

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews with family, staff, Nurse Practitioner (NP), and Contracted Medical Transportation Company, the facility failed to ensure a resident was safely transported by Transport Technician #1 and Transport Technician #2 when Resident #126's stretcher tipped sideways at an uneven section of pavement as the resident was being pushed to the transportation vehicle through a parking lot following an appointment. The transport technicians and a passerby returned the stretcher to an upright and stable position. The resident was secured to the stretcher and did not fall, however she complained of pain when she returned to the facility. An x-ray revealed a fracture of the fourth through sixth right ribs and she required an increase in the dosage of her pain medication and the addition of an opioid pain medication. The facility also failed to eliminate the potential for an avoidable accident when a cognitively intact resident (Resident #127) was given discharge medications that included 14 tablets of 5 milligram cyclobenzaprine (muscle relaxant) that were prescribed for another resident. Resident #127 realized the facility had provided her with her own medications in addition to the unprescribed cyclobenzaprine when she returned to her home and she contacted the facility to notify them of the error. This deficient practice affected two (Resident #126, Resident #127) of eight residents reviewed for accidents. The findings included: 1. Resident #126 was admitted to the facility on [DATE] with diagnoses that included 2-part displaced fracture of the surgical neck of the left humerus (a break where the upper arm bone is snapped into two main pieces near the shoulder and shifted out of place), closed left hip fracture exacerbated by influenza infection, Chronic Obstructive Pulmonary Disease (COPD), Coronary Artery Disease (CAD), acute kidney injury on chronic kidney disease, paroxysmal atrial fibrillation (heart rhythm disorder where the heart beats fast and out of order starting and stopping on its own), hypertension (occurs when blood pushes too strongly against your artery walls), and hyperlipidemia (commonly known as high cholesterol). Resident #126 had an order dated 1/9/26 for acetaminophen (medication used to treat mild to moderate pain) 650 milligrams (mg) by mouth every 8 hours as needed (PRN) for pain. Resident #126 had an order dated 1/9/26 to record vital signs including pain level every day and evening shift for 14 days. (continued on next page)		

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER
REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	Resident #126 had an order dated 1/14/26 that read apply menthol topical analgesic (medication designed to relieve pain) gel 5% to posterior neck topically every 5 hours PRN for pain. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident #126 had moderate cognitive impairment. Resident #126 was dependent on staff assistance to complete all activities of daily living and had frequent episodes of pain with a pain intensity of 9 (scale from 0-10 with zero being no pain and 10 as the worst pain you can imagine). Resident #126's MDS also revealed she had received no pain medication in the 5-day look back period for this assessment. Resident #126 had an order dated 1/20/26 to record vital signs 6 times a day for 3 days for elevated white blood cell count including pain. Review of the care plan revealed a focus area created on 1/9/26 of actual pain, acute, with a goal to be pain free within 1 hour of the intervention as voiced by Resident #126. The interventions included to administer pain medication as prescribed and note the effectiveness; observe for and document characteristics of pain; location, severity, frequency and precipitating factors; and observe for side effects of pain medication. A review of Resident #126's Medication Administration Record (MAR) from 1/9/26 through 2/9/26 indicated she was administered PRN menthol topical analgesic 1 time and PRN acetaminophen 11 times. Her pain level (on a scale of 0-10 with 0 being no pain and 10 being the worst pain possible) was documented once as 3 (1/22/26), once as 6 (2/4/26), once as 8 (2/8/26), and twice as 9 (1/9/26 and 1/30/26). All remaining pain levels were documented as 0 between 1/9/26 and 2/9/26. Review of a facility investigation, completed by the Director of Nursing (DON), documenting events that occurred on 2/10/26 revealed at 12:58 PM Resident #126 was transferred from her bed in the facility onto the Contracted Medical Transportation Company's stretcher which was then placed into their van to be transported to the Imaging Center. At 1:03 PM Resident #126 arrived at the Imaging Center. Upon the completion of the Imaging Center appointment as the Contracted Medical Transportation Company Technicians (Transport Technicians #1 and #2) were pushing the stretcher through the Imaging Center's paved parking lot to return to the facility, the right stretcher wheel hit a pothole in the pavement causing the stretcher to begin to fall to the right. During this time a passerby in the parking lot came to assist the 2 technicians with placing the stretcher upright. At 4:30 PM Resident #126 arrived back at the facility at which time staff heard Resident #126 yell out as Transport Technicians #1 and #2 were leaving the room. A review of the written statement dated 2/10/26 at 4:30 PM by Transport Technician #1 revealed they and Transport Technician #2 transported Resident #126 to an Imaging Center appointment on 2/10/26. While leaving the Imaging Center with Resident #126 on the stretcher there was a pothole/break in the pavement. The right side of stretcher's wheel went over the pothole/break in the pavement and caused the right side of the stretcher to tip to the right. Resident #126 did not fall out of the stretcher. A woman in the parking lot of the Imaging Center came over and assisted them to stabilize the stretcher. A review of the written statement by Transport Technician #2 dated 2/10/26 at 4:42 PM revealed (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	there were several potholes in the pavement of the Imaging Center parking lot. The stretcher with Resident #126 started to tilt to the right and Transport Technicians #1 and #2 grabbed the stretcher as it was going down, and a stranger came to help keep the stretcher upright. Transport Technician #2 noted that Resident #126 did not fall out of the stretcher nor was she injured. A telephone interview was conducted on 7/28/26 at 2:30 PM with the Contracted Medical Transportation Company's Chief Operating Officer. He stated he was traveling and would email additional investigation notes and contact numbers for the technicians (Transport Technicians #1 and #2) that transported Resident #126 on 2/10/26. A follow up email was sent to the Contracted Medical Transportation Company's Chief Operating Officer on 7/28/26 at 4:30 PM. The information requested was not received. An interview with Nurse #3 was held on 7/29/26 at 4:00 PM. Nurse #3 recalled she was working on 2/10/26 when Transport Technicians #1 and #2 returned to the facility with Resident #126 from a scheduled appointment. Nurse #3 stated she asked Resident #126 how her appointment went and Resident #126 said it went fine. Nurse #3 indicated about 30 minutes later Resident #126's family member stated the resident was in pain. Nurse #3 went to Resident #126's room to inquire about the location of the pain. Resident #126 stated the pain was in her back. Resident #126's pain level was an 8 at that time which was higher for Resident #126 than most days. Nurse #3 administered PRN acetaminophen at that time which was effective. Nurse #3 indicated she then proceeded to assess Resident #126 and found a scratch on her right arm that had not been there before her appointment at the Imaging Center. Nurse #3 stated she notified the NP #1 of Resident's pain at that time. A telephone interview was conducted with Resident #126's family member on 7/28/26 at 9:45 am. She stated she met Resident #126 at the facility after her appointment on 2/10/26. She indicated that she remembered Resident #126 was in her bed and stated, damn, they hurt me. The MAR indicated PRN menthol topical analgesic gel and PRN acetaminophen 650 mg were administered on 2/11/26 and Resident #126's pain level was 8. An interview with Nurse #1 was conducted on 7/28/26 at 2:45 PM. She reported on 2/12/26 Resident #126's family member reported the resident was having pain in her right shoulder. Nurse #1 stated Resident #126's pain was occasional in the past but became frequent this day. Nurse #1 stated Resident #126 received pain medication on 2/12/26 and it was effective. Nurse #1 then notified the NP #1 who ordered mobile x-ray to come to the facility to obtain images. Review of the radiology result report dated 2/12/26 at 3:55 PM revealed an acute right posterior (back portion of the ribs) 4th through 6th rib fracture. Resident #126 had an order dated 2/12/26 to assess pain on every shift for 5 days. Resident #126 had an order dated 2/12/26 for tramadol (opioid medication used to treat moderate to severe pain) 50 mg, give 1 tablet every 12 hours PRN for moderate and severe pain for 14 days. The MAR indicated on 2/12/26 PRN acetaminophen 650 mg and PRN tramadol 50 mg was (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	administered and Resident #126's pain level was 10. Resident #126 had an order dated 2/13/26 Lidoderm patch 5%, apply to right ribs topically for rib pain, apply in the morning and remove per schedule. On 2/13/26 Resident #126's order for acetaminophen 650 mg PRN every 8 hours was changed to a routine order of 1000 mg three times a day for pain. The MAR indicated PRN tramadol 50 mg was administered on 2/13/26. Resident #126's pain level on 2/13/26 was 2 and on 2/14/26 through 2/16/26 the pain level was 0. On 2/16/26 Resident #126's order for acetaminophen 1000 mg three times a day for pain was changed to acetaminophen liquid 160mg/5ml (milliliters), give 30 ml by mouth 3 times a day for pain. On 2/19/26 Resident #126's order for PRN Tramadol was discontinued. An interview with NP #1 was held on 7/28/26 at 1:30 PM. She explained that Resident #126 went to an appointment on 2/10/26 via the Contracted Medical Transportation Company and upon her return she complained of pain to her family member. The NP #1 stated the pain was reported to her on 2/12/26 at which time she ordered an x-ray. The x-ray results revealed right rib fractures at ribs #4, #5, and #6. After this incident on 2/10/26 additional pain medications were required to control Resident #126's pain level. An interview with the DON was held on 7/28/26 at 4:35 PM and revealed a family member of Resident #126 had attended the Imaging Center appointment on 2/10/26 and told the Nurse #3 when she was visiting the resident at the facility on the afternoon of the resident's return from the appointment that Resident #126 had stated to her damn, they hurt me. The DON explained that on 2/11/26 she began her facility investigation starting with staff interviews. The DON added on 2/11/26 after hearing from the family member that the resident had complained of worsening pain and the transportation staff hurting Resident #126, she concluded that during the Contracted Medical Transportation Company's transport on 2/10/26 to and from the Imaging Center was when the incident happened. The Contracted Medical Transportation Company completed interviews that included written statements with Transportation Technicians #1 and #2. On 7/29/26 at 9:30 AM an interview was held with the Administrator. The Administrator confirmed he would expect all residents, including Resident # 126, to be transported safely and without injury. The facility provided a corrective action plan that was not acceptable to the State Agency. 2. Resident #127 was admitted to the facility on [DATE]. Review of Resident #127's admission note dated 6/4/26 revealed Resident #127 was alert and oriented to person, place, time, and situation. Review of Resident #127's discharge note dated 6/8/26 revealed Nurse #5 documented Resident #127 (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0689 Level of Harm - Actual harm Residents Affected - Few Note: The nursing home is disputing this citation.	was discharged from the facility on 6/8/26 with a friend. The nurse documented she provided the resident with all belongings including her medications with education. During an interview on 7/29/26 at 12:32 PM Nurse #5 stated she was the nurse who discharged Resident #127 on 6/8/26. She further stated when Resident #127 discharged , she had gathered all the resident's medications, provided the medications to Resident #127, educated the resident on what to take and when, and told Resident #127 to call the facility with any concerns. She stated later that week, she did not recall what date, Resident #127 called back and informed the facility that she had also been given one packet of medication for another resident. She did not know what the medication was or how much of the medication the resident received. The nurse stated Resident #131, whose packet of medication had been given to Resident #127, was discharged on 6/7/26, prior to Resident #127's discharge. She told the Director of Nursing that Resident #127 had another resident's medication. During an interview on 7/29/26 at 12:46 PM the Director of Nursing stated Resident #127 called the facility, she could not remember the date but believed she spoke with Nurse #5, and made the facility aware she was provided someone else's medications when she was discharged from the facility. Nurse #5, who discharged Resident #127 on 6/8/26, then called and told the Director of Nursing that Resident #127 got the wrong medication included in with her discharge medications. The Director of Nursing called Resident #127 but did not remember the date. She explained that she remembered Resident #127 called on a Tuesday and she picked the medication up that Wednesday or Thursday of the same week but could not recall exact dates. Resident #127 informed her she got another resident's medication and wanted to let them know. The medication was a single pack containing fourteen 5 milligram (mg) cyclobenzaprine tablets for Resident #131. The Director of Nursing asked if the resident got all of her medication and Resident #127 confirmed she had all of her medication and just got an extra packet of someone else's medications. She told the resident not to take the medication and to not throw the medications away. The Director of Nursing then drove to the resident's home and picked up the packet of fourteen 5 mg cyclobenzaprine tablets. The Director of Nursing returned the medication to the facility to be returned to the pharmacy because Resident #131, who the cyclobenzaprine tablets belonged to, had been discharged on 6/7/26 and his prescriptions had already been called to his pharmacy. He already had all of his medications and was not missing this pack. During an interview on 7/30/26 at 8:38 AM the Administrator stated residents should not be discharged with medications from other residents. During an interview on 7/30/26 at 10:02 AM Nurse Practitioner #1 stated she remembered Resident #127. Nurse Practitioner #1 confirmed Resident #127 was not prescribed cyclobenzaprine. She stated if Resident #127 had taken the 5 mg cyclobenzaprine tablets when they were incorrectly sent home with the resident at discharge, the main concerns would be muscle weakness, drowsiness, and increased risk of falls.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews the facility failed to provide written advance directive information and/or an opportunity to formulate an advance directive (Residents #8, #9, and #14). This was for 3 of 7 residents reviewed for advance directives. The findings included; a. Resident #8 was admitted to the facility on [DATE] with a diagnosis of stroke. A physician's order dated 4/17/26 was for Do Not Resuscitate (DNR) code status. Resident #8's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. There was no documentation in Resident #8's medical record of education regarding the formulation of an advance directive and/or that an opportunity to formulate an advance directive was offered. b. Resident #9 was admitted to the facility on [DATE] with a diagnosis of stroke. A physician's order dated 6/16/26 was for Do Not Resuscitate (DNR) code status. Resident #9's significant change in status Minimum Data Set (MDS) assessment dated [DATE] revealed he was moderately cognitively impaired. There was no documentation in Resident #9's medical record of education regarding the formulation of an advance directive and/or that an opportunity to formulate an advance directive was offered. c. Resident #14 was admitted to the facility on [DATE] with a diagnosis of stroke. A physician's order dated 6/27/23 was for Do Not Resuscitate (DNR) code status. Resident #14's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was severely cognitively impaired. There was no documentation in Resident #14's medical record of education regarding the formulation of an advance directive and/or that an opportunity to formulate an advance directive was offered. On 7/29/26 at 3:00 PM an interview with the Admissions Director indicated that when a resident was admitted to the facility, she spoke with either the resident or their representative about what the resident's desired code status would be and explained the different code statuses to them and also had this same conversation again on readmission. She reported that if the resident or their representative specified something like the resident didn't want to be on a ventilator, she spoke with them about a MOST (Medical Orders for Scope of Treatment) is a medical order sheet that translates a seriously ill person's end-of-life care wishes into actionable instructions. It covers key decisions like medical interventions and artificial nutrition/hydration) form. The Admissions Director went on to say she also asked on admission whether the resident had a living will or healthcare power of attorney and if the answer was yes, she asked for a copy and then uploaded it into the resident's medical record. She reported that if the resident or representative indicated they didn't have an advance directive such as a living will or a health care power of attorney, she let them know that if this was something they were interested in, they could let her know and she would send them in the right direction. She stated these conversations were not documented anywhere in a resident's medical record. On 07/29/2026 at 3:49 PM in a telephone interview Social Worker (SW) #1 stated she was the facility's SW from October 2024 until July 11th, 2026. She reported that when a resident was admitted to the facility she usually had a conversation with the Admissions Director to determine if a resident had an advance directive such as a living will or a health care power of attorney. She indicated this was not anything she documented in the record. SW #1 stated that the only thing she really spoke to residents or their representatives about and documented in the medical record was the resident's code status. On 07/29/2026 at 4:18 PM an interview with Social Worker #2 indicated she had been the facility's SW for about 2 weeks. She stated that if a resident had a power of attorney, she made sure this was on file so that when she was doing care plan invitations, she knew who to send the invitation to. She (continued on next page)		

Department of Health & Human Services
Centers for Medicare & Medicaid Services

Printed: 10/09/2026
Form Approved OMB
No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	indicated she had not had any conversations with residents or their representatives about formulating advanced directives such as a living will or a health care power of attorney. On 07/30/2026 at 10:15 AM an interview with the Administrator indicated his understanding was that the biggest thing the facility was concentrating on was code status. He reported the other conversations were mainly for information purposes. He stated if a resident or family member reported that the resident had a living will or a health care power of attorney document, the facility requested a copy of this for the resident's medical record.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to protect the privacy of Resident # 131 when a medication prescribed for Resident # 131 was sent home with Resident # 127. This practice had the potential to affect 1 of 1 resident reviewed for privacy. Findings included: Resident #131 was admitted to the facility on [DATE]. Resident #127 was admitted to the facility on [DATE]. Review of Resident #127's discharge note dated 6/8/26 revealed Nurse #5 documented Resident #127 was discharged from the facility on 6/8/26 with a friend. The nurse documented she provided the resident with all belongings including her medications with education. During an interview on 7/29/26 at 12:32 PM Nurse #5 stated she was the nurse who discharged Resident #127 on 6/8/26. She further stated when Resident #127 discharged, she had gathered all the resident's medications, provided the medications to Resident #127, educated the resident on what to take and when, and told Resident #127 to call the facility with any concerns. She stated later that week Resident #127 called back and informed Nurse #5 that she had also been given one packet of medication for Resident #131. The nurse stated Resident #131, whose packet of medication had been given to Resident #127, was discharged already and was out of the facility. She told the Director of Nursing who went to Resident #127's house and picked up the packet of medications that was incorrectly included with Resident #127's medications. During an interview on 7/29/26 at 12:46 PM the Director of Nursing stated Resident #127 called the facility and made the facility aware she had someone else's medications (Resident #131) following her discharge. Nurse #5 who discharged Resident #127 then called and told the Director of Nursing that the resident got the wrong medication included in Resident #127's discharge medications. She called Resident #127 who informed her she got the other resident's medication and wanted to let them know. The medication was a single pack containing fourteen 5 milligram cyclobenzaprine (Flexeril) tablets and was for Resident #131. The Director of Nursing then drove to Resident #127's home and picked up the packet of fourteen 5 mg cyclobenzaprine tablets belonging to Resident #131. She stated she remembered Resident #127 called on a Tuesday and she picked the medication up that Wednesday or Thursday of the same week but could not recall exact dates. She remembered that Resident #131's name was on the cyclobenzaprine packet when she picked it up and this was a privacy concern. During an interview on 7/30/26 at 8:38 AM the Administrator stated residents should not be discharged with medications for other residents. He confirmed that a pack of cyclobenzaprine was labeled with Resident #131's name and was sent home with Resident #127 and this was a privacy concern.		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and staff and Nurse Practitioner (NP) interviews the facility failed to prime an insulin pen prior to the administration of the insulin (Resident #38) and failed to ensure the resident rinsed their mouth with water without swallowing after the administration of an inhaled medication that contained a steroid (a medication that reduces swelling and calms the immune system) (Resident #50). This was for 2 of 4 residents whose medication administration was observed. The facility's medication error rate was 6.9 % (percent). The findings included: 1. Resident #38 was admitted to the facility on [DATE] with a diagnosis of Diabetes Mellitus (DM). Resident #38's annual Minimum Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. A physician's order for Resident #38 dated 6/27/26 was for insulin degludec (a long acting injected insulin medication to improve blood sugar control in people with DM) subcutaneous (beneath the skin) insulin pen injector 100 units per milliliter inject 58 units subcutaneously once daily for DM. The insulin degludec manufacturer's instructions for use provided by the facility revealed the following: Priming your [insulin degludec] FlexTouch Pen: Step 7: Turn the dose selector to select 2 units. Step 8: Hold the Pen with the needle pointing up. Tap the top of the Pen gently a few times to let any air bubbles rise to the top. Step 9: Press and hold in the dose button until the dose counter shows '0'. The '0' must line up with the dose pointer. A drop of insulin should be seen at the needle tip. Selecting your dose: Step 10: .Check to make sure the dose selector is set to '0'. Turn the dose selector to select the number of units you need to inject. On 07/28/2026 at 10:50 AM a continuous observation of insulin degludec administration for Resident #38 by Nurse #8 was conducted. Nurse #8 was observed to obtain Resident #38's insulin degludec pen from the medication cart, attach the needle after sanitizing the port, and dial the pen to 58 units. She entered Resident #38's room, explained the procedure to Resident #38, prepared the injection area on Resident #38's right arm, and injected the 58 units of insulin subcutaneously. Nurse #8 then exited Resident #38's room. At 10:55 AM in the hallway outside of Resident #38's room, an interview with Nurse #8 indicated she normally primed insulin pens by dialing the pen to 2 units, attaching the needle, expressing the 2 units, and then dialing the pen to the correct dose before administering it to the resident to ensure the air was out of the needle and the resident got the correct dose of medication, however she was nervous being observed and had forgotten to do it this time. On 07/28/2026 at 1:38 PM in an interview Staff Development Coordinator (SDC) #2 stated Nurse #8 did know she was supposed to prime Resident #38's insulin pen prior to administering the ordered dose of insulin and didn't do that. She indicated Resident #38's insulin pen should have been primed prior to the administration of the ordered dose of insulin to ensure she got the correct dose. On 7/29/26 at 1:15 PM an interview with the Director of Nursing indicated that if the manufacturer's instructions instructed that an insulin pen should be primed before the administration of the ordered dose of insulin, then the nurse should have followed these instructions to ensure the resident received the correct dose of insulin. On 07/30/2026 at 10:09 AM in an interview Resident #38's Nurse Practitioner (NP) stated that if the manufacturer's instructions indicated that the insulin pen should be primed, then it would be important for the nurse to do this to ensure the resident got the full insulin dose that was prescribed for them. She reported she was not aware of any harm to Resident #38 as a result of this one instance. On 7/30/26 at 10:15 AM an interview with the Administrator indicated nurses should be following the manufacturer's instructions when administering medications. 2. Resident #50 was admitted to the facility on [DATE] with a diagnosis of chronic obstructive pulmonary disease (COPD). Resident #50's Quarterly Minimum (continued on next page)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345372	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/30/2026
NAME OF PROVIDER OR SUPPLIER Wilson Pines Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 403 Crestview Avenue Wilson, NC 27893	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Data Set (MDS) assessment dated [DATE] revealed she was moderately cognitively impaired. She did not reject care during the look-back period of this assessment. A physician's order for Resident #50 was for fluticasone furoate 100 micrograms (a steroid medication), umeclidinium 62.5 micrograms (a medication that relaxes the muscles in the airway to improve breathing), and vilanterol 25 micrograms (a medication that relaxes the muscles in the airway to improve breathing) aerosol powder 1 puff once daily for COPD. Wait 1 minute between puffs. Rinse mouth after use. The fluticasone furoate 100 micrograms, umeclidinium 62.5 micrograms, and vilanterol 25 micrograms aerosol powder manufacturer's instructions for use provided by the facility revealed the following: Warnings and Precautions: Candida Albicans (yeast) infection of the mouth and pharynx (throat) may occur. Monitor patients periodically. Advise the patient to rinse his/her mouth with water without swallowing after inhalation to help reduce the risk. On 07/29/2026 at 8:35 AM a continuous observation of medication administration was conducted for Resident #50 with Nurse #9. Nurse #9 was observed to hand the prepared fluticasone furoate 100 micrograms, umeclidinium 62.5 micrograms, and vilanterol 25 micrograms aerosol powder inhaler to Resident #50, who took one puff, and then handed it back to Nurse #9. Nurse #9 was then observed to hand Resident #50 a cup of prepared laxative solution mixed with water which Resident #50 drank and swallowed. Nurse #9 was not observed to provide Resident #50 with water, or to instruct or encourage Resident #9 to rinse her mouth with water without swallowing after the use of the inhaler. At 8:58 AM, outside Resident #50's room, in an interview, Nurse #9 confirmed that she had not provided Resident #50 with water or instructed or encouraged Resident #9 to rinse her mouth with water without swallowing after Resident #50 used her inhaler. Nurse #9 stated she usually did this with other residents and had done this in the past for Resident #50, however Resident #50 did not like to do the rinse after she used her inhaler and had refused to do it in the past. She reported she had not documented or notified anyone of Resident #50's past refusals. She reported she didn't know why she didn't offer or encourage Resident #50 to rinse with water in this instance. She indicated she knew it was important for Resident #50 to rinse with water without swallowing after using her inhaler which contained a steroid to prevent a yeast infection in her mouth. On 07/29/2026 at 11:15 AM the Director of Nursing reported that Nurse #9 should have offered Resident #50 water to rinse and spit every time after Resident #50 used her inhaler to prevent the medication from lingering in Resident #50's mouth and resulting in a side effect such as a yeast infection or mouth discomfort, even if Resident #50 had refused to do this in the past. She stated Nurse #9 should also have documented and reported Resident #50's past refusals so that this behavior could have been incorporated into Resident #50's care plan. On 07/30/2026 at 10:09 AM in an interview Resident #50's Nurse Practitioner stated that it would have been important for Resident #50 to rinse her mouth with water and spit after the use of her inhaler to ensure that no medication remained in her mouth and prevent the overgrowth of yeast due to the steroid medication contained in the inhaler. She reported she was not aware of any evidence that Resident #50 had any mouth discomfort or oral yeast infection. On 7/30/26 at 10:15 AM an interview with the Administrator indicated nurses should be following the manufacturer's instructions and physician's orders when administering medications. He stated Resident #50's past refusals to rinse her mouth with water after using her inhaler should have been documented, and a provider should have been notified.		