

Division of Health Service Regulation

STATE OF NORTH CAROLINA DIVISION OF HEALTH SERVICE REGULATION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 09/29/2022
NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING			STREET ADDRESS, CITY, STATE, ZIP CODE 3501 SENIOR VILLAGE LANE WILSON, NC 27896		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
D 000	Initial Comments The Adult Care Licensure Section and the Wilson County Department of Social Services conducted an annual and follow-up survey and complaint investigations on September 27, 2022 to September 29, 2022. The complaint investigations were initiated by the Wilson County Department of Social Services on August 31, 2022.	D 000			
D 079	10A NCAC 13F .0306(a)(5) Housekeeping and Furnishings 10A NCAC 13F .0306 Housekeeping and Furnishings (a) Adult care homes shall (5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards; This Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observation, interviews, and record review the facility failed to ensure the Special Care Unit (SCU) was free from hazards with residents with known wandering behaviors where a maintenance cart was left unattended with various tools and painting supplies left unattended. The findings are: Request for a policy for storage of hazardous materials on the Special Care Unit (SCU) was made on 09/28/22 and was not made available prior to survey exit. 1. Observation of resident room 200 on the SCU on 09/28/22 at 12:04pm revealed:	D 079			

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Peter Durrell

TITLE

Administrator

(X6) DATE

10/26/22

STATE FORM

6889

NUS311

RECEIVED

Continuation sheet 1 of 31

Reviewed and Acknowledged ———— AT 11.02.22

NOV 01 2022

ADULT CARE LICENSURE SECTION
RALEIGH

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 3601 SENIOR VILLAGE LANE WILSON, NC 27896
---	---

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 1</p> <ul style="list-style-type: none"> -The room door was open. -There was a maintenance cart in the residents room with a cordless drill, screwdrivers, and pliers. -There was no staff in the room. -There were no residents in the room. -The room had two resident's belongings. <p>Observation of the SCU hallway on 09/28/22 from 12:00pm to 12:15pm revealed:</p> <ul style="list-style-type: none"> -The door to resident room 200 door was open. -There was a resident that went from room 202 across the hallway into room 205 at 12:05pm. -There was a resident that was ambulating in the hallway without staff at 12:06pm. -The resident that went into resident room 205 wandered back into resident room 202 at 12:08pm. <p>Interview with the Maintenance Director on 09/28/22 at 12:18pm revealed:</p> <ul style="list-style-type: none"> -He was hanging a television in resident room 200 and went to go get a cord to complete the job. -The Assistant Resident Care Coordinator (ARCC) came and found him to tell him about the cart at 12:16pm. -When he left the maintenance cart on the SCU he normally told the personal care aides (PCAs) to stand with the cart. -He could not recall if he notified any staff on the SCU that he was leaving to go get a cord. <p>Interview with a PCA on the SCU on 09/28/22 at 12:25pm revealed:</p> <ul style="list-style-type: none"> -She was not aware that the Maintenance Director had left the cart unattended in resident room 200. -Her and the other PCA were finishing up with the lunch meal service in the dining room. 	D 079	<p>It is the policy of Wilson Assisted Living to maintain a facility free of obstructions and hazards.</p> <p>Staff have been in-serviced on the necessity to secure all areas and items they are responsible for to avoid any hazards or obstructions for residents.</p> <p>Admin/RCC or designee will monitor weekly to ensure compliance.</p>	10/19/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 2</p> <p>Interview with ARCC on 09/28/22 at 12:15pm revealed:</p> <ul style="list-style-type: none"> -The maintenance cart should not have been left unattended on the SCU. -There were at least 4 residents that wandered into rooms on the SCU. -The Maintenance Director should have alerted staff on the SCU that he was leaving the unit so that they could stand at the maintenance cart until he returned or he should have taken the maintenance cart with him. -Residents on the SCU had cognitive impairment such as forgetfulness, confusion and memory loss. -Hazardous items such as tools on the maintenance cart should not be available to residents. -She was not aware of any residents getting a hold of any tools from the maintenance cart in the past. <p>Interview with the Resident Care Coordinator (RCC) on 09/29/22 at 10:19am revealed:</p> <ul style="list-style-type: none"> -She expected the Maintenance Director to take the maintenance cart with him when he was not using it on the SCU. -Hazardous objects such as tools should not be available to residents on the SCU because of their dementia. -She was not aware of any residents that used hazardous items when they were left unattended. <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed she expected hazardous items such as the tools on the maintenance cart to be supervised by staff when not in use on the SCU.</p> <p>Telephone interview with the facility's Mental Health Provider (MHP) on 09/28/22 at 10:30am</p>	D 079		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 079	<p>Continued From page 3</p> <p>revealed she expected all hazardous items to be secured on the SCU for resident safety based on the resident population and their cognitive impairment.</p> <p>2. Observation of the Special Care Unit (SCU on 08/31/22 at 4:00pm revealed: -There was an unattended work cart of a painter that was in the hallway when the painter was in a resident's room and another time when the painter was not in the SCU. -Residents were observed walking near the unattended painter's cart on several occasions.</p> <p>Interview with the Administrator on 08/31/22 at 4:30pm revealed she was unaware of the painter's cart being unattended and would speak with him about it.</p> <p>Observation of the SCU on 09/06/22 at 2:00pm revealed there was an unattended work cart of the painter's in the hallway as residents walked by or near the cart.</p> <p>Interview with the Administrator on 09/26/22 at 2:05pm revealed that she was supposed to speak with the painter about his unattended cart but neglected to do so.</p>	D 079		
D 270	<p>10A NCAC 13F .0901(b) Personal Care and Supervision</p> <p>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.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 4</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#1) resulting in a resident from the Special Care Unit (SCU) eloping from the facility, without staff knowledge, to a busy 4 lane highway where she was located by family.</p> <p>The findings are:</p> <p>Review of Resident #1's current FL-2 dated 05/11/22 revealed: -Diagnoses include dementia, diabetes mellitus, chronic obstructive pulmonary disease, peripheral vascular disease, and aortic stenosis. -She was semi-ambulatory with a cane and wore glasses. -She was intermittently disoriented. -She was incontinent of bowel and bladder. -Her level of care was SCU.</p> <p>Review of Resident #1's Resident Register dated 02/21/22 revealed: -She was admitted to the facility on 02/24/22. -She required assistance ambulation. -She had significant memory loss and must be redirected. -She used a cane to ambulate.</p> <p>Review of Resident #1's SCU Admission Criteria Review dated 02/21/22 revealed: -It was marked yes that she had a diagnosis of dementia. -It was marked yes that she habitually wandered</p>	D 270	<p>At Wilson Assisted Living it is our policy to provide supervision for each resident that meets their specific needs.</p> <p>Facility added alarms to doors entering and exiting the SCU. New covers were added to key pads for additional layer of protection. Residents in SCU were put on 15 minute checks for location. Staff were in-serviced on being aware of what they see and hear and behaviors of residents that could signal a desire to elope. They discussed ways to communicate and share the responsibilities of monitoring residents.</p> <p>Admin/RCC or designee will monitor weekly to ensure compliance.</p>	10/29/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	--	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 5</p> <p>and/or would wander out of the building and not be able to find her way back.</p> <p>Review of Resident #1's current care plan dated 05/10/22 revealed: -She had wandering behaviors and she sun-downed at night. -She wandered in and out of rooms. -She was sometimes disoriented. -She required extensive assistance with ambulating (with a cane).</p> <p>Review of Resident #1's Licensed Health Professional Support (LHPS) Quarterly Review dated 08/08/22 revealed: -She ambulated using assistive device that required physical assistance (cane). -She resided in the SCU and was forgetful at times.</p> <p>Review of Resident #1's SCU profile completed 07/27/22 revealed: -She had wandering behaviors. -She had cognitive impairment including short term and long-term memory loss. -She had severe impairment for decision making skills and was unable to make decisions alone.</p> <p>Review of Resident #1's fall assessment dated 08/10/22 revealed: -She scored 4 points under level of consciousness and mental status for intermittent confusion. -She scored 3 points for history of falls. -She scored 4 points for ambulatory and incontinent. -She scored 1 point for balance problems while standing and 1 point for balance problems with walking. -She scored 2 points for orthostatic changes.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 6</p> <ul style="list-style-type: none"> -She scored 4 points for high-risk medications. -She scored 2 points for predisposing disease. -She scored 1 point for an equipment device (cane). -Her total score was 22 points. -A score of 10 points or more meant a resident was a high risk for falls. <p>Review of Resident #1's Mental Health Provider (MHP) visit note dated 08/24/22 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was seen for a routine visit. -She was confused, disoriented, and slow to respond. -Resident #1's assessment revealed she had cognitive impairment with short-term and long-term memory loss. -Resident #1's treatment plan included monitoring for risks of falls and other safety concerns. <p>Review of Resident #1's primary care provider (PCP) visit note dated 08/29/22 revealed:</p> <ul style="list-style-type: none"> -She was confused and oriented to person. -Resident #1's treatment plan included providing a safe, supportive, and secure environment. <p>Review of Resident #1's physician communication form and incident/accident report dated 08/31/22 revealed:</p> <ul style="list-style-type: none"> -There was no time noted on the physician communication form. -Resident #1 walked out behind an individual and went out the front door. -Emergency Medical Services (EMS) was called and "resident checked out fine". -Hospice was notified. -Under the physician reply/new orders section the PCP wrote "aware please monitor- hospice following". -The form was signed electronically by the PCP and dated 09/05/22 at 1:31pm. 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 7</p> <p>Review of Resident #1's "30-minute check for falls and/or location" document dated 08/31/22 revealed:</p> <ul style="list-style-type: none"> -Resident #1 was on 30-minute checks for falls and/or location. -At 5:30pm, her location was documented as dining room by the personal care aide (PCA). -At 6:00pm, her location was documented as hallway by the PCA. -At 6:30pm, her location was documented as front porch by the PCA. -At 7:00pm, her location was documented as front porch by the PCA. -At 7:30pm, her location was documented as leave of absence by the PCA. -At 8:00pm, her location was documented as leave of absence by the PCA. -At 8:30pm, her location was documented as hallway by the PCA. <p>Review of Resident #1's facility progress noted dated 08/31/22 revealed:</p> <ul style="list-style-type: none"> -The resident followed another person out of the unit door and walked out the front door. -Resident was returned to the facility by family member coming to visit. -EMS was called. -Resident did not go to the emergency room. -Her vital signs were stable; and she had no apparent injury. -Family, hospice provider, and primary care provider (PCP) were notified. -There was no date noted on the progress note. <p>Review of the EMS report dated 08/31/22 revealed:</p> <ul style="list-style-type: none"> -EMS received a call at 6:40pm on 08/31/22 for a resident that needed medical evaluation. -Upon arrival to the facility at 6:55pm Resident #1 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 8</p> <p>was found sitting on the front porch with her family.</p> <p>-According to the family, Resident #1 was supposed to be in the locked memory care unit; and she was found walking on the main road by herself by her family who brought her back to the facility.</p> <p>-The family on the scene wanted the resident evaluated and assessed by EMS.</p> <p>-Resident #1's vital signs were taken and an electrocardiography (EKG) was performed.</p> <p>-Resident #1's family did not want the resident to be transported to the hospital.</p> <p>-Assessment of Resident #1 revealed she was confused and oriented to person and place.</p> <p>Telephone interview with Resident #1's family member on 09/28/22 at 10:26am revealed:</p> <p>-She was called by a family member on 08/31/22 between 6:20pm and 6:25pm that she found Resident #1 on the corner of road and the four-lane highway.</p> <p>-The resident was standing on the corner of the road next to the stop sign, looking both directions, appearing to try to cross the street.</p> <p>-The resident did not have her cane with her and there was no one else with her.</p> <p>-The family member stopped the car and crossed the heavy traffic to stop Resident #1 before she crossed into traffic.</p> <p>-The resident was walked back to the facility by the family member.</p> <p>-The family member alerted staff that the resident was back at the facility.</p> <p>-Staff was not aware that the resident had left the facility.</p> <p>-Resident #1 was in the SCU because of cognitive impairment and she was not to be out of the facility without supervision.</p> <p>-She expected staff to provide Resident #1 with</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 9</p> <p>supervision for her safety and well-being.</p> <p>Observation of the location where Resident #1 was found by family members on 09/28/22 from 4:00pm to 4:15pm revealed:</p> <ul style="list-style-type: none"> -The location was approximately 900 feet from the front door of the building on the corner of a four lane highway (with a center turn lane) and single road. -There was a stop sign on the right side of the intersection where Resident #1's family member stated she was standing. -There were no sidewalks on the four lane highway where the Resident #1 was found. -The speed limit on the single road was 15 miles per hour (mph). -The speed limit on the four lane highway was 45 mph. <p>Review of Resident #1's PCP visit note dated 09/07/22 revealed:</p> <ul style="list-style-type: none"> -She had an elopement from the facility a few days ago where she walked out of the building behind a group of people. -She was found walking down near the stop sign. -No injuries were found on exam. <p>Interview with a PCA on 09/28/22 at 8:23am revealed:</p> <ul style="list-style-type: none"> -She was not working on 08/31/22 when Resident #1 eloped. -Resident #1 was a wanderer and needed frequent re-direction. -PCA's were responsible for filling out the 30 minute checks on all residents on the SCU. -After Resident #1's elopement, 30 minute checks were increased to 15 minute checks on all of the residents. -If "leave of absence" was documented on the checklist it meant that the resident was out of the 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 10</p> <p>facility.</p> <ul style="list-style-type: none"> -The residents were split up among PCAs to monitor locations based on their staffing assignments. <p>Interview with a medication aide (MA) on 09/28/22 at 8:00am revealed:</p> <ul style="list-style-type: none"> -She was working on the SCU second shift (3:00pm to 11:00pm) as the MA. -She completed the Incident/Accident Report on 08/31/22 for Resident #1. -She was not aware that Resident #1 had eloped from the building until her family brought her back to the facility. -She was alerted by another staff member that Resident #1 was on the front porch with her family; and she went out to evaluate the resident. -When she went to the front porch, she found Resident #1 with her family members. -She called 911, filled out the incident/accident report, notified the PCP and Resident #1's hospice provider. -Resident #1 had no injuries that she was aware of. -She did not recall the time that she was alerted to Resident #1 being on the front porch but knows that it was after dinner. -Prior to the event on 08/31/22 PCAs were responsible for completing 30-minute location checks on all the residents on SCU. -After Resident #1 eloped on 08/31/22, the PCAs now complete a 15-minute location check on all SCU residents. -The MA signed off on the location documentation sheets at the end of the shift. <p>Interview with the Assistant Resident Care Coordinator (RCC) on 09/29/22 at 8:50am revealed:</p> <ul style="list-style-type: none"> -Resident #1 was a wanderer and required 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 11</p> <p>constant supervision on the SCU.</p> <p>-PCAs on the SCU documented location checks on all residents every 15 minutes.</p> <p>-Prior to Resident #1's elopement on 08/31/22, resident's locations were documented every 30 minutes.</p> <p>-She was not working on 08/31/22 when Resident #1 eloped.</p> <p>-She was very concerned that Resident #1 was out of the facility without staff's knowledge because "anything could have happened" including she could have fallen, been hit by a car, or abducted.</p> <p>Interview with the RCC on 09/29/22 at 10:19am revealed:</p> <p>-She had just left the facility before receiving a call from staff that Resident #1 was found by family.</p> <p>-She was alarmed to hear that Resident #1 was out of the facility without supervision.</p> <p>-Resident #1 required constant supervision when away from the SCU because of her dementia diagnosis.</p> <p>-She was concerned that Resident #1 might have been injured if her family had not located her when they did.</p> <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed:</p> <p>-She watched video footage of Resident #1 leaving the facility on 08/31/22.</p> <p>-A resident from the assisted living (AL) side of the facility went onto the SCU.</p> <p>-The door to the SCU was locked but there is a button on the wall that the resident pressed to go onto the SCU.</p> <p>-The AL resident rarely went on the SCU and she was not sure why the resident went to the SCU on the evening of 08/31/22.</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 12</p> <ul style="list-style-type: none"> -When the AL resident opened the door to the SCU, Resident #1 stepped out of the door and walked out of the front door. -The time was approximately 6:15pm when Resident #1 left the facility on 08/31/22. -Residents on the SCU required constant supervision when they were not on the SCU to prevent injury. -It was concerning to her that Resident #1 left the facility without staff knowledge because she was at risk for injury. -The intersection where Resident #1 was found is "dangerous and there was a high volume of traffic". <p>Telephone interview Resident #1 hospice Registered Nurse on 09/29/22 revealed:</p> <ul style="list-style-type: none"> -Hospice was notified of her elopement from the facility on 08/31/22. -it was concerning that Resident #1 made it out of the facility without the facility's knowledge considering she was on a SCU. <p>Interview with the facility's LHPS Registered Nurse on 09/29/22 at 9:12am revealed:</p> <ul style="list-style-type: none"> -She expected residents from the SCU to be supervised at all times when off of the unit. -Residents on the SCU are vulnerable with their diagnoses of dementia and cognitive impairment. -It was concerning that Resident #1 left the facility without staff's knowledge and was not supervised. -Residents on the SCU should be under direct supervision when out of the unit for their safety. <p>Telephone interview with Resident #1's MHP on 09/29/22 at 10:30am revealed:</p> <ul style="list-style-type: none"> -She was extremely concerned that Resident #1 eloped from the facility without staff knowledge. -Resident #1 was on the SCU because of her 	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 13</p> <p>dementia and cognitive impairment.</p> <p>-It was not safe for Resident #1 to be out of the facility unsupervised.</p> <p>-Resident #1 was at risk for serious injury by being outside of the facility unsupervised without staff's knowledge.</p> <p>Telephone interview with the Office Manager at Resident #1's PCP office on 09/29/22 at 8:39am revealed:</p> <p>-The PCP was notified on 08/31/22 that Resident #1 eloped from the facility.</p> <p>-The expectation was that residents on the SCU were supervised at all times when off of the SCU because of their diagnoses.</p> <p>-It was dangerous for Resident #1 to be out of the building without staff supervision due to possible injury including falls or being hit by a car.</p> <p>Attempted interview with the PCA that was working on second shift on 08/31/22 revealed that she no longer was employed by the facility.</p> <p>Attempted telephone interview with Resident #1's PCP on 09/28/22 at 2:08pm and 09/29/22 at 8:39am were unsuccessful.</p> <p>Based on observations, interviews and record reviews, it was determined that Resident #1 was not interviewable.</p> <p>The facility failed to ensure that Resident #1 was supervised based on her needs and diagnoses including cognitive impairment, short term and long term memory loss, confusion, and wandering tendencies. The lack of supervision resulted in Resident #1 eloping from the facility's Special Care Unit, without staff's knowledge to a busy intersection where she was at risk for injury including falls or being hit by a vehicle. The</p>	D 270		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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	<p>Continued From page 14</p> <p>facility's failure resulted in serious neglect which constitutes a Type A1 Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/07/22 for this violation.</p> <p>THE CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED OCTOBER 29, 2022.</p>	D 270		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance.</p> <p>This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure personal belongings were not lost or broken for 2 of 5 residents sampled including two sets of dentures (#1) and articles of clothing (#5) on the Special Care Unit (SCU).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL-2 dated 05/11/22 revealed: -Diagnoses include dementia, diabetes mellitus, chronic obstructive pulmonary disease, peripheral vascular disease, and aortic stenosis. -She was intermittently disoriented and was on the Special Care Unit (SCU).</p> <p>Observation of Resident #1's room on 09/28/22 at 10:48am revealed there was an empty denture cup on the dresser and Resident #1 did not have</p>	D 338	<p>It is the policy of Wilson Assisted Living to provide and promote all of NC Declaration of Resident Rights and ensure their rights are maintained and exercised without hindrance.</p> <p>All staff are In-serviced on these rights at hire and yearly thereafter.</p>	10/31/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 15</p> <p>any dentures in her mouth.</p> <p>Telephone interview with Resident #1's family member on 09/28/22 at 10:26am revealed:</p> <ul style="list-style-type: none"> -The resident was admitted to the facility with a set of dentures with upper and lower plates. -Two weeks after she was admitted to the facility the top plate of dentures went missing and the bottom plate of dentures were broken. -Staff was not able to locate the dentures. -Approximately 6 weeks later the resident's family replaced the dentures and within 3 days the second set of dentures was missing. -She feels like it was a dignity issue because the resident did not like to be seen without her dentures in. -The family was told by the Administrator that she would "follow-up with them" on where the facility was at in locating the dentures and they still have not heard back from the Administrator. <p>Interview with a personal care aide (PCA) at 09/28/22 at 9:43am revealed:</p> <ul style="list-style-type: none"> -Resident #1's dentures had been missing for at least 3 weeks. -Resident #1 took her dentures out to eat and sometimes folded them up in a napkin. -Resident #1 would put the dentures in her pocket and would often time not give them to staff. <p>Interview with the Resident Care Coordinator (RCC) on 09/29/22 at 10:19am revealed:</p> <ul style="list-style-type: none"> -She was aware that Resident #1's dentures were missing. -When she was made aware that Resident #1's dentures were missing, she brought in extra staff members to look for the dentures. -The facility was not able to locate the dentures and she notified Resident #1's family of that. -Resident #1 was not cooperative with staff if they 	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 16</p> <p>asked for her dentures to keep them in a secure spot.</p> <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed: -She was aware that Resident #1's dentures were missing. -The RCC spoke with the family and updated them after they were not able to locate the dentures.</p> <p>Based on observations, interviews and record reviews, it was determined that Resident #1 was not interviewable.</p> <p>2. Review of Resident #5's FL-2 dated 11/03/21 revealed: -Diagnoses included dementia, chronic obstructive pulmonary disease, diabetes mellitus type 2 and hypertension. -She was Intermittently disoriented and was on the Special Care Unit (SCU).</p> <p>A telephone interview with Resident #5's family member on 09/23/22 at 2:10 pm revealed: -She was frustrated with the facility regarding her family member's clothing. -She was always having to replace her family member's clothes because the facility was always losing clothes that had been purchased for her family member. -After her family member passed away, she went to the facility to pack up her belongings and "It broke my heart that when my family member's belongings were packed up, because it was just one box of clothing and a lot of clothes had been purchased for her." -Her family member had asked her to buy her a shirt with butterflies on it because she loved butterflies; she finally found a shirt for her family</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	<p>Continued From page 17</p> <p>member and bought it, only for it to be lost by the facility.</p> <p>Interview with the Resident Care Coordinator (RCC) on 09/29/22 at 10:19am revealed: -She was not aware of any missing clothing items for Resident #5. -If she was made aware of a missing items, the staff went on a search and started in the laundry room looking for the item. -Most of the time, when she was made aware of the missing clothing items the staff was able to locate it after searching for it. -When clothing items were missing they were able to locate them in the laundry or in other resident's rooms on the SCU.</p> <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed she was not aware of any of Resident #4's clothing items that were missing and staff on the SCU was responsible for ensuring resident's clothing items remained in the resident's possession.</p>	D 338		
D 378	<p>10a NCAC 13F .1006 (b) Medication Storage</p> <p>10A NCAC 13F .1006 Medication Storage</p> <p>(b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained in a safe manner under locked security except when under the immediate or direct physical supervision of staff in charge of medication administration.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record</p>	D 378		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 378	<p>Continued From page 18</p> <p>review, the facility failed to ensure the medication cart on the assisted living (AL) side of the facility remained locked when not under direct supervision by staff members administering medications.</p> <p>The findings are:</p> <p>Review of the facility's policy on Storage of Medications, undated, revealed: -All medications, prescriptions and non prescription, administered by facility staff, including those requiring refrigeration, will be kept locked except when staff responsible for medication administration are in close proximity and can see the medication cart. -Accessibility to locked storage areas will be allowed only to persons responsible for medication administration, the Administrator or person in charge.</p> <p>Observation of the assisted living (AL) 100 hallway on 09/27/22 at 8:45am revealed: -The survey team entered the building and there was no staff present at the nursing station. -The 100 hallway had a medication cart parked between room 104 and 106 that was unlocked. -There were two housekeepers on the AL hallway that came out of rooms at 8:50am. -The medication aide (MA) assigned to the AL hallway came from the back of the facility down the 300 hallway at 8:56am.</p> <p>Interview with the MA on 09/27/22 at 8:58am revealed she was called away from the cart by another staff member and forgot to lock the cart.</p> <p>Second observation of medication cart on the AL hallway on 09/27/22 between 9:35am and 9:45am revealed the medication cart was unlocked and</p>	D 378	<p>Wilson Assisted Livings policy is to have all medications secured in locked areas for access by staff charged with Medication Administration.</p> <p>Med Aides were in-serviced on proper storage and requirements of keeping all medications in a locked space.</p> <p>Admin/RCC or designee will do random checks and monitor weekly for compliance.</p>	10/20/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 378	<p>Continued From page 19</p> <p>unattended by staff.</p> <p>Observation of the hallway on 09/27/22 at 9:39am revealed there was a resident standing in the hallway next to room 107 across from the unlocked medication cart.</p> <p>Interview with the MA on 09/27/22 at 9:50am revealed:</p> <ul style="list-style-type: none"> -She was away from the medication cart to check daily temperatures on the residents. -She thought that she had locked the medication cart. -It was the facility's policy that the medication cart should be kept locked unless in use. -It was important for the medication cart to stay locked for resident safety. <p>Interview with the Resident Care Coordinator (RCC) on 09/29/22 at 10:19am revealed:</p> <ul style="list-style-type: none"> -It was the facility's policy that medication carts should be kept locked except when staff are administering medications and can see the medication cart. -She was not aware of any residents having access to the medication cart when it was unlocked. -She expected the MAs to keep the medication carts locked when they were not in use. <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed she expected the medication carts to be locked when not in use by the MA for resident safety.</p>	D 378		
D 451	<p>10A NCAC 13F .1212(a) Reporting of Accidents and Incidents</p> <p>10A NCAC 13F .1212 Reporting of Accidents and</p>	D 451		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	<p>Continued From page 20</p> <p>Incidents</p> <p>(a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the notification of the local county department of social services for 1 of 5 sampled residents (#4) who had a fall that required treatment at the emergency room.</p> <p>The findings are:</p> <p>Review of Resident #4's FL-2 dated 03/17/22 revealed: -Resident #4 was diagnosed with dementia/Alzheimer's, essential hypertension, anxiety disorder and hyperlipidemia. -No information was noted for Resident #4's orientation or ambulatory status.</p> <p>Review of Resident #4's Incident Report dated 05/10/22 revealed: -At 5:30am, Resident #4 had a witnessed fall in her bedroom. -No first aid was administered, but Resident #4 had swelling on the front right side of her head. -Resident #4 was transported to the hospital by Emergency Medical Services (EMS). -The primary care provider (PCP) was notified of the incident by fax. -There was no documentation of the incident being sent to the local social services.</p> <p>Review of Resident #4's EMS report dated</p>	D 451	<p>It is the policy of Wilson Assisted to comply with the requirements to notify county DSS of accidents/ incidents resulting in death, requiring EMS, hospitalization or medical treatment.</p> <p>RCC will continue to fax accident/ Incident reports to county DSS and receive a transmittal "OK" receipt. RCC will also email reports to DSS with a read receipt request to ensure it is received. Administrator will be CC'd on emails.</p> <p>Admin/RCC or designee will do periodic checks to ensure compliance.</p>	10/19/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 451	<p>Continued From page 21</p> <p>05/10/22 revealed: -EMS was dispatched to the facility for a fall victim at 6:02 am. -Upon arrival, Resident #4 was found standing and walking around the room with staff present. -The chief complaint was a fall and evaluation was requested by staff. -Resident #4 denied any injuries or feeling unwell, but did have a cough, a temperature of 100.5 Fahrenheit and was administered 1000 mg of acetaminophen (a medication used to treat fever).</p> <p>Review of Resident #4's hospital Emergency Provider Record dated 05/10/22 revealed: -Resident #4 was seen by the provider for a chief complaint of a fall. -She was alert and oriented to person only. -She reported no injuries from the fall and did not recall hitting her head. -There was no reported loss of consciousness, however the fall was unwitnessed by the facility.</p> <p>Review of Resident #4's Radiology Report dated 05/10/22 revealed the computerized tomography (CT) scan showed no evidence of acute intracranial abnormality.</p> <p>Review of Resident #4's Emergency Department (ED) Summary Report dated 05/10/22 revealed: -Resident #4 was identified as a high fall risk. -The stated complaint was that Resident #4 was a memory care resident who arrived via Emergency Management Services (EMS) from the facility because she fell due to tripping over her shoes that were on the wrong feet.</p> <p>Review of Resident #4's hospital Patient Visit Information report dated 05/10/22 revealed she was discharged with no new orders and was to</p>	D 451		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	--	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 22</p> <p>follow-up with her primary care provider (PCP) in two days.</p> <p>Interview with the local county Adult Home Specialist (AHS) on 09/29/22 at 11:00am revealed: -She was not aware of Resident #4's fall on 05/10/22 that required the resident to be evaluated at the emergency room. -She did not receive the incident report for Resident #4's fall that required evaluation that the emergency room on 05/10/22.</p> <p>Interview with the Resident Care Coordinator (RCC) on 09/29/22 at 10:19am revealed: -It was her responsibility to ensure that incident reports that were reportable to the local county Department of Social Services (DSS). -It was her understanding that reportable incidents included when a resident went to the emergency room for a fall. -She was not aware that the AHS did not receive the incident report when Resident #4 went to the emergency room for a fall on 05/10/22. -It was an oversight on her part that the incident report did not go to DSS for Resident #4 on 05/10/22.</p> <p>Interview with the Administrator on 09/29/22 at 12:05pm revealed: -She expected the RCC to send all reportable incidents to the local county DSS. -She was not aware that Resident #4's incident report on 05/10/22 that required evaluation at the emergency department for a fall was not sent to the local county DSS.</p> <p>10A NCAC 13F .1212(e) Reporting of Accidents and Incidents</p>	D 451		
D 454		D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 23</p> <p>10A NCAC 13F .1212 Reporting Of Accidents And Incidents (e) The facility shall assure the notification of a resident's responsible person or contact person, as indicated on the Resident Register, of the following, unless the resident or his responsible person or contact person objects to such notification: (1) any injury to or illness of the resident requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but no later than 24 hours from the time of the initial discovery or knowledge of the injury or illness by staff and documented in the resident's file; and (2) any incident of the resident falling or elopement which does not result in injury requiring medical treatment or referral for emergency medical evaluation, with notification to be as soon as possible but not later than 48 hours from the time of initial discovery or knowledge of the incident by staff and documented in the resident's file, except for elopement requiring immediate notification according to Rule .0906(f)(4) of this Subchapter.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the notification of the family member within 24 hours for 1 of 5 sampled residents (#5) who had an illness that required referral for emergency medical evaluation.</p> <p>The findings are: Review of Resident #5's FL-2 dated 11/03/21 revealed: -Diagnoses included dementia, chronic</p>	D 454	<p>It is Wilson Assisted Livings policy to notify residents' responsible party or contact person of any illness or injury requiring medical treatment or ER as well as falls and elopement.</p> <p>Med Aides were in-serviced on the need to contact the resident's responsible party or contact person. They must, at a minimum, leave a voicemail but preferably have a conversation. If not able to leave a voicemail they must continue to reach out until they can speak with someone. RCC will contact responsible party next business day to follow-up.</p> <p>RCC or designee will monitor periodically to ensure necessary notifications are being made.</p>	10/20/22

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	--	---

NAME OF PROVIDER OR SUPPLIER
WILSON ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE
**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 454	<p>Continued From page 24</p> <p>obstructive pulmonary disease, diabetes mellitus type 2, and hypertension. -She was intermittently disoriented. -She required assistance with bathing and dressing. -She was on continuous oxygen 3L (liters per minute) via nasal cannula.</p> <p>Review of Resident #5's subsequent FL-2 dated 09/01/22 revealed: -Diagnoses included right upper lobe pneumonia, bronchospasm, sepsis, and hypoxemia. -Resident was not oriented to person, place, or time. -Resident required extensive assistance with ambulation, toileting, eating, transfers, dressing, and bathing.</p> <p>Review of Resident #5's Resident Register revealed an admission date of 09/23/21.</p> <p>Review of a physician communication report dated 08/30/22 revealed: -The reason for the report was to notify the primary care provider (PCP) of Resident #5's emergency room (ER) visit. -Resident #5 was sent to the ER on 08/30/22. -Resident #5 was sent to the ER because she was leaning to one side in the wheelchair and could not stand. -The report was electronically signed by Resident #5's PCP acknowledging receipt of the report.</p> <p>Review of the local Emergency Medical Services (EMS) report revealed: -The EMS arrived at the facility around 5:56am. -Resident #5 was found leaning over to the right side in the wheelchair, alert but confused, breathing and conscious. -Resident #5 had altered mental status according</p>	D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 25</p> <p>to staff.</p> <ul style="list-style-type: none"> -The resident complained of pain in her legs. -Resident #5 was transported to the ER and arrived there around 6:30am. <p>Review of Resident #5's hospital summary report dated 09/06/22 revealed:</p> <ul style="list-style-type: none"> -The resident was seen in the ER on 08/30/22 for a urinary tract infection (UTI) and possible atrial fibrillation. -The resident was admitted to the hospital on 08/30/22 and discharged back to the facility on 09/06/22 with hospice in place. -Resident #5's family member was contacted by the discharge nurse on 08/31/22 via voicemail. -The charge nurse spoke to Resident #5's family member on 09/01/22 when she returned the call in response to the voicemail on 08/31/22. -Resident #5's family member was not aware that the resident had been transported to the ER and subsequently admitted to the hospital on 08/30/22. <p>Telephone interview with Resident #5's Power of Attorney (POA) on 09/23/22 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -The night of 09/02/22 or 09/03/22, a voice message was left for her by someone from the local hospital saying they needed to speak with her regarding the discharge of Resident #5 from the local hospital. -When she heard the voice mail, she thought the hospital had called the wrong number because she had no idea Resident #5 had been taken to the hospital; and she was the power POA for Resident #5. -She called the hospital the next day and was informed Resident #5 had been in the hospital for three days. -She called the facility and spoke with the medication aide (MA), asked if Resident #5 was 	D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 26</p> <p>in the hospital and asked why she had not been notified.</p> <p>-The MA informed her that around 08/30/22, a staff member noticed something was not right with Resident #5 and called the emergency medical services (EMS).</p> <p>-She was very upset with the facility's staff and "really let them have it and gave them a piece of my mind."</p> <p>-She had no idea Resident #5 had been in the hospital for three days.</p> <p>-The Resident Care Coordinator (RCC) called and seemed to be upset because someone was supposed to have notified her about Resident #5 being sent to the hospital.</p> <p>-The RCC informed her the two MAs she spoke with on the telephone had been suspended for not notifying her about her family member being sent to the hospital.</p> <p>-The RCC told her that the first MA supposedly told the second MA to call the POA, but the call never took place.</p> <p>-She was very upset and having a hard time with this because hospital staff told her Resident #5 had been crying and asking for her during the time when she had no idea her family member was in the hospital.</p> <p>-"I lost three (3) whole days of being able to see my family member that I can never get back."</p> <p>Interview with the personal care aide (PCA) on 09/29/22 at 9:13am revealed:</p> <p>-She was assisting Resident #5 to the bathroom when the resident became weak and could not stand on 08/30/21 around 5:30am.</p> <p>-She assisted the resident back in her wheelchair.</p> <p>-She immediately notified the MA who came to the resident's room.</p> <p>-The MA notified the RCC who was in the facility and she also came to the resident's room.</p>	D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	---	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 27</p> <p>-The EMS was called and the resident was transported to the ER on 08/30/22 around 6:00am..</p> <p>Interview with the MA on 09/29/22 at 7:58am revealed:</p> <p>-She worked on the 3rd shift and covered the assisted living and memory care unit on 08/30/22.</p> <p>-She was called to Resident #5's room on the morning of 08/30/22 around 5:30am by the PCA because the resident was "not acting herself."</p> <p>-The resident was leaning to one side in the wheelchair.</p> <p>-She notified the RCC who came to the resident's room.</p> <p>-The EMS was called and the resident was transported to the ER.</p> <p>-She called Resident #5's family member but she could not leave a message because the voice mail was full.</p> <p>-She communicated with the incoming MA on the 1st shift that she was unable to reach Resident #5's family member and if she would continue trying to reach her.</p> <p>-She was not aware that the family member had not been notified until the next night on 08/31/22 when the family member called the facility.</p> <p>-She informed the family member that she tried calling her but could not leave a message because the voice mail was full.</p> <p>-When a resident goes to the hospital, the MA was to inform the RCC, the family, and the PCP by completing a physician communication report and faxing the report to the PCP.</p> <p>-She thought the family member had been notified about Resident #5's hospitalization.</p> <p>Interview with the Assistant Resident Care Coordinator (ARCC) on 09/29/22 at 8:45am revealed:</p>	D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 28</p> <ul style="list-style-type: none"> -She was the incoming MA on the morning Resident #5 was sent to the ER. -She was not aware the family member had not been notified that the resident was sent to the ER. -She remembered being informed by the outgoing MA that Resident #5 had been sent to the ER. -She did not recall being told to continue trying to reach the family member because her voice mail was full and a message could not be left by the outgoing MA. <p>Interview with the RCC on 09/29/22 at 10:19am revealed:</p> <ul style="list-style-type: none"> -She was called to Resident #5's room on 08/30/22 by the PCA and the MA. -Resident #5 was not at her baseline and was leaning to one side in her wheelchair. -Resident #5 was sent to the ER for evaluation and management. -The process was for the MA to notify her, the PCP and the family when a resident was sent to the ER. -She thought the family had been notified at the time the resident was sent to the ER. -She discovered later that the MA had called the family member could not leave a message because the voice mail was full. -She expected staff to continue calling the family member and to inform the incoming staff to continue trying to reach the family member. -She was not aware Resident #5's family member had not been notified until that next night 08/31/22 when the family member called the facility because she received a telephone voice message from the hospital discharge nurse regarding the resident's hospitalization. -She called the family member on 08/31/22 after the family member had called the facility and spoke to the MA. 	D 454		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL098027	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED R 09/29/2022
--	--	---	---

NAME OF PROVIDER OR SUPPLIER WILSON ASSISTED LIVING	STREET ADDRESS, CITY, STATE, ZIP CODE 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 454	<p>Continued From page 29</p> <ul style="list-style-type: none"> -The MA called her after the telephone call from the family member. -She went to the facility that night to investigate as to why the family member was not notified that Resident #5 had been sent to the ER. <p>Interview with the Administrator on 09/29/22 at 12:00pm revealed:</p> <ul style="list-style-type: none"> -She was not aware the family member was not notified of Resident #5's hospitalization until she was told by the MA. -The MA informed her that she tried to call the family member but the telephone voice mail was full. -The MA informed her that she told the incoming MA to continue calling the family member but apparently she did not. -She expected the family or responsible person to be notified when a resident was sent to the ER. 	D 454		
D914	<p>G.S. 131D-21(4) Declaration of Residents' Rights</p> <p>G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation.</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure residents free of neglect and received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations as related to personal care and supervision.</p> <p>The findings are:</p>	D914		

Division of Health Service Regulation

PRINTED: 10/11/2022
FORM APPROVED

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

HAL098027

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: _____

B. WING: _____

(X3) DATE SURVEY
COMPLETED

R
09/29/2022

NAME OF PROVIDER OR SUPPLIER

WILSON ASSISTED LIVING

STREET ADDRESS, CITY, STATE, ZIP CODE

3501 SENIOR VILLAGE LANE
WILSON, NC 27896

(X4) ID
PREFIX
TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL
REGULATORY OR LSC IDENTIFYING INFORMATION)

ID
PREFIX
TAG

PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE
CROSS-REFERENCED TO THE APPROPRIATE
DEFICIENCY)

(X5)
COMPLETE
DATE

D914 Continued From page 30

Based on observations, interviews and record reviews, the facility failed to provide supervision in accordance with the resident's assessed needs for 1 of 5 sampled residents (#1) resulting in a resident from the Special Care Unit (SCU) eloping from the facility, without staff knowledge, to a busy 4 lane highway where she was located by family. [Refer to Tag 270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation)].

D914

It is the policy of Wilson Assisted Living to ensure that all residents are free of mental and physical abuse, neglect and exploitation and receive adequate and appropriate care.

Staff were in-serviced on Residents' Rights with an emphasis on appropriate supervision.

10/24/22