11 p.m. - 6:45 p.m.

Review of documentation of Resident #5's 15 minute check sheet dated 07/01/2019 revealed there were no 15 minute checks documented for

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 _____	R-C 07/16/2019

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 #5 from 10:45 p.m.- 6:45 a.m. Review of documentation of Resident #5's 15 minute check sheet dated 07/02/2019 revealed there were no 15 minute checks documented for Resident #5 from 11:00 p.m.- 6:45 a.m. Review of documentation of Resident #5's 15 minute check sheet dated 07/03/2019 revealed there were no 15 minute checks documented for Resident #5 from 11:15 p.m.- 6:45 a.m. Review of documentation of Resident #5's 15 minute check sheet dated 07/04/2019 revealed: -There were no 15 minute checks documented for Resident #5 from 7:00 a.m.- 8:15 a.m. -There were no 15 minute checks documented for Resident #5 from 3:30 p.m. - 6:45 a.m. Review of the facility's 15 minute check sheet dated for 07/05/2019 revealed there were no 15 minute checks documented for Resident #5 from 3:15 p.m.- 6:45 a.m. Interview with a MA on 07/15/2019 at 6:05 p.m. revealed: -She was working 2nd shift on the back hall on 06/30/2019. -A police officer called and another police officer came to the facility and asked if Resident #5 lived at the facility. -The officer asked the MA if Resident #5 was at the facility and she said he should be, but she would go and check for him. -The officer asked her if she would "go and lay eyes on him." -She ran to the SCU and first looked in Resident #5's room and asked the staff if they had seen Resident #5. -By them time MA had finished looking for	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 _____	R-C 07/16/2019

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	D 270		

Resident #5, a police officer was walking in the facility.
-The MA did not recall what time the officer called and came by but it was after dinner which was served at 5 pm or 5:15 p.m.
-The officer saw Resident #5's picture on the medication administration record and stated that was the man they had taken to the hospital.
-The MA called the Administrator.
-The Administrator spoke with every staff that was in the SCU.
-She spoke with the PCA who was working in the the SCU and was assigned to provide care to Resident #5 on 06/30/2019.
-Staff were supposed to "lay their eyes on each resident every 15 minutes within their unit."
-All the staff stopped what they were doing and started looking for Resident #5.
-She then followed proper procedure for "Resident Elopement"and contacted the SCC, and the resident care coordinator (RCC) to let them know what was going on.
-The Administrator was off the day of incident.
-The Administrator came to the facility and immediately began to investigate to find out what happened and what could have happened.

Interview with a 2nd shift PCA on 07/15/2019 at 6:20 p.m. revealed:
-On 06/30/19, the residents on the SCU were at dinner about 5:00 p.m. and finished up around 5:30 p.m.
-She assisted a resident to the rest room and when she returned, she observed Resident #5 in the hallway.
-Another staff had observed the resident outside. She assumed that Resident #5 came back in and was seen.
-Resident #5 was like everyone else in the SCU and she was told "as long as they could see the

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 _____	R-C 07/16/2019

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	D 270		

residents, they were allowed to go outside because it was a fenced in area."
-The residents were allowed to go outside alone because it was fenced in and "they were not expecting Resident #5 to hop the fence."
-She and other staff started doing their rounds around 6:00 p.m. to prepare residents for bed.
-Resident #5 was her responsibility during the shift and she should have checked on him (at least every 30 minutes).
-She was not aware Resident #5 was not in the building until the MA walked into the SCU and asked where Resident #5 was.
-She informed the MA that Resident #5 was outside, but she assumed that he went back to his room.
-Resident #5 was taken to the hospital to be checked out. When he returned, he seemed fine.
-The staff were all busy on 6/30/19; they were assisting the residents in the SCU to bed.
-She had been told that Resident #5 had wandering behaviors by other PCAs.
-When she first started working at the facility, she would see Resident #5 sitting on the front porch of the facility with a staff.
-Because of behaviors (eloping from the SCU), they stopped taking him out of the SCU to sit on the front porch because "they were afraid he might jet off."
-Hopping the fence was not something you would see him doing.
-She told the Administrator the day after it happened that if she needed her to take full responsibility, she would because she have paid more attention because he was in her unit.
-All residents were receiving 30 minute checks, but now he was getting fifteen (15) minute checks and all checks were recorded in the aide book.
-After that incident, it was very strict and they immediately changed it to everyone who went

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 _____	R-C 07/16/2019

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	D 270		

outside had to be accompanied, even smokers.

2. Review of Resident #4's FL-2 dated 02/20/19 revealed:
- Diagnoses included dementia, type 2 diabetes, hypertension, and hypothyroidism.
-The resident's current level of care was the special care unit (SCU).
-The resident was admitted to the facility on 01/15/19.

Review of Resident #4's care plan dated 02/28/19 revealed:
-The resident was ambulatory and wandered.
-The resident was totally dependent for toileting.
-The resident required supervision for ambulation.

Observation of Resident #4 on 07/10/19 at 11:10am revealed:
-The resident was sitting on a couch in the SCU TV room with her eyes closed.
-Both knees had open red wounds the size of a dime with thin scabbing over both wounds.

Interview with a nursing assistant (NA) on 07/10/19 at 11:15am revealed:
-Resident #4 had fallen but she did not know the date.
-She usually checked on Resident #4 every 2 hours if the resident was not in the activity/dining room.
-The medication aides (MA) were responsible for completing the accident reports when residents fell.

Review of an Accident/Injury report for Resident #4 dated 04/22/19 at 1:10pm revealed staff observed Resident #4 on the floor in her bedroom, sitting on her "bottom". The resident

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 _____	R-C 07/16/2019

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	D 270		

was not in pain and was not transported to the emergency room (ER).

Review of Resident #4's PCP visit record dated 4/24/19 revealed:
-There was a contusion on the resident's right knee which appeared to be fading as her fall was several days ago.
-There was no incident report. There was no other injury.

Review of Resident #4's Progress notes dated 05/03/19 at 9:14pm revealed:
-The hospice nurse received a call from the facility that Resident #4 had fallen and a visit was made by the hospice nurse.
-The resident was setting in a chair and a staff had an ice pack to area on the resident's left cheek.
-The resident had fallen and struck her left cheek which was red and slightly swollen.
-Teaching was done regarding fall prevention and home safety.

Review of Resident #4's Progress notes dated 05/05/19 (no time documented) revealed:
-The hospice nurse received a call that Resident #4 had fallen and a visit made by the hospice nurse.
-Staff stated the resident missed the chair and ended up on her bottom on the floor.
-The resident had no redness or bruising, and teaching was done with staff regarding fall prevention and home safety.

Review of Resident #4's PCP visit record dated 5/10/19 revealed:
-The resident was seen by her PCP to follow-up on report of fall on 5/5/19.
- Staff reported that the resident was found on the

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 _____	R-C 07/16/2019

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	D 270		

floor in a sitting position.
-Staff reported the resident slid out of a chair and the staff assisted her back in her chair.
-The hospice nurse assessed the resident for injuries with none reported.

Review of Resident #4's Nurse's Notes dated 05/24/19 at 9:00am:
-The hospice nurse made a visit after Resident #4 had fallen.
-The resident had a swollen, bruised area to her right temple and a bruise to her left hand.
-The resident denied any pain.

Review of Resident #4's PCP visit record dated 5/30/19 revealed:
-The resident was seen by her PCP due to follow-up of a fall (no date).
-The resident had a fall incident and sustained a bruise on the right side of her face and right temporal area.
-The resident has limited range of motion with poor tone and decreased muscle strength.
-The resident is ambulatory with a history of repeated fall. She requires assistance with activities of daily living (ADLs).

Review of an Accident/Injury report for Resident #4 dated 05/31/19 at 9:15am revealed:
-Staff observed Resident #4 walking fast as if running.
-Staff "commanded" the resident to slow down, but the resident stumbled over her feet and lost balance and fell to the floor on the left side causing a bruise over her eye and swelling.
-Hospice and the resident's primary care physician (PCP) were notified and a cold compress was applied to the resident's left eye.

Review of an Accident/Injury report for Resident

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 _____	R-C 07/16/2019

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	D 270		

#4 dated 06/19/19 at 5:10am revealed:
- Resident #4 slid out of bed and set on her "bedside mat" while she was trying to get up. The resident was alone.
-The resident stated she was trying to get up and she slid and sit on the bedside mat.
-The resident stated she did not hurt her head.

Review of Resident #4's PCP visit record dated 6/20/19 revealed:
-Resident #4 was seen by her PCP after a fall in the facility.
-The resident was seated on the floor and the fall was unwitnessed, but she did not sustain any injury.
-The resident's eye and face was bruised from a previous fall, but were healing.
-The resident requires assistance with ADLs.
-Due to recurrent falls and with the decline in the resident's cognitive function and with irregular gait, the facility will monitor her activities.

Review of Resident #4's Nurse's Notes dated 06/24/19 at 9:15am:
-The hospice nurse made a visit and a staff reported Resident #4 was found on a mat beside her bed during 3rd shift.
-There were no injuries.

Review of an Accident/Injury report for Resident #4 dated 06/27/19 at 2:30pm revealed:
-Staff observed Resident #4 in her room on her knees, sitting on the floor mat.
- Staff assisted the resident with body check, no marks or bruises where found.

Review of an Accident/Injury report for Resident #4 dated 07/08/19 at 9:30am revealed:
-Resident #4 was walking and lost her balance.
-The resident was alone.

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 _____	R-C 07/16/2019

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 -First aide was applied to both knees. Interview with a nursing assistant (NA) on 07/11/19 at 11:07am revealed: -Resident #4 fell "a lot" and the staff kept her in the activity room to decrease her falls. -She had most of her falls in the activity room -The resident's last fall was a few days ago, she fell in the hallway and injured her knees. -The resident wandered into other residents' rooms at times. -Residents on the SCU were routinely checked every 2 hours when in bed (incontinence care) and every 30 minutes when out of room. -Resident #4 was checked every 2 hours when she was in her room/in bed and every 30 minutes when she was out of her room. -Supervision checks did not change after Resident #4 sustained a fall. -A fall mat was placed on the floor beside the resident's bed a few weeks ago to prevent injuies if the resident fell out of bed. Interview with Resident #4's family on 07/11/19 at 11:45am revealed: -The resident was admitted to the facility in January 2019. -She had concerns about the resident's care and safety at the facility. -She had pictures of some horrible bruises which the resident sustained from a fall. -The resident was constantly falling and the Special Care Coordinator (SCC) "lied" to the family about the falls. -A few months ago, the resident had 3 falls in 10 days and the facility never increased her supervision. -The family placed a nannie cam in the resident's room on 3/20/19 and did not report it to anyone at the facility.	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 _____	R-C 07/16/2019

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 32 -On May 22, 2019 at 12:53pm, the family was viewing the nannie cam and observed Resident #4 fall in her room beside her bed, the resident was yelling for help for about 30 minutes, but staff never responded. -The family called the facility while observing the nannie cam, spoke to the SCC, and requested she go to the resident's room to check on her. -The family observed the SCC go into Resident #4's room and called for assistance and picked the resident off the floor. -The SCC came back to the phone and informed the family the resident was in the bathroom and was ok. -The resident had a fall later in May 2019 and sustained facial bruising. She was not sure how or when the resident fell but took pictures of the facial bruises on May 29, 2019. -She discussed the resident's falls/injuries and concerns about her supervision with the Administrator and the SCC on several occasions within the last 2-3 months, but there had not been any changes. -She discussed fall interventions with the hospice nurse after the resident's last fall in May 2019 and the hospice nurse ordered a fall mat to be placed on the floor at the resident's bed. Interview with the Administrator on 07/12/19 at 10:29am revealed: -She had told Resident #4's family the floor mat was a trip hazard because the resident fell most of the time getting out of bed onto the floor mat. -Resident #4's family member wanted the floor mat on the floor beside the bed at all times. -The mat was placed in the resident's room by the hospice nurse more than a month ago. -The family member has placed a "nannicam" in Resident #4's room and has seen everything (falls in the room).	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 _____	R-C 07/16/2019

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 33	D 270		

-The resident was checked every 2 hours when she was in bed and every 30 minutes when out she was out of her room.
-When the resident was in the TV room, staff supervised her and other residents constantly.
-There were no supervision changes after Resident #4 sustained a fall.

Interview with the SCC on 07/12/19 at 11:15pm revealed:
-She was aware of Resident #4's multiple falls.
-Staff were required to check on residents every two hours when in bed or in their rooms and checked residents every 30 minutes when they were out of their rooms.
-Resident #4 was checked every 2 hours when she was in bed or in her room and every 30 minutes when she was out of her room.

Interview with Resident #4's PCP on 07/15/19 at 11:25am revealed:
-The resident's repeated falls were related to her cognitive decline.
-The resident had a walker but forgot to use it when ambulating. The staff should remind her to use walker to decrease falls.
-The facility was not able to provide one to one supervision to help prevent falls but should be checking on the resident at least every 15 minutes.

Second interview with a nursing assistant (NA) on 07/15/19 at 11:45am revealed:
-She checked on Resident #4 every 2 hours for incontinent care or assistance to the bathroom.
-Residents' who fell were checked every 30 minutes.
-Resident #4 was checked every 30 minutes when she was out of her room.
-She did not know if other staff sat with the

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 _____	R-C 07/16/2019

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 34 resident in her room. A second interview with Resident #4's family on 7/16/19 at 1:40pm revealed: -After Resident #4 fell on 05/03/19 in the activity room and injured her eye and bruised her face, she asked the Administrator to check the facility's camera to confirm the fall but the Administrator told her no. -She was concerned the staff was not supervising the resident because whenever she visited the facility the SCU staff were not watching the residents, they "hung out" in the far end of the activity room talking to each other and on their phones, while the resident's sat on the other end of the room with the TV on. -There were never staff in the hall checking on the residents who were walking and in their rooms. -She had repeatedly observed staff in residents' rooms talking on their phones. -The SCC informed her the staff was required to check on all residents every 2 hours and she did not care if the staff took their lunch break at the same time as long as they performed their two hour checks. Interview with two PCAs in the SCU on 07/10/19 revealed: -Residents on the SCU were checked every two hours when in their rooms, but every 30 minutes when out of their rooms. -Resident #4 was checked every two hours when she was in her room and when awake she was in the activity room and the staff kept an eye on her but she still had falls. -Resident #4 had a fall mat at her bed to help prevent her from getting hurt if she fell from her bed.	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 _____	R-C 07/16/2019

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 35	D 270		

Resident #4's hospice nurse, but she was not available for interview during the survey.

3. Review of Resident #10's FL-2 dated 04/07/19 revealed:
- Diagnoses included dementia, osteoporosis, hypertension, and insomnia.
-The resident was intermittently disoriented and was incontinent of bowel and bladder.

Review of Resident #10's care plan dated 3/04/19 revealed;
-The resident was ambulatory and had limited strength and range of motion of upper extremities.
-The resident required assistance with toileting, and ambulation.

Review of Resident primary care provider (PCP) visit records dated 4/10/19 revealed:
-Resident #10 was seen by her PCP after a fall.
-The resident was transported to the hospital for evaluation.
-The resident had poor tone and strength of joints, bones and muscles.

Review of Resident #10's Accident/Injury report dated 05/07/19 at 11:10pm revealed:
-The staff reported that she heard a sound in the resident's room and when she went to check, found the resident on the floor.
-The resident stated she went to the bathroom and on her way back to bed she lost her balance and fell and hit her head on the floor.

Review of Resident #10's PCP visit records dated 5/08/19 revealed:
-The resident was seen for a follow-up after a fall on 5/07/19.
-The resident reported she was going to the

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 _____	R-C 07/16/2019

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 36	D 270		

bathroom and on her way back to bed and lost her balance, fell and hit her head.
-The resident was seen at the local emergency room (ER) and was diagnosed with a right wrist contusion.
-The resident was ordered Naproxen 375mg 2 times a day for 10 days and a brace was applied to the right wrist and the resident complained of right wrist pain at this visit.

Review of Resident #10's Accident/Injury report dated 05/08/19 at 7:00pm revealed:
-The resident was laying at the back door (SCU exit door at the end of the hall).
-The resident was alone.
-There were no injuries.

Interview with another resident's family member on 7/16/19 at 11:40am revealed:
-She was at the facility on 5/08/19 during the evening with another family member.
- Resident #10 was observed leaning on the exit door at the end of the hallway in the SCU.
-The door opened and Resident #10 fell on her back outside the door on the pavement.
-There were no staff in the hallway or in other resident rooms. But there was one staff in a resident room talking on her cell phone
-They screamed for help and the staff walked into the hall very slow.
-The staff was not in a hurry even though the family was running toward the resident.

Review of Resident #10's Accident/Injury report dated 05/10/19 at 5:20pm revealed:
-The resident fell out of bed.
-The resident was alone.
-The resident was not able to verbalize what happened.
-The resident was transported to the local ER by

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 _____	R-C 07/16/2019

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 37	D 270		

emergency medical service (EMS).

Review of Resident #10's PCP visit records dated 5/22/19 revealed:
-The resident was seen by her PCP to follow-up on right wrist injury after a fall on 5/07/19.
-The resident had a history of recurrent falls.
-Her right wrist was better, and she was able to move it without difficulty.
-The resident denied pain and the brace was discontinued.

Review of Resident #10's Accident/Injury report dated 05/25/19 (no time) revealed:
-Resident #10 was found lying on the floor, no injuries.
-The resident was alone.

Review of Resident #10's Accident/Injury report dated 05/25/19 at 11:45pm revealed:
-Resident #10 was found lying on the floor.
-The resident stated she fell out of bed and she hit her head on the floor.
-The resident was transported to the local ER by EMS.

Review of Resident #10's PCP visit records dated 5/29/19 revealed:
-The resident was seen by her PCP after multiple falls from her bed.
-The facility staff reported the resident had a tendency to get out of bed with her eyes closed.
- Since she had repeated falls, the resident's family provided a walker for the resident's use.
-New care plans were implemented to prevent further falls such as a mat on the floor beside the bed and a concave mattress.
-The resident continued to require assistance with her activities of daily living (ADLs).
-The resident reported previous injuries from falls

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 _____	R-C 07/16/2019

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

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D 270	Continued From page 38	D 270		

and weakness.
-The resident's gait was irregular with the right side of her body weaker.

Review of Resident #10's physician orders dated 6/24/19 revealed orders for a fall mat at bedside and a concave mattress.

Observations on 7/16/19 at 11:25am revealed:
-Resident #10 was standing in the hallway in front of the facility's treatment cart and did not have her walker.
-There were no staff in the hallway, but 3 staff were sitting in the activity room and 1 staff was in an empty resident room.
-The resident was reaching/fumbling for the items and sneezed. The resident stumbled sideways but did not fall.
-The MA walked out of the activity room about 30 seconds after the incident.

Interview with the Special Care Coordinator (SCC) on 7/12/19 at 11:15am revealed:
-Resident #10 had several falls in the last few months.
-Her last fall was on 7/08/19, but she did not know what happened.
-An accident report was completed but she did not know where it was. The Administrator should have it.
-Staff should be checking the resident every 30 minutes and incontinent care should be done every 2 hours.
-She was aware the resident had fallen near the exit door, but not aware she had fallen out of the door.

Interview with a nursing assistant (NA) on 7/15/19 at 11:30pm revealed:
-Resident #10 was on 30 minute checks because

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 _____	R-C 07/16/2019

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

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D 270	Continued From page 39	D 270		

of repeated falls.
-Staff did sat in SCU activity room when residents were in the room.

Interview with Resident #10's PCP on 7/15/19 at 11:25am revealed:
-The resident was at high risk for falls because she had an unsteady gait.
-The resident had repeated falls and required ER evaluations with some of the falls.
-The resident has a concave mattress on her bed which was ordered recently and a fall mat, but the staff should check on her every 15 minutes.
-The resident's last fall was reported last week (7/9/19).

Interview with Resident #10's family on 7/15/19 at 4:20pm revealed:
-The resident has been sent to the ER four times in the last 3-4 months because of falls.
-She required staples in her head one time due to a cut from a fall in May 2019.
-The resident was very unsteady on her feet and he bought her a walker.
-The resident forgot to use walker most of the time.
-He did not know how often the staff checked on her or assisted her with ambulation.
-The SCU usually had enough staff when he visited.

Interview with the medication aide on 7/16/19 at 11:30am revealed:
-Staff should be checking on residents in the hallway every 30 minutes.
-Resident #10 should be checked every 30 minutes.
-The resident had never been placed on 15 minute checks after falls.
-The resident had a fall mat (since last month)

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 _____	R-C 07/16/2019

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

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D 270	Continued From page 40 which was placed beside her bed when she was in the bed. -The resident had a concave mattress (since last month) on her bed to prevent her from falling off her bed. Interview with the Administrator on 7/16/19 revealed: -She was aware that Resident #10 had repeated falls and required staples in her head after a fall. -The resident was ordered a concave mattress for her bed and it was delivered on 6/24/19. -The resident had a fall mat at her bed. -Staff checked on the resident every 30 minutes and performed incontinent care every 2 hours. -Resident #10's supervisory checks had never changed after sustaining falls. -She was not aware the resident sustained a fall last week, but would follow- up. The facility failed to provide supervision for 3 of 7 sampled residents resulting in one resident (#5) with dementia wandering away from the facility unsupervised 2 times after climbing over the fence surrounding the secured outside area of the SCU and staff not aware the resident was missing until a local law enforcement contacted the facility after being found in a neighborhood close to a busy street; and 2 residents (#4 and #10) sustaining multiple falls in 6 months resulting in injuries and emergency room visits. The facility's failure resulted in substantial risk of serious physical harm and neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/14/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2	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 _____	R-C 07/16/2019

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

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D 270	Continued From page 41 VIOLATION SHALL NOT EXCEED August 15, 2019.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to implement a primary care provider order for a reaching and grabbing tool for 1 of 7 sampled residents (#11) who had a history of falling from her wheelchair while reaching down to pick things up and sustaining lacerations and abrasions. The findings are: Review of Resident #11's current FL-2 dated 06/24/19 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, insomnia, depression and schizophrenia.	D 276		

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 _____	R-C 07/16/2019

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

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D 276	Continued From page 42 Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 01/25/19. Review of a primary care provider (PCP) visit note for Resident #11 dated 04/10/19 revealed: -There was documentation Resident #11 reported falling when she tried to pick up things. -There was an order for a reaching/grabbing tool. Telephone interview with Resident #11's family member on 07/15/19 at 6:35pm revealed: -She received calls from staff approximately three times per week saying Resident #11 had fallen. -She left messages for the Administrator to find out what was going on, but never received a call back. -No one from the facility contacted her about getting a reaching/grabbing tool for Resident #11. Review of Accident/Incident Reports dated 04/05/19 through 06/28/19 and emergency room (ER) visit summaries dated 02/18/19 through 06/29/19 for Resident #11 revealed: -There were 5 emergency room (ER) visits between 02/18/19 and 04/10/19 documenting Resident #11 fell. -On 02/18/19, there was ER documentation Resident #11 fell and sustained a subdural hematoma (Bleeding around the brain). -On 03/04/19, there was ER documentation Resident #11 was seen for lower back and neck pain due to a fall. -On 03/24/19, there was ER documentation Resident #11 fell from her wheelchair and sustained a right eyebrow laceration (cut). -There were 18 incidents documented with Resident #11 being found on the floor after 04/10/19.	D 276		

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 _____	R-C 07/16/2019

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

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D 276	Continued From page 43	D 276		

-There was documentation 11 of the 18 incidents were related to the resident reaching for something.
-For example, there were three accident/incident reports for Resident #11 dated 06/26/19; the resident fell reaching down twice and third time trying to get "stuff" out of her drawer.
-There were three falls on 06/28/18; at 2:50pm trying to pick up a snack off the floor, at 7:30pm trying to pick toothpaste up off the floor and at 11:26pm the resident was found on the floor and taken to the ER with abrasions at multiple sites.

Telephone interview with a medication aide (MA) on 07/15/19 at 7:06pm revealed:
-Resident #11 slid out of her chair a lot trying to pick something up off the floor.
-Resident #11 was able to pick things up if it was on a table.
-She did not know why Resident #11 fell frequently from picking items up from the floor; "maybe she dropped it, threw it or knocked it down."
-She did not know anything about a reaching/grabbing tool to help Resident #11 pick things up from the floor.

Telephone interview with Resident #11's Physical Therapist (PT) on 07/16/19 at 11:55am revealed:
-Resident #11 had weakness in both upper extremities with one arm being worse than the other.
-Resident #11 had decreased strength and range of motion in both arms.
-Resident #11 required maximum assistance with transfers with two staff for safety.
-He would "not trust" Resident #11 to bend over and pick something up from the floor while seated in her wheelchair.
-Resident #11 had poor center or sitting balance

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 _____	R-C 07/16/2019

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

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D 276	Continued From page 44	D 276		

and it would be a fall risk for the resident to lean forward and pick something up from the floor.
-He did not recall whether Resident #11 had a reaching/grabbing tool.

Telephone interview with Resident #11's PCP on 07/15/19 at 11:13am revealed:
-Resident #11 did not have any deformities of her hands; the resident apparently had some weakness or neuropathy in her hands which was why she dropped things, but the PCP did not see that.
-A reaching/grabbing tool may have helped Resident #11 to pick up things.

Telephone interview with the Insurance Clerk at the local medical supply companyon 07/16/19 at 11:13am revealed:
-The reaching/grabbing tool was not covered by Resident #11's insurance.
-The reaching/grabbing tool cost $21.95.
-There was no request for a reaching/grabbing tool in Resident #11's record at the medical supply company.

Interview with the Resident Care Coordinator (RCC) on 07/15/19 at 5:11pm revealed:
-Resident #11 had problems with holding things in her hands.
-The insurance company did not cover the reaching/grabbing tool and Resident #11 did not have the funds to pay for it.
-She had tried to contact Resident #11's guardian for monies to pay for the reaching/grabbing tool, but the guardian did not return her calls.

Second interview with the RCC on 07/16/19 at 3:35pm revealed:
-She had checked with the Business Office Manager (BOM) when the order was first written

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 _____	R-C 07/16/2019

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D 276	Continued From page 45 for the reaching/grabbing tool. -The BOM said Resident #11 did not have the money to buy the reaching/grabbing tool. -She made the primary care provider aware they were not able to get the reaching/grabbing tool in April 2019. Upon request on 07/15/19, there was no documentation of communication with the PCP regarding the reaching/grabbing tool for Resident #11. Interview with the Administrator on 07/15/19 at 1:25pm revealed she would have to check for a receipt for a reaching/grabbing tool. Second interview with the Administrator on 07/15/19 at 4:15pm revealed: -There was no receipt for the reaching/grabbing tool because the insurance did not cover it. -Resident #11 did not have the funds to cover payment for the reaching/grabber tool. -Nothing else was done to get a reaching/grabbing tool for Resident #11. Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable.	D 276		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and	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 _____	R-C 07/16/2019

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

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D 358	Continued From page 46 (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO CONTINUING TYPE A2 VIOLATION Based on these findings, the previously Unabated Type A2 Violation was abated. Non-compliance continues. THIS IS TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to assure potassium chloride was discontinued as ordered by the primary care provider for 1 of 6 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 07/08/19 revealed: -Diagnoses included end stage renal disease, type II diabetes mellitus, hypertension, hyperkalemia and hemodialysis dependent. -There was no order for potassium chloride. Review of a hospital discharge summary dated 07/03/19 for Resident #2 revealed: -Resident #2 presented to the emergency room	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 _____	R-C 07/16/2019

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

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D 358	Continued From page 47	D 358		

with altered mental status and a fall and was admitted to the hospital on 07/02/19.
-Resident #2 had a potassium level of 5.5 (According to the National Kidney Foundation normal potassium levels in the blood range from 3.5 to 5.0).
-Resident #2's diagnoses included a urinary tract infection and hyperkalemia (According to the National Kidney foundation hyperkalemia is having too much potassium in the blood and symptoms can include muscle weakness, numbness, tingling, nausea, vomiting, shortness of breath and chest pain.; sudden and/or very high potassium levels can be life threatening).
-There was an order to stop potassium chloride 20 mEq daily.

Observations of medications on hand for Resident #2 on 07/15/19 at 4:50pm revealed:
-There was a medication card with a pharmacy label that had Resident #2's name and instructions for potassium chloride 20 mEq daily.
-The pharmacy label indicated 28 potassium chloride 20 mEq tablets were dispensed on 06/26/19.
-There were 10 tablets remaining.

Review of Resident #2's June 2019 electronic medication record (eMAR) revealed:
-There was an entry for potassium chloride 20 mEq daily at 9:00am.
-There was documentation the potassium chloride was administered at 9:00am 06/01/19 through 06/30/19.

Review of Resident #2's July 2019 eMAR revealed:
-There was an entry for potassium chloride 20 mEq daily at 9:00am.
-There was documentation the potassium

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 48	D 358		

chloride was administered at 9:00am on 07/01/19 and 07/02/19.
-There was documentation the potassium chloride was not administered on 07/03/19.
-There was documentation the potassium chloride was discontinued on 07/04/19.
-There was an "X" marked on the remaining dates for the month of July 2019.
-There were no entries to restart administration of potassium chloride.

Observation of Resident #2 on 07/15/19 at 10:58am revealed the resident was sleeping in his bed.

Observation of Resident #2 on 07/16/19 at 11:55am revealed the resident was sitting in his wheelchair in the hallway with his head down, sleeping.

Interview with Resident #2 on 07/16/19 at 11:55am revealed:
-He was tired but okay.
-He did not have any pain or weakness.

Interview with a medication aide (MA) on 07/16/19 at 9:50am revealed:
-She had administered Resident #2's morning medications on 07/10/19.
-Potassium chloride was not on Resident #2's eMAR so she did not give it.
-She could not say why the potassium chloride was still on the medication cart for Resident #2, "It may have been overlooked."
-She did not know why there were only 10 tablets remaining.
-She always pulled the medication cards for medications that "popped up" on the computer screen.
-She did not notice the potassium chloride on the

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 _____	R-C 07/16/2019

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 49	D 358		

medication cart for Resident #2 because she only pulled the medication cards for what she was giving.
-When a medication was discontinued on the eMAR she checked the order in the resident's record to confirm the medication was discontinued, then she removed the medication card from the cart and sent it back to the pharmacy.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 07/16/19 at 9:37am revealed:
-The last order for potassium chloride 20 mEq daily for Resident #2 was dated June 2018.
-Potassium chloride 20 mEq daily for Resident #2 was discontinued 07/02/19 following a hospital admission.
-The potassium chloride was discontinued on Resident #2's eMAR on 07/03/19.
-The pharmacy sent 28 potassium chloride 20 mEq tablets to the facility on 06/19/19 for Resident #2; the facility documented receipt on 06/21/19.
-There were 12 days between 06/21/19 and 07/03/19 so the facility should have had 16 tablets remaining.
-Administering potassium chloride once it was discontinued could cause increased potassium levels in the blood.

Interview with the Resident Care Coordinator (RCC) on 07/16/19 revealed:
-She had talked with the MAs on duty on 07/15/19 and 07/16/19 about the facility's process for discontinued medications.
-There were two MAs who's initials were documented on the eMAR as administering 8:00am medications from 07/03/19 through 07/15/19, that she had not spoken with yet.

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 _____	R-C 07/16/2019

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 50	D 358		

-The potassium chloride for Resident #2 should have been removed from the medication cart when it was discontinued.
-The MAs should have noticed the potassium chloride still on the medication cart and questioned why it was still on the cart.

Telephone interview with a hemodialysis representative on 07/16/19 at 10:05am revealed:
-Resident #2's last potassium level at hemodialysis was 6.1 on 07/01/19.
-The result was "a little high" and Resident #2 was due for a recheck on 07/17/19.

Telephone interview with Resident #2's primary care provider (PCP) on 07/16/19 at 12:19pm revealed:
-The potassium chloride was discontinued for Resident #2 because he had a high potassium level while he was in the hospital on 07/02/19.
-It was a common problem for the potassium levels to go up and down with chronic end stage renal disease and hemodialysis.
-She would only be concerned if Resident #2 had symptoms of a high potassium level including chest pain, weakness and/or increased confusion.
-A potassium level would be drawn at hemodialysis on 07/17/19.

Interview with the Administrator on 07/16/19 at 11:55am revealed:
-She did know why potassium chloride that had been discontinued for Resident #2 was still on the medication cart.
-MAs were expected to remove medications that were discontinued from the medication cart immediately to prevent the medication from being administered.
-MAs were expected to check the eMAR and the

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 _____	R-C 07/16/2019

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 51 medication prior to administering the medication; not just "pop" the medications from memory. -The RCC was responsible for monitoring medication administration and medication cart audits. Attempted telephone interview on 07/16/19 at 11:01am with the MA who documented administering morning medications 07/04/19 through 07/09/19 was unsuccessful. The facility failed to assure medications were administered as ordered by the primary care provider. The failure of the facility to discontinue the administration of potassium chloride for Resident #11 who had a history of hyperkalemia, end stage renal disease and was dependent on dialysis was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2019.	D 358		
D 421	10A NCAC 13F .1104(c) Accounting For Resident's Personal Funds 10A NCAC 13F .1104 Accounting For Resident's Personal Funds (c) A record of each transaction involving the use of the resident's personal funds according to Paragraph (b) of this Rule shall be signed by the resident, legal representative or payee or marked by the resident, if not adjudicated incompetent,	D 421		

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 421	Continued From page 52	D 421		

with two witnesses' signatures at least monthly verifying the accuracy of the disbursement of personal funds. The record shall be maintained in the home.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to assure an accurate accounting of 4 of 4 sampled residents' personal funds including a record of each transaction signed by the resident or legal representative and remaining balances; and failed to make residents' personal funds available on request to the resident or legal representative. (Resident #6, #7,#8 and #11)

The findings are:

1. Review of Resident #11's current FL-2 dated 06/24/19 revealed diagnoses included hypertension, chronic obstructive pulmonary disease, insomnia, depression and schizophrenia

Review of Resident #11's Resident Register revealed the resident was admitted to the facility on 01/25/19.

Review of Resident #11's Resident Trust Fund Account ledger dated 05/07/19 revealed:
-On 05/07/19, there was documentation $66.00 was deposited leaving a balance of $66.00.
-On 05/08/19, there was documentation $66.00 was withdrawn for "April Meds" leaving a balance of $0.
-On 06/06/19, there was documentation $66.00 was deposited leaving a balance of $66.00.
-On 06/12/19, there was documentation $66.00 was withdrawn for "May Meds" leaving a balance

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 _____	R-C 07/16/2019

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

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D 421	Continued From page 53	D 421		

of $0.
-On 07/01/19, there was documentation $190.00 was deposited leaving a balance of $190.00.
-On 05/08/19, there was documentation $190.00 was withdrawn for [name of nursing home] leaving a balance of $0.

Review of Accident/Incident Reports dated 04/05/19 through 06/28/19 and emergency room (ER) visit summaries dated 02/18/19 through 06/29/19 for Resident #11 revealed:
-There were 5 emergency room (ER) visits between 02/18/19 and 04/10/19 documenting Resident #11 fell.
-On 02/18/19, there was ER documentation Resident #11 fell and sustained a subdural hematoma (Bleeding around the brain).
-On 03/04/19, there was ER documentation Resident #11 was seen for lower back and neck pain due to a fall.
-On 03/24/19, there was ER documentation Resident #11 fell from her wheelchair and sustained a right eyebrow laceration (cut).
-There were 18 incidents documented with Resident #11 being found on the floor after 04/10/19.
-There was documentation 11 of the 18 incidents were related to the resident reaching for something.
-For example, there were three accident/incident reports for Resident #11 dated 06/26/19; the resident fell reaching down twice and third time trying to get "stuff" out of her drawer.
-There were three falls on 06/28/19; at 2:50pm trying to pick up a snack off the floor, at 7:30pm trying to pick toothpaste up off the floor and at 11:26pm the resident was found on the floor and taken to the ER with abrasions at multiple sites.

Review of a primary care provider (PCP) visit

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 _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(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 421	Continued From page 54	D 421		

note for Resident #11 dated 04/10/19 revealed:
-There was documentation Resident #11 reported falling when she tried to pick up things.
-There was an order for a reaching/grabbing tool.

Telephone interview with Resident #11's Guardian on 07/16/19 at 10:37am revealed:
-He had not given the facility permission to use all of Resident #11's personal funds monies toward pharmacy copayments.
-He had not been contacted about getting a reaching/grabbing tool for Resident #11.

Interview with the Business Office Manager (BOM) on 07/15/19 at 5:37pm revealed:
-She thought Residents understood that there $66.00 was being used toward copayments for there medication.
-There were copayments for medications the facility had to pay for Resident #11.
-She took a portion of the resident's personal funds monies and paid towards the pharmacy balance; if there was a remaining amount, it stayed in the resident's trust account.

Interview with the Resident Care Coordinator (RCC) on 07/16/19 at 3:35pm revealed:
-She had checked with the BOM when the order was first written for the reaching/grabbing tool.
-The BOM said Resident #11 did not have the money to buy the reaching/grabbing tool; she did not ask the BOM why the money was not available.

Interview with the Administrator on 07/15/19 at 4:15pm revealed:
-Resident #11 did not have the funds to cover payment for the reaching/grabber tool.
-The facility had not received all the payments for room and board for Resident #11.

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 _____	R-C 07/16/2019

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 421	Continued From page 55 Second interview with the Administrator on 07/16/19 at 3:35pm revealed: -She did not know that Resident #11's personal funds monies had been used entirely for pharmacy copayments. -Resident #11 should have been able to use her personal funds monies to purchase the reaching/grabbing tool. -If the BOM was not aware Resident #11 needed the reaching/grabbing tool, then she may have just gone ahead and paid the pharmacy bill. The BOM was not available for a second interview after 2:00pm on 07/16/19. Based on observations, interviews and record reviews, it was determined Resident #11 was not interviewable. Refer to interview with the Administrator on 07/16/19 at 3:35pm. 2. Review of Resident #6's current FL-2 dated 02/07/19 revealed diagnoses included diabetic, hyperlipidemia, bipolar and gastroesophageal reflux disease Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 02/05/19. Interview with Resident #6's on 07/10/19 at 11:21am revealed: -She had not given the facility permission to use all of her personal funds monies toward pharmacy copayments. -She had been without personal monies since her admission at the beginning of the year. -She had asked the Business Office Manager	D 421		

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 _____	R-C 07/16/2019

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 421	Continued From page 56	D 421		

(BOM) for $10 of her $66.00 in resident funds to buy personal snacks.
-The Business Office Manager (BOM) was aware that Resident #6 was not receiving her $66.00
-She felt horrible and worthless that she could not buy herself personal items and personal snacks.
-She expressed her concerns around early spring to present of having no personal monies with the Business Office Manager and Administrator.

-The resident's family member was aware the resident was not receiving her money.

Review of Resident #6's Resident Trust Fund Account ledger dated 05/07/19 revealed:
-On 04/09/19, there was documentation $66.00 was deposited leaving a balance of $66.00.
-On 04/09/19, there was documentation $40.00 was withdrawn for "March Meds" leaving a balance of $26.00
-There was one entry documented with resident signature and one witness signature.
-On 04/09/19, there was documentation $26.00 was withdrawn for personal use leaving a balance of $0.
-On 04/09/19, there was one entry documented with resident signature and one witness signature.
-On 04/30/19, there was documentation a balance of $0.
-On 05/07/19, there was documentation $66.00 was deposited leaving a balance of $66.00.
-On 05/07/19, there was documentation $66.00 was withdrawn for "April Meds" leaving a balance of $0.
-On 05/07/19, there was one entry documented with no resident signature and one witness signature.
-On 05/30/19, there was documentation a balance of $0.

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 _____	R-C 07/16/2019

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 421	Continued From page 57 -On 06/06/19, there was documentation $66.00 was deposited leaving a balance of $66.00. -On 06/12/19, there was documentation $66.00 was withdrawn for "May Meds" leaving a balance of $0. -On 06/12/19, there was one entry documented with no resident signature and one witness signature. -On 06/30/19, there was documentation a balance of $0. -On 07/05/19, there was documentation $66.00 was deposited leaving a balance of $66.00. -On 07/08/19, there was documentation $66.00 was withdrawn for "June Meds" leaving a balance of $0. -On 07/08/19, there was one entry documented with no resident signature and one witness signature. -The trust fund account covered the period of April 2019 through July 2019. -There were no resident signatures from 04/30/19 through 07/08/19 on the Trust Fund Account. Interview with the Business Office Manager (BOM) on 07/15/19 at 5:37pm revealed: -We had not received any payments for room and board for Resident #6 since her admission. -She spoke with Resident #6 regarding copayments for medications the facility had to pay for her. -She payed $66.00 monthly to the pharmacy for Resident #6 copayments for medications. -She thought Resident #6 understood that her $66.00 was being used toward copayments for her medication. -There were copayments for medications the facility had to pay for Resident #6. -She did not know residents had the right to choose how much to pay toward pharmacy copayments.	D 421		

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 _____	R-C 07/16/2019

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

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D 421	Continued From page 58	D 421		

-She took a portion of the resident's personal funds monies and paid towards the pharmacy balance; if there was a remaining amount, it stayed in the resident's trust account.
-The resident could request any remaining amount from the trust account.
-She would have a staff member, any staff to sign as a witness signature.

Interview with the Administrator on 07/11/19 at 4:37pm revealed:
-The facility had not received all the payments for room and board for Resident #6.
-She did not know that Resident #6's personal funds monies had been used entirely for pharmacy copayments.
-Resident #6 should have been able to use her personal funds monies to purchase personal items.

Second interview with the Administrator on 07/16/19 at 3:35pm revealed:
-Personal funds monies were to be used for medical appointment and pharmacy copayments.
-The Business Office Manager (BOM) took a portion of the resident's personal funds monies and paid towards the pharmacy balance; if there was a remaining amount, it stayed in the resident's trust account.
-The BOM had always handled the residents' personal funds monies and made payments to the pharmacy.
-There was no policy on how the money was dispensed.

Attempted telephone interview with Resident #6's responsible person on 07/16/19 at 11:27am were unsuccessful.

Attempted telephone interview with Resident #6's

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 _____	R-C 07/16/2019

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 421	Continued From page 59 Case Manager on 07/12/19 at 12:08pm were unsuccessful. Refer to interview with the Administrator on 07/16/19 at 3:35pm. 3. Review of Resident #8's current FL-2 dated 02/12/19 revealed diagnoses included dementia, diabetes, anxiety disorder, asthma, and mild depression. Interview with the county representative on 07/10/19 at 10:11am revealed: -Resident #8 was had not been receiving any of her $66 resident funds for the past year. -The resident's family member was aware the resident was not receiving her money. -The Business Office Manager (BOM) was aware that Resident #8 was not receiving her $66. -Resident #8's $66 resident funds were being paid to the contracted pharmacy for a past due bill. -She spoke with the contracted pharmacy on 06/9/19 and Resident #8's bill was $236.60. -The resident and her family member did not give the BOM permission to use the residents $66 residents' funds. -The resident had asked the BOM for $20 of her $66 in resident funds to get her hair done or buy snacks. -The BOM, Resident #8, the Administrator, and Resident # 8's family member had a meeting 3 weeks ago to discuss the resident's funds. Review of Resident #8's "Resident Trust Fund Account" revealed: -The trust fund account was lined and contained six columns which were labeled as follows: date, transaction, withdrawal, deposit, balance, resident's signature, and 2 different columns	D 421		

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 _____	R-C 07/16/2019

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 421	Continued From page 60	D 421		

labeled witness.
-The trust fund account covered the period of January 2019 through July 2019.
-There were no resident signatures anywhere on the Trust Fund Account
-The first entry dated 01/01/19 documented a $0 balance with no resident or witness signatures.
-The second entry dated 01/07/19 documented a deposit of $22 and a balance of $22 dollars with no resident or witness signatures.
-The third entry dated 01/09/19 documented a withdrawal of $22 for a December 2018 pharmacy payment with no resident signature and two witness signatures documented.
-The fourth entry dated 01/31/19 documented a $0 balance with no resident or witness signatures.
-The fifth entry dated 02/05/19 documented $66 deposit and $66 balance with no resident or witness signatures.
-The sixth entry dated 02/13/19 documented a $66 withdrawal for January 2019 medications with no resident signature and two witness signatures.
-The seventh entry dated 02/28/19 documented a $0 balance with no resident or witness signatures.
-The eighth entry dated 03/05/19 documented a $66 deposit and a $66 balance with no resident or witness signatures.
-The ninth entry dated 03/13/19 documented a $66 withdrawal for February 2019 medications with no resident signature and one witness signature.
-The tenth entry dated 03/31/19 documented a $0 balance with no resident or witness signatures.
-The eleventh entry dated 04/04/19 documented a $66 deposit and a $66 balance with no resident or witness signatures.
-The twelfth entry dated 04/15/19 documented a $66 withdrawal for March 2019 medications with

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 _____	R-C 07/16/2019

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 421	Continued From page 61	D 421		

no resident signature and two witness signatures.
-The thirteenth entry dated 04/30/19 documented a $0 balance with no resident or witness signatures.
-The fourteenth entry dated 05/01/19 documented a $66 deposit and $66 balance with no resident signature or witness's signature.
-The fifteenth entry dated 05/08/19 documented a $66 withdrawal for April 2019 medications with no resident and two witness signatures.
-The sixteenth entry dated 05/31/19 documented a $0 balance with no resident or witness signature.
-The seventeenth entry dated 06/06/19 documented a $66 deposit and $66 balance with no resident or witness signatures.
-The eighteenth entry dated 06/12/19 documented a $66 withdrawal for May 2019 medications with no resident signature and two witness signatures.
-The nineteenth entry dated 06/30/19 documented a $0 balance with no resident or witness signature.
-The twentieth entry dated 07/05/19 documented a $66 deposit and $66 balance with no resident or witness signature
-The twenty-first entry dated documented a $66 withdrawal for June 2019 medications with no resident signature and one witness signature. h

Interview with Resident #8 on 7/12/19 at 3:16pm revealed:
-The resident had not received any resident funds in a year.
-She had been living at the facility for the last 9 years.
-She talked to the BOM, the Administrator, the county representative, and her family member about her funds two weeks ago.
-The resident did not tell anyone to use her

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 _____	R-C 07/16/2019

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 421	Continued From page 62	D 421		

resident funds to pay her pharmacy bill.
-The resident did not sign anything to use her resident funds to pay her pharmacy bill.
-The resident would like to use her resident funds to get her hair done or pay for snacks.
-The resident's family member paid for drinks and snacks for the resident to have in her room.

Interview with Resident #8's family member on 7/15/19 at 12:04pm revealed:
-The resident had not received any of the monthly $66 in resident funds in a year.
-The resident was at another facility who did not charge the resident for her medications.
-The resident's pharmacy bill followed her to the current facility because they used the same pharmacy.
-The resident nor her signed or gave verbal permission to anyone to take the resident's entire $66 monthly funds to pay the pharmacy bill.
-Family had been bringing the resident snacks, drinks, and newspapers for the past year.
-She contacted the county representative after several conversations with the BOM and the Administrator did not help.
-She had been told since February 2019 by the BOM that the resident was going to receive some money.
-She, the resident, the county representative, the BOM, and the Administrator had a meeting 2 to 3 weeks ago to discuss the resident not receiving her funds.
-The family member, the resident, and the county representative were told the resident would start to receive $10 monthly from the BOM starting in July 2019.
-She advised the resident still had not received any of the $66.
-She called the pharmacy and was told that the resident did not have to pay her full $66 in

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 _____	R-C 07/16/2019

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 421	Continued From page 63	D 421		

residents funds to the pharmacy bill.
-The pharmacy would accept any amount the resident was able to pay.

Interview with the BOM on 7/15/19 at 5:35pm revealed:
-Resident #8 was at the facility a while before being transferred to another facility.
-When Resident #8 came back to the facility her unpaid pharmacy bill from the other facility followed her.
-The BOM verbally told Resident #8 that her $66 in resident funds were being paid to her past due pharmacy bill.
-The BOM did not remember when she and Resident #8 made this verbal agreement.
-The BOM did not have any documentation to show when she had this conversation with Resident #8.
-Resident #8 and her family member had not signed any documentation agreeing to the $66 being paid monthly to the past due pharmacy bill.
-The BOM was aware that Resident #8 had dementia.
-The BOM met with Resident #8, her family member, the county representative, and the Administrator and they discussed the resident's funds about two to three weeks ago.
-The resident would start to receive $10 a month and pay $56 to the pharmacy bill starting July 2019, this was a verbal agreement.
- Resident #8 had not requested any money for July 2019.

Interview with the Administrator and the Resident Care Coordinator (RCC) on 7/16/19 at 3:35pm revealed:
-The Administrator did have a meeting with Resident #8, her family, the county representative , and the BOM, it was agreed Resident #8 would

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 _____	R-C 07/16/2019

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 421	Continued From page 64	D 421		

receive $10 a month.
-Resident #8 had not asked for $10 July 2019.

Refer to interview with the Administrator on 07/16/19 at 3:35pm.

4. Review of Resident #7's current FL-2 dated 8/6/18 revealed diagnoses included chronic obstructive sleep apnea, hypertension, and dementia.

Review of Resident #7's "Resident Trust Fund Account" revealed:
-The trust fund account was lined and contained six columns which were labeled as follows: date, transaction, withdrawal, deposit, balance, resident's signature, and two different columns labeled witness.
-The trust fund account covered the period of January 2019 through July 2019.
-The first entry dated 01/01/19 documented a $0 balance, with no resident or witness signatures.
-The second entry dated 01/07/19 documented a deposit of $66 and a balance of $66.
-The third entry dated 01/08/19 documented a $31.85 withdrawal for December 2018 medications and a balance of $34.15 with a resident signature and two witness signatures.
-The fourth entry dated 01/08/19 documented a withdrawal of 34.15 for personal use with a resident signature and two witness signatures.
-The fifth entry dated 01/31/19 documented a $0 balance with no resident or witness signatures.
-The sixth entry dated 02/05/19 documented a $66 deposit and $66 balance.
-The seventh entry dated 02/05/19 documented a $58.57 withdrawal for January 2019 medications and a $7.43 balance remaining with a resident signature and two witness signatures.
-The eight entry dated 02/05/19 documented a

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 421	Continued From page 65 $7.43 withdrawal for personal use with a resident signature and two witness signatures. -The ninth entry dated 02/28/19 documented a $0 balance. -The tenth entry dated 03/05/19 documented a $66 deposit and a $66 balance. -The eleventh entry dated 03/06/19 documented a $9.79 withdrawal for February 2019 medications and a $56.21 balance remaining with a resident signature and two witness signatures. -The twelfth entry dated 03/06/19 documented a $56.21 withdrawal for personal use with a resident signature and two witness signatures. -The thirteenth entry dated 03/31/19 documented a $0 balance with no resident or witness signatures. -The fourteenth entry dated 04/04/19 documented a $66 deposit and a $66 balance with no resident or witness signatures. -The fifteenth entry dated 04/05/19 documented a $23.60 withdrawal for March 2019 medications and a balance of $42.40 with a resident signature and two witness signatures. -The sixteenth entry dated 04/05/19 documented a $42.40 withdrawal for personal use with a resident signature and 2 witness' signature. -The seventeenth entry dated 04/30/19 documented a $0 balance with no resident or witness signatures. -The eighteenth entry dated 05/7/19 documented a $66 deposit and a $66 balance with no resident or witness signatures. -The nineteenth entry dated 05/08/19 documented a $66 withdrawal for April 2019 medications and a $0 balance, with no resident signature and two witness signatures. -The twentieth entry dated 05/31/19 documented a $0 balance with no resident signature or witness signatures. -The twenty-first entry dated 06/06/19	D 421		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 421	Continued From page 66	D 421		

documented a $66 deposit and a $66 balance with no resident or witness signatures.
-The twenty-second entry dated 06/12/19 documented a $63.83 withdrawal for May 2019 medications and a balance of $2.17 with a resident signature and two witness signatures.
-The twenty-third entry dated 06/12/19 documented a $2.17 withdrawal for personal use and a $0 balance with a resident signature and two witness' signatures.
-The twenty-fourth entry dated 06/30/19 documented a $0 balance with no resident signature or witness signatures.
-The twenty-fifth entry dated 07/05/19 documented a $66.00 deposit and $66.00 balanced with a resident signature and no witness signatures.
-The twenty-sixth entry dated 07/08/19 documented a $46.74 withdrawal for June 2019 medications and a $19.26 balance with a resident signature and one witness signature.
-The twenty-seventh entry dated 07/08/19 documented a $19.26 withdrawal for personal use with no resident signature and one witness signature.

Interview with Resident #7 on 07/12/19 at 3:35pm revealed:
-She had been at the facility for the last 4 years.
-She used to get $50 or $60 when she first came to the facility 4 years ago.
-She had not received $50 or $60 in a year.
-The Business Office Manager (BOM) decided how much money she would get each month.
-The resident did not sign anything to change how much of her resident funds she received monthly.
-She only received $15 for the month of July 2019.
-She was told by the BOM that her pharmacy bill was past due, and she had to pay to get the bill

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D 421	Continued From page 67 caught up. -She did not know how much her pharmacy bill was past due. -She said her copay for her medicine was about $20 a month. -She was no longer able to pay for life insurance due to not getting her monthly funds. -Her family member had taken over paying her life insurance policy. -She would like to have some of her resident funds to buy things from the store. Attempted telephone interview with Resident #7's family member on 7/15/19 at 12:02pm was unsuccessful. Interview with the BOM on 7/15/19 at 5:45pm revealed: -The BOM had a verbal agreement with Resident #7 to pay the amount of the resident's pharmacy bill first then give the resident what was leftover. -The BOM did not know when she made the verbal agreement with Resident #7. Refer to interview with the Administrator on 07/16/19 at 3:35pm. Interview with the Administrator and the Resident Care Coordinator (RCC) on 7/16/19 at 3:35pm revealed: -The resident's funds went to their pharmacy bill first and the resident received whatever amount was left. -If the resident had no pharmacy bill the $66 stayed in a resident's trust account. -The BOM decided how money was dispensed to the pharmacy for each resident. -The BOM had always handled the personal funds. -The BOM was out on medical leave from	D 421		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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D 421	Continued From page 68 November 2018 through February 2019. -The Administrator filled in for the BOM and did not pay any resident pharmacy bills from November 2018 through February 2019. _____ The facility failed to maintain an accurate accounting of personal funds for 4 of 4 sampled residents including a resident or legal representaive signature for each transaction and failed to make personal funds available on request by the resident or legal representative. The facility's failure to make personal funds available for use according to the preference of the resident or legal representative resulted in a reaching/grabbing tool not being purchased for Resident #11 who had a history of falls while reaching for things and Resident #8 not having access to money for personal hygiene products and hair care which was detrimental to Resident #8 and Resident #11 and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 08/01/19 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED AUGUST 15, 2019.	D 421		
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.	D912		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

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

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D912	Continued From page 69 This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents received care and services which were adequate, appropriate and in compliance with relevant federal and state laws and rules and regulations related to medication administration and personal funds. The findings are: 1. Based on observations, interviews and record reviews, the facility failed to assure potassium chloride was discontinued as ordered by the primary care provider for 1 of 6 sampled residents (#2) [Refer to Tag 358 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 2. Based on observations, interviews and record reviews, the facility failed to assure an accurate accounting of 4 of 4 sampled residents' personal funds including a record of each transaction signed by the resident or legal representative and remaining balances; and failed to make residents' personal funds available on request to the resident or legal representative (Resident #6, #7,#8 and #11) [Refer to Tag 421 10A NCAC 13F .1104(c) Accounting for Resident's Personal Funds (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights	D914		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D914	Continued From page 70 Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free neglect related to supervision and management of the facility. The findings are: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 7 sampled residents (#4, #5, and #10) including a resident (#4) who left the facility by climbing over the special care unit secured fence two times unsupervised, and two residents (#4, and #10) who sustained multiple falls in 6 months resulting in injuries and visits to the emergency room. [Refer to Tag 270 10A NCAC 13F .0901(b) Personal Care & Supervision (Type A2 Violation)]. 2. Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, personal funds, personal care and supervision [Refer to Tag 980, G.S. 131D-25-Implementation (Type A2 Violation)].	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation	D980		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D980	Continued From page 71 Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the Administrator failed to assure the overall management, operations, and policies and procedures of the facility were developed and implemented to maintain substantial compliance with the rules and statutes governing adult care homes as related to health care, medication administration, personal funds, personal care and supervision. The findings are: Review of the facility census report for 07/10/19 revealed there were 51 residents in the facility. Non-compliance was identified at violation level in the following rule areas: 1. Based on observations, interviews, and record reviews, the facility failed to provide supervision for 3 of 7 sampled residents (#4, #5, and #10) including a resident (#4) who left the facility by climbing over the special care unit secured fence two times unsupervised, and two residents (#4, and #10) who sustained multiple falls in 6 months resulting in injuries and visits to the emergency room. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A2 Violation)].	D980		

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	HAL098027	A. BUILDING: _____ B. WING _____	R-C 07/16/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D980	Continued From page 72 2. Based on observations, interviews and record reviews, the facility failed to assure potassium chloride was discontinued as ordered by the primary care provider for 1 of 6 sampled residents (#2) [Refer to Tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)]. 3. Based on observations, interviews and record reviews, the facility failed to assure an accurate accounting of 4 of 4 sampled residents' personal funds including a record of each transaction signed by the resident or legal representative and remaining balances; and failed to make residents' personal funds available on request to the resident or legal representative (Resident #6, #7,#8 and #11) [Refer to Tag 421 10A NCAC 13F .1104(c) Accounting for Resident's Personal Funds (Type B Violation)]. Interview with a family member on 07/16/19 at 1:45pm revealed: -She or her family members visited the facility one to two times per week. -Staff were always congregated in the dining on the special care unit (SCU) on their phones. -There was no staff on the halls. -She had talked to the Special Care Coordinator (SCC) and Administrator in May 2019 and nothing was done. -There was no monitoring to make sure staff were doing their jobs. Interview with the Resident Care Coordinator (RCC) on 07/12/19 at 11:15am revealed: -She took a "firm approach" with staff to make sure staff knew their job duties were serious and to make sure staff was doing their job. -She went out in halls and checked that staff were	D980		

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D980	Continued From page 73	D980		

performing their job duties throughout the day.
-She walked around the facility "constantly" throughout the day when she was working.
-She assisted staff with providing direct care, cooking and cleaning if needed.
-When she was not in the facility, she called to make sure staff was on the hall.

Interview with the Administrator on 07/12/19 at 11:30am revealed:
-She, the RCC and Special Care Coordinator (SCC) were in the facility on 2nd and 3rd shifts, but not all the time.
-She also monitored staff and residents via facility cameras.
-If something happened, she would check the camera and find out what happened, where staff was at and what was going on.
-She regularly called the facility and spoke with staff while watching on the camera.
-If she observed staff congregated in the dining room, she would call staff and ask staff why all staff were in the dining room and direct staff to be on the hall.

Second interview with the Administrator on 07/15/19 at 9:55am revealed:
-Staff were made aware on 07/12/19 that use of electronic devices was not allowed while on duty and the staffs' primary responsibility was care and supervision of the residents.
-She had posted signs saying "No devices of any kind" in the staffs' break room and inside cabinets containing the binders where staff documented.
-Monday through Friday during business hours, she the RCC and SCC, were responsible for monitoring staff providing care and supervision to residents.
-The medication aides (MAs) on duty for evenings, nights and weekends were responsible

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WILSON ASSISTED LIVING	3501 SENIOR VILLAGE LANE WILSON, NC 27896

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D980	Continued From page 74 for monitoring that personal care aides (PCAs) were doing what they were supposed to do. The Administrator failed to oversee the overall management of the facility and implementation of rules and regulations including supervision, medication administration and residents' personal funds. The Administrator's failure resulted in Resident #5, who resided on the special care unit, leaving the facility unnoticed on two occasions; Resident #10 sustaining injuries from multiple falls requiring emergency room treatment; Resident #2 receiving 6 doses of potassium chloride after it was discontinued due to high potassium a level; and Resident #11 not being able to purchase a reaching/grabbing tool which could have prevented falls which occurred while reaching for things on the floor. The Administrator's failures resulted in substantial risk of serious neglect and harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/19 for this violation. THE CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 15, 2019.	D980		