

Division of Health Service Regulation

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br><b>HAL098023</b> | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: <b>01</b><br><br>B. WING _____ | (X3) DATE SURVEY COMPLETED<br><br><b>R</b><br><b>07/08/2025</b> |
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| NAME OF PROVIDER OR SUPPLIER<br><br><b>WILSON HOUSE</b> | STREET ADDRESS, CITY, STATE, ZIP CODE<br><b>1800 MARTIN LUTHER KING JR. PARKWAY<br/>WILSON, NC 27893</b> |
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| (X4) ID PREFIX TAG | SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) | (X5) COMPLETE DATE |
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| {C 000}            | <p>Initial Comments</p> <p>Report by Suzanna Fay of a Follow Up Construction Survey by Documentation on July 8, 2025.</p> <p>Based on documentation received by this office on June 27, 2025, all previously cited deficiencies have been corrected and no further action is required at this time.</p> | {C 000}       |   |                    |

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_