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 01/12/2023

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 conducted a Follow Up survey on January 11, 2023 and January 12, 2023.	D 000		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to notify the county department of social services of incidents resulting in injury requiring medical treatment and referral to a local hospital for emergency medical evaluation for 2 of 9 sampled residents (#6, #8). The findings are: 1. Review of Resident #6's current FL-2 dated 10/12/22 revealed diagnoses included coronary artery disease, cerebrovascular accident, hypertension, lymphedema, osteoarthritis, mild cognitive impairment, depression, and reflux. Review of a hospital emergency department after visit summary dated 12/27/22 for Resident #6 revealed: -The resident was seen for a fall. -Patient instructions reviewed with the resident were for a facial bruise (contusion).	D 451		

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D 451	Continued From page 1 Review of an Accident/Injury Report for Resident #6 dated 12/27/22 revealed: -Resident #6 fell while trying to get out of bed. -The body assessment diagram on the accident/injury report had a line pointing to the forehead and bruising was checked as the type of injury. -Resident #6 was sent to a local hospital emergency room. -The Resident Care Coordinator (RCC) documented email notification to the regulatory agency on 01/02/"22". Interview with a medication aide (MA) on 01/11/23 at 9:42am revealed: -She did not know of any residents "right off hand" who had fallen within the last three months. -Resident #6 was currently in the hospital. Interview with a personal care aide on 01/11/23 at 12:16pm revealed Resident #6 was a fall risk. Telephone interview with Resident #6's family member on 01/12/23 at 8:12am revealed: -The family member was contacted by the facility when Resident #6 fell and was told the resident was on the way to the hospital. -The family member did not remember who called from the facility. Interview with the county Adult Home Specialist (AHS) on 01/12/23 at 10:31am revealed: -She received an incident/accident report for Resident #6 dated 12/27/22 from the facility today (01/12/23) at 8:47am. -She had not received any prior notification of the incident/accident report and hospital emergency room visit until today (01/12/23).	D 451		

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D 451	Continued From page 2	D 451		

Interview with the Facility Manager/Resident Care Coordinator (FM) on 01/12/23 at 10:10am revealed:
-She sent the accident/injury report for Resident #6 to the regulatory agency (County Department of Social Services) AHS today (01/12/23).
-She tried to send the notification to the county Department of Social Services AHS on 01/02/23.
-She had not noticed the 01/02/23 email "went to a fail/send draft folder - not sent" until verification of regulatory agency was requested by surveyor earlier today (01/12/23).
-She normally did not check her email to verify that emails were transmitted.
-The MAs were responsible to fax reports to the county AHS in her absence.

Interview with the Administrator on 01/12/23 at 11:12am revealed:
-She (Administrator) was supposed to be copied on the email of the incident/accident report.
-She never got an email showing an incident/accident on 12/27/22 for Resident #6.
-She knew Resident #6 had a fall.
-She did not know the date of the fall.
-She did not know "for a fact" that Resident #6 went to the hospital after the fall.
-Incident/accident reports were to be sent to the county department of social services (DSS) by the Facility Manager within 24 to 48 hours.
2. Review of Resident #8's current FL dated 08/11/22 revealed diagnoses included cognitive impairment and memory loss, diabetes mellitus type II and hypertension.

Review of Resident #8's accident/injury report dated 12/23/22 revealed:
-The incident occurred at 10:47am.
-Resident #8 slipped off her bed onto the floor.
-Resident #8 vitals included temperature was

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97.3, respiration was 17, blood pressure was 157/82 and pulse was 78.
-Resident #8 was taken to the emergency room (ER) and was transported by emergency medical staff (EMS).
-The accident/injury report was signed by the Resident Care Coordinator (RCC) on 12/29/22.
-The accident/injury reported was emailed and faxed to the County Department of Social Services (DSS) on 12/29/22.

Review of the Physician Communication Report dated 12/23/22 revealed:
-The reason for the report was due to a fall and was described as the resident "slipped off the bed to the floor."
-Resident #8 was sent to the ER.
-There was no apparent injury.
-The report was signed by the Supervisor in charge on 12/23/22.
-Resident #8 was scheduled for a follow up with her Primary Care Provided (PCP) on 12/25/22.
-The Physician signed the report on 12/28/22 and noted Resident #8 was sent to the ER and will continue to be monitored.

Review of Resident #8's ER discharge summary dated 12/23/22 revealed:
-Resident #8 was seen due to a fall injury.
-Resident #8 was treated for sacral contusion, head injury and contusion of right knee.
-Resident #8 was to follow up with her Primary Care Provider (PCP) within 5 days.

Interview with the County Adult Home Specialist (AHS) on 01/12/23 at 10:25am revealed:
-She received the 12/23/22 accident/injury report via email on 01/12/23 at 8:47am.
-The accident/injury report documented that Resident #8 had slipped off the bed onto the

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floor.
-The accident/injury report was signed by the RCC on 12/29/22.

Interview with the RCC on 01/12/23 at 10:11am revealed:
-Resident #8 had a fall on 12/23/22 and was sent to the ER for treatment.
-The RCC provided copies of the facility's accident/injury report and the Physician Communication Report.
-The RCC had emailed and faxed the accident/injury report to the County DSS on 12/29/22.
-The RCC did not provide documentation to support when the accident/injury report was submitted to the County DSS.
-The RCC checked her sent email folder on 01/05/23 and learned the 12/23/22 accident/injury report had not transmitted as sent to the County DSS.
-The RCC emailed the accident/injury report to the County DSS on 01/05/23 around 8:00am after she learned the 12/23/22 had not transmitted as sent.
-Accident/injury reports were sent to the County DSS within 48 hours of after the incident/accident via email and she copied the Administrator on all the emails.
-If the Medication Aides (MA) sent an accident/injury report to the County DSS via fax, the RCC would follow up and resend the accident/injury report to the County DSS via email.

Interview with the Administrator on 01/12/23 at 11:12am revealed:
-She was not aware of Resident #8's fall on 12/23/22.
-The RCC had tried to send the accident/injury

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D 451	Continued From page 5 via email on 12/23/22 but it was "kicked back". -She had the Information Technology (IT) staff to research issues with the accident/injury report not being able to be transmitted as sent on 12/23/22 but no issues were found. -The RCC was responsible for submitting the accident/injury reports to the County DSS within 24 to 48 hours of all accidents or incidents were injuries occurred and required medical attention or if a resident had to go to the ER. -If a MA completed the accident/injury report and faxed the report to DSS, the RCC was to follow up with the report being submitted to DSS. -It was the expectation that all accident/injury reports that were needed to be submitted to DSS was to be submitted within 48 hours.	D 451		