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 08/29/2024

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 an annual and follow-up survey on August 28, 2024 and August 29, 2024.	D 000		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure food items being stored and served to residents were sealed, labeled, and dated. The findings are: Observation of the facility's refrigerator on 08/28/24 at 9:45am revealed: -There were three food items in the refrigerator that were not sealed and not labeled with the dates or what the items were.	D 283		

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D 283	Continued From page 1 -Sandwich ham was sitting on a shelf in a plastic bag opened and not dated or labeled. -Sliced cheese was sitting on a shelf in a plastic bag opened and not dated or labeled. -Sausage links were sitting on a shelf in a plastic bag opened and not dated or labeled. Observation of the freezer on 08/28/24 at 9:45am revealed: -There were four food items in the freezer that were not sealed and not labeled with the dates or what the items were. -Smoke sausages were sitting on a shelf in a plastic bag opened and not dated or labeled. -Sliced steak patties were sitting on a shelf in a plastic bag opened and not dated or labeled. -Frozen okra was sitting on a shelf in a plastic bag opened and not dated or labeled. -Hot dogs were sitting on a shelf in a plastic bag opened and not dated or labeled. Interview with the Dining Service Manager (DSM) on 08/28/24 at 9:50am revealed: -She was not aware that the items in the refrigerator and freezer were not sealed and not labeled with a date or name of the item. -She did not know why the food items were not sealed or labeled. -The dietary staff met monthly and discussed that all opened food must be sealed and labeled. -She was responsible for making sure that all opened food were sealed and labeled. Interview with the Executive Director (ED) on 08/29/24 at 1:15pm revealed: -She was not aware opened food items had not been sealed and labeled in the kitchen. -She was aware opened food items must be sealed and labeled with a date and the name of the item.	D 283		

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D 283	Continued From page 2 -Her expectation was for dietary staff to seal all opened food and label each item with the name and date before end of each shift.	D 283		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to ensure a therapeutic diet was served as ordered for 2 of 5 sampled residents (#3 and #5) including a mechanical soft diet (#3) and a no concentrated sweets (NCS) diet (#5). The findings are: 1. Review of Resident #3's current FL-2 dated 08/09/23 revealed: -Diagnoses included mycoplasma pneumoniae, pulmonary fibrosis, and aspiration/dysphagia. -There was an order for a mechanical soft diet and nectar thick liquids. Review of Resident #3's diet order form revealed: -The resident was on a mechanical soft diet. -The resident was ordered nectar thick liquids. -The diet order sheet was signed by the Resident Care Coordinator (RCC) on 08/12/24. -The diet order sheet was signed by the primary are provider (PCP) on 08/14/23. Review of the daily diet modification summary	D 310		

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report revealed:
-There was not a diet modification menu for lunch on 08/28/24 because a substitution meal was served.
-Steak fries should have been chopped with sauce when served as mechanical soft.
-Green beans should have been chopped when served as mechanical soft.
-Chicken breast should have been ground/chopped when served as mechanical soft.

Observation of lunch service for Resident #3 on 08/28/24 at 12:00pm revealed:
-Resident #3's plate consisted of a chicken sandwich cut in quarters, steak fries, and green beans.
-He ate his food very slowly.
-He was the last resident in the dining room still eating when lunch was over.
-He ate the majority of his food.

Interview with a personal care aide (PCA) on 08/29/24 at 12:15pm revealed:
-Resident #3 was on a chopped diet with thickened liquids.
-Kitchen staff prepared food, plated food and PCAs served the food to residents.
-Resident #3's meals were chopped.
-He took longer to eat than the other residents in the dining room.
-He had difficulty eating his food at times.

Interview with the Dining Services Manager on 08/29/24 at 12:45pm revealed:
-Resident #3 was on a mechanical soft diet with thickened liquids.
-She had a daily diet modification to follow.
-She did not have a diet modification to follow for the substitute lunch served on 08/28/24.
-He had been getting his food chopped.

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D 310	Continued From page 4 -He was usually the last resident finished with his meals. -He had difficulty eating his food even chopped. Interview with the RCC on 08/29/24 at 12:50pm revealed: -The meal Resident #3 was given on 08/28/24 was not mechanical soft. -The fries and green beans should have been chopped up. -The chicken should have been chopped up finely. -The dietary staff was responsible for ensuring that residents received their therapeutic diets as ordered. -The staff in the kitchen may not have been paying close attention to his diet order. Interview with the Executive Director on 08/29/24 at 1:00pm revealed: -She expected kitchen staff to follow the diets as prescribed by the physician. -Resident #3 should have had his food served mechanical soft as the menu specified. -Herself, the Dietary Manager, and the RCC were responsible for ensuring residents received therapeutic diets as ordered. -She was concerned that Resident #3 would have problems swallowing and would not be able to eat the food he was served. -She was not sure why Resident #3 was not served his therapeutic diet as ordered. Telephone interview with Resident #3's PCP on 8/29/24 at 11:40am revealed: -Resident #3 was on a mechanical soft diet because he had a slower reaction time when eating. -He needed softer food to be able to swallow properly.	D 310		

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-He should not have gotten a chicken sandwich cut in quarters, steak fries, and green beans.
-She expected staff to follow therapeutic diets as ordered.
-She was concerned that Resident #3 could choke on his food and could get pneumonia.

2. Review of Resident #5's current FL-2 dated 01/16/24 revealed:
-Diagnoses included vascular dementia, paranoid schizophrenia, and major depression disorder.
-There was a diet order for no concentrated sweets (NCS).

Observations during the initial kitchen tour on 08/28/24 at 9:40am revealed:
-There was a resident diet list order posted on the wall above the steaming table in the kitchen.
-Resident #5 was listed as having a NCS diet.

Observation of Resident #5's lunch meal served on 08/28/24 from 12:00pm to 12:20pm revealed:
-Resident #5's meal served was a chicken sandwich, French fries, strings beans, vanilla ice cream, water, and tea.
-He consumed 100% of the chicken sandwich, 100% of the French fries, 100% of the string beans, 100% of the vanilla ice cream, 100% of the water, and 75% of the tea.

Interview with the Dining Service Manger (DSM) on 08/28/24 at 12:30pm revealed:
-She was not aware that Resident #5 was served vanilla ice cream.
-She usually set the NCS diet dessert to the side as she prepared the meals but that did not happen because she got behind assisting the new dietary staff and forgot to place an alternative to the side for lunch on 08/28/24.
-If regular diets received ice cream, she would

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give the residents with NCS diets sherbet or fruit.
-She was responsible to make sure all diets were served correctly.

Interview with the Resident Care Coordinator (RCC) on 08/28/24 at 12:38pm revealed:
-She was aware that Resident #5 had an order for a NCS diet.
-She was not aware that Resident #5 had been served vanilla ice cream during lunch.
-She was unsure why the dietary staff served the vanilla ice cream.
-She and the DSM was responsible for all diet orders to be served correctly.

Interview with the Executive Director (ED) on 08/28/24 at 1:15pm revealed:
-She was aware that Resident #5 had an order for a NCS diet.
-She was not aware that Resident #5 had been served vanilla ice cream during lunch.
-She expected the dietary staff to follow the diet order.
-She expected the medication aide (MA) and personal care aide (PCA) to keep an eye on what was being served to the resident.
-The DSM and the RCC was responsible to make sure residents received the diet the PCP ordered.

Telephone interview with Resident #5's primary care provider (PCP) on 08/28/24 at 12:50pm revealed:
-Resident #5 was on a NCS diet and should not get sweets.
-She was not aware that he was getting sweets at any time.
-If he continued to eat sweets, his diabetes could become uncontrolled, and he would need to be placed on insulin therapy.
-The staff should follow the diet order.

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D 310	Continued From page 7 Based on observation, interviews, and record review, it was determined Resident #5 was not interviewable.	D 310		