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	HAL065019	A. BUILDING: _____ B. WING _____	09/12/2025

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 09/10/25 through 09/12/25.	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; Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care items in unlocked shower rooms that were accessible to residents in a Special Care Unit (SCU). The findings are: Review of the facility's Policy and Procedure Regarding Secure Personal Care Items/Ingestible/Secure Unit with an effective date of 11/2011 and last revised date of 05/2024 revealed: -The policy applied to Alzheimer's and dementia care communities.	D 079		

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

Kayla Jakubczak | Executive Director | 10/20/2025

Reviewed and Acknowledged 10/20/25 KC

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D 079	Continued From page 1 -Residents living in memory care areas were encouraged to use their favorite personal care items. -Proper storage for those items was appropriate since residents living with dementia may not be able to recognize how personal care items or toiletries were used and that consumption of personal care items substances (such as shaving cream and mouthwash) may be harmful. -Personal care items in the resident's apartment or spa areas labeled with "keep out of reach of children" must be labeled with the resident's name and stored in a locked drawer or cabinet. -Policy Detail: Personal care items labeled as "Keep Out of Reach of Children" must be secured in a locked drawer or cabinet. -Personal care items should be labeled with the resident's name and kept in a locked drawer or cabinet for safe use. -Items may include but were not limited to liquid care products such as soap, shampoo, conditioner, lotion, bulk liquid products, bars of soap, toothpaste, mouthwash, denture cleaning substances such as polydent, cologne, perfume, deodorant, curling irons, hot irons, blow dryers, razors, shaving cream, nail care items and sharps. -If a wall mounted dispenser is not available, a small quantity of liquid soap that is not labeled "Keep Out of Reach of Children" may be left in the bathroom for resident hand washing. -If a resident is in a private apartment and can successfully navigate a key independently to keep their apartment door consistently locked without prompts or reminders then small bottles/ containers (no bulk supply) of personal care items may be visibly left out or unlocked in their apartment if the product is not identified with a "Keep Out of Reach of Children" label. -If a medical emergency occurs with the	D 079	Provide in-service training to all staff on removal of any item in resident apartments that contain “Keep out of Reach of Children” on the label or any other potentially dangerous items. Housekeeper to inspect each apartment for items not allowed during each apartment clean, remove them and bring the items to management Provide a list of items not allowed in resident apartments to families of new residents. Re-educate families of tenured residents of items not allowed in resident apartments via a monthly newsletter. Conduct weekly sweep of each apartment and remove any items with the label “Keep out of reach of children” or any other items that should not be accessible to the residents.	10/16/25 10/16/25 10/16/25 10/16/25

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D 079	Continued From page 2 consumption or ingestion of foreign substances into the body, the Health and Wellness Director, nurse or designee was responsible for calling 911, Poison Control Center, and notifying the physician/healthcare provider of the event for care and treatment. Review of the facility's census report received on 09/10/25 revealed 29 residents resided in the Special Care Unit (SCU) facility. Observations of the SCU on 09/10/25 during the initial tour from 8:30am to 9:37am revealed residents ambulated freely in the halls to and from their rooms to the other areas of the SCU. Observations in the A hall shower room on 09/10/25 at 9:16am revealed: -The room door handle was locked but the door was easily pushed open. -A resident was ambulating independently in the room. -There were no staff present in the shower room. -There were personal care items in individual baskets labeled with residents' names on shelves by the door. -The baskets and shelves contained lens cleaner, shaving creams, body washes, hygiene and barrier system foam, and a disposable razor. -The warning label on the lens cleaner advised to keep the product out of the reach and children and not to ingest. -The warning label on the shaving cream and body wash advised to keep the product out of the reach of children. -The warning label for the hygiene and barrier system foam advised that the product was not intended for oral ingestion. -The warning label for the combination shampoo and body wash advised the products were for	D 079	Repair spa room door in A hall so it closes tightly Install automatic door closing device on A Hall laundry room door Install keypad entry locks on all laundry and spa rooms and disable manual locking mechanism	10/3/25 10/3/25 10/10/25

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D 079	Continued From page 3 external use only. Observations in the B hall laundry room on 09/10/25 at 9:26am revealed: -The door was unlocked. -There were no staff present in the laundry room. -There was an unlocked door in the laundry room labeled "Bathroom" that led to the B hall shower room. Observations of the B hall shower room on 09/10/25 at 9:26am revealed: -The door entry door to the shower room from the laundry room was unlocked. -There were no staff present in the shower room. -There were personal care items in individual baskets labeled with residents' names on shelves by the door. -The baskets and shelves contained shampoos, conditioners, skin cleansers, body washes, lotions, foam cleanser, and disinfectant spray. -The shampoos, conditioners, body wash and skin cleanser contained alcohol. -The foam skin cleanser label advised that the product was for external use only. -The disinfectant spray warning label cautioned that the product could cause eye irritation and was flammable and should be stored in areas inaccessible to children. Observations of room B6 on 09/10/25 at 9:37am revealed: -The resident was ambulating in the room alone. -There were no staff present in the room. -There were 2 facial creams and a bar of soap on the bathroom sink. -She used her own personal care products. Interview with the housekeeper on 09/12/25 at 10:37am revealed:	D 079		

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D 079	Continued From page 4 -Personal care products were kept in the shower rooms. -Shower rooms and laundry room doors were kept locked to keep residents from getting into the rooms. -She thinks personal care products were not kept in resident rooms because residents may have overused the products. -She noticed the A hall shower room door not closing on Wednesday (09/10/25). -The B hall laundry room door was always locked so someone may have forgotten to lock it back on Wednesday (09/10/25). -She never saw personal care products in any of the residents' rooms. -If personal care products were found in a resident's room, staff were supposed to remove the products and place them in the resident's basket in the shower room. Interview with a personal care aide (PCA) on 09/11/25 at 10:41am revealed: -The shower room doors were kept locked. -Personal care products were stored in the shower rooms. -There was no personal care products kept in resident rooms. -Some residents had wandering behavior, and staff did not want the residents to eat or drink any of the personal care products. -The resident in room B6 liked to put on her make up. -Personal care products were removed from the bathroom in room B6 in the past, but family members continued to bring personal care items to the resident. -Staff explained to the family of the resident in room B6 that the personal care products could not be stored in the room, but they continued to provide the products to the resident.	D 079		

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-She had not told management about the family of the resident in room B6 bringing in personal care products after the products were removed and they were informed of the concerns with the resident having access to personal care products.
-Staff were supposed to check resident rooms every shift to ensure there were no personal care products in the room but that did not always happen because they had other tasks.
-No residents ingested any personal care products that she was aware of.
-She was unsure why the shower room was unlocked on 09/10/15.

Interview with a medication aide (MA) on 09/12/25 at 10:13am revealed:
-Personal care products were stored in the shower rooms.
-Shower rooms were kept locked.
-If personal care products were accessible to residents, there was a risk of the residents eating or drinking the products.
-No residents ingested personal care products that she was aware of.
-She was unsure why the shower room was unlocked on 09/10/25.

Interview with the Health and Wellness Coordinator (HWC) on 09/10/25 at 10:00am revealed:
-The doors to the shower room and laundry room were supposed to be locked at all times.
-Personal care products were kept in the shower rooms.
-Personal care products were not allowed in resident rooms because of the risk of residents ingesting the products due to confusion.
-Random rooms checks were done by the PCAs once per week to ensure there were no personal care products in the residents' rooms, but they

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D 079	Continued From page 6	D 079		

did not keep a record of the room checks.

Interview with the Health and Wellness Director (HWD) on 09/10/25 at 3:21pm revealed:
-Residents were not supposed to have personal care products in their rooms.
-She was not aware the resident in room B6 had personal care products in her room.
-She did not know why the resident in room B6 had personal care products in her room.
-Resident rooms were checked on Mondays to ensure there were no personal care products in the rooms.
-All staff were supposed to look for personal care products each time they went into the residents' rooms.
-She was not aware the B hall laundry room door was unlocked on 09/10/25.
-She did not know why the laundry room was unlocked.
-There had not been a problem with the A hall shower room door latching that she was aware of.

Interview with the Administrator on 09/10/25 at 9:30am revealed:
-He was not aware the B hall laundry room door was unlocked.
-He was not aware the A hall shower door was not closing properly.
-The laundry room door should have been locked at all times.
-Personal care products were supposed to be secured.
-Residents could have had gotten into the personal care products.

Interview with the facility's contracted primary care provider (PCP) on 09/11/25 at 10:57am revealed:
-The residents in the facility were diagnosed with

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D 079	Continued From page 7 dementia and mental impairments. -It was not acceptable for residents to have personal care products in their rooms. -Shower rooms should have been locked so that only staff could access the area. -If personal care products looked like something to drink, the residents would drink it. -Ingestion of personal care products could lead to poisoning.	D 079		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 3 of 5 sampled fixtures that were readily accessible and used by residents with water temperatures ranging from 120.2 to 126.9 in the facility which is a special care unit (SCU). The findings are:	D 113	Install Temperature Activated Flow Reducers in each spa room Engage the services of a licensed plumber to inspect the mixing valve and make any repairs necessary to enable community to maintain water temperatures within range. Take water temperatures weekly in common areas and at least monthly in each resident apartment. Lower hot water heater thermostats and/or adjust the mixing valve should any temperatures be outside of 100 degrees F to 116 degrees F	10/15/25 9/25/25 10/7/25

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D 113	Continued From page 8 Review of the facility's census report provided on 09/10/25 revealed 29 residents resided in the special care unit (SCU) facility. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety issues memo revealed a hot water temperature of 120 degrees Fahrenheit (°F) can cause first degree burns within 8 minutes and second degree burns within 10 minutes. A hot water temperature of 124 degrees Fahrenheit (°F) can cause first degree burns within 2 minutes and second degree burns within 4.2 minutes. A hot water temperature of 125.6 degrees Fahrenheit (°F) can cause first degree burns within 45 seconds and second degree burns within 1.5 minutes. (A first degree burn is a superficial burn affecting the outer layer of skin. A second degree burn affects both the outer and second layer of skin and may cause blistering.) Review of the Environmental Health Section inspection report dated 04/15/25 revealed a demerit for hot water temperatures exceeding 116°F at faucets used by residents. Observation of water temperatures on 09/10/25 from 9:16am to 10:59am in the B hall shower room revealed the hot water temperature in the shower was 120.2°F. Observations in room B6 on 09/10/25 at 9:37am revealed: -The hot water temperature at the sink in the resident's bathroom was 126.9°F. -There was no shower in the resident bathroom. Interview with the resident residing in room B6 on 09/10/25 at 9:37am revealed:	D 113		

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-She had no issues with the water in her sink.
-The water had never been too hot.
-She showered herself in the hall shower.
-She had no issues with the shower water being too hot.

Observations in room C3 on 09/10/25 from 9:16am to 10:59am revealed:
-The hot water temperature at the sink in the resident bathroom was 126.7°F.
-There was no shower in the resident bathroom.

Interview with the private sitter for the resident in room C3 on 09/10/25 at 9:42am revealed:
-The resident did not perform her own personal care.
-She provided personal care to the resident using the sink in the room as well as the showers on B hall.
-She had no concerns about the water being too hot.

Interview with a second private sitter for the resident in room C3 on 09/11/25 at 2:57pm revealed:
-She worked with the resident Monday, Wednesday and Friday from 1:00pm to 5:00pm and 1:00pm until (no set end time) on Tuesday and Thursday.
-She had no concerns about the water temperature.
-She provided personal care to the resident using the resident's bathroom sink as well as the hall shower.

Interview with a Maintenance Director on 09/10/25 at 9:25am revealed:
-He was responsible for the water temperatures in the facility being in range.
-He checked the water temperatures in the facility

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weekly.
-He thought any water temperatures above 108°F was good.
-He read some literature that said any water temperature above 108°F was good.
-All the facility's water temperatures ranged from 115°F to 125°F.
-He was not aware the hot water temperature was not supposed to be above 116°F.
-He would adjust the hot water heater temperature.

Second observation of the hot water temperature in the bathroom sink for room C3 on 09/11/25 at 7:38am revealed the hot water temperature was 122°F with visible steam.

Second observation of the hot water temperature in the bathroom sink of room B6 on 09/11/25 at 7:46am revealed the hot water temperature was 124°F with visible steam.

Second observation of the hot water temperature in the B hall shower on 09/11/25 at 7:53am revealed the hot water temperature was 126°F with visible steam.

Second interview with the Maintenance Director on 09/11/25 at 7:36am revealed:
-He had been the Maintenance Director for the facilities since 03/10/25.
-He was not aware that Environmental Health cited the facility for water temperatures being above 116°F.
-The Environmental Health report from 04/15/25 was not reviewed with him.
-The regional maintenance manager came "every once in a while" but he was unsure if he was present when Environmental Health came.
-He checked water temperatures weekly, in a

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different area every week; he checked a different room and different spa room every week.
-The facility had 2 water heaters with one controlling the hot water temperature for the kitchen and one controlling the hot water temperature for the rest of the facility.
-He started adjusting the hot water temperature yesterday when informed of the range by the surveyor.
-The hot water temperatures were still too high this morning so he turned the temperature down again.

Review of the facility's monthly water temperature logs dated June of 2025 through September of 2025 revealed:
-The log documented 1 water temperature for each of the 4 resident halls, 1 water temperature for the "restroom" and 1 water temperature for the kitchen.
-The area that was tested on each hall was not listed.
-Water temperatures ranged from 111°F - 120°F for the halls and restroom.

Recheck of the hot water temperature on 09/11/25 at 2:45pm revealed:
-The B hall shower fluctuated between 113°F and 114°F.
-The hot water temperature in the sink in room B6 was 117.6°F.
-The hot water in the sink in room C3 was 114.4°F.

Interview with a personal care aide (PCA) on 09/11/25 at 10:41am revealed:
-She also worked as a medication aide (MA) but worked as a PCA yesterday (09/10/25) and today (09/11/25).
-Residents had a shower schedule.

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-Residents were assisted by staff with showers.
-Staff turned the water on, tested the water with bare hands to make sure the water was not too hot, the residents felt the water before getting into the shower and staff adjusted the temperature of the water if needed.
-No residents had been burned or complained of the water being too hot.
-Residents would let staff know if the water was too hot or too cold when they tested it.
-Staff stayed with the residents through the entire shower.
-Residents were not left alone in the shower rooms and the shower room doors were kept locked.
-She had not noticed the water being too hot.
-She always mixed hot and cold water for showers.
-The resident in room B6 washed her hands in her room on her own and never complained about the water temperature or burns.
-The resident in room C3 had a private sitter who did everything for her, so she did not wash her hands on her own in the sink.
-There were residents that walked around on the unit.

Interview with the Health and Wellness Coordinator (HWC) on 09/10/25 at 10:00am revealed:
-Water temperatures should be up to 100°F.
-She obtained the information regarding the hot water temperatures possibly from the facility's policy, but she was not sure.
-She was not aware of the state mandated policy of water temperatures being at a minimum of 100°F and a maximum of 116°F.
-She was unsure how many hot water heaters were in the building.
-There were no hot water heater issues that she

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BROOKDALE WILMINGTON	3501 CONVERSE DRIVE WILMINGTON, NC 28403

(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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was aware of.

Second interview with the HWC on 09/11/25 at 8:19am revealed signs cautioning staff and residents of hot water temperatures had been posted in all areas that were accessible to residents or used by staff to assist residents.

Interview with a MA on 09/12/25 at 10:13am revealed:
-No residents had been burned by the hot water.
-Residents showered with the assistance of a PCA.
-The PCA adjusted the water temperature for the residents.

Interviews with the Health and Wellness Director (HWD) on 09/10/25 at 1:35pm and 3:21pm revealed:
-She did not know what the hot water temperature range was.
-Maintenance was responsible for maintaining water temperatures.
-Maintenance checked hot water temperatures but she was unsure how often.
-She was concerned about burns to the residents' frail skin with hot water temperatures that were too high.
-None of the residents had complained about the water being too hot.
-None of the residents provided personal care to themselves.
-All residents were on a shower schedule and the PCAs assisted with the showers by turning the water on for the residents and assisting them depending on their care plan.
-Most of the residents required full assistance with showers.
-She was aware Environmental Health cited the facility for hot water temperatures being higher

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than 116°F on 04/15/25.
-She thought the water temperatures had been corrected.
-All management including the Activity Director (AD), Maintenance Director, Business Office Manager (BOM) and Administrator were made aware of the Environmental Health report the day after their visit.
-The Administrator was responsible for checking behind maintenance to ensure the water temperatures were corrected.
-She was not aware of any issues with the hot water tank.
-The Maintenance Director lowered the temperature to the hot water heater after the surveyor brought the high hot water temperatures to his attention today (09/10/25).

Interviews with the Administrator on 09/10/25 at 9:30am and 3:40pm revealed:
-He was the interim Administrator and had been at the facility for 1 week.
-The hot water temperature should be 112°F - 116°F.
-The facility did not have a policy on hot water temperatures.
-The Maintenance Director was responsible for maintaining water temperatures.
-He was responsible for checking behind the Maintenance Director to ensure water temperatures were maintained.
-The shower room water temperatures had been checked weekly, but the residents' rooms had not been checked.
-The water temperature in resident rooms should have been checked monthly.
-There had been no high hot water temperatures that he was aware of since he had been at the facility.
-No residents had been burned or complained

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about the water being too hot.
-He was not aware of any resident that was independent enough to shower by themselves.
-There were no showers in the residents' rooms.
-All residents had to go to the shower rooms for showers and had to be let in by a staff member because the doors were locked.
-He was not aware that Environmental Health cited the facility for hot water temperatures being higher than 116°F on 04/15/25.
-He was not aware of any documentation on what took place after Environmental Health cited the facility on the water temperatures.
-High water temperatures raised concern for scalding of residents.

Interview with the facility's contracted primary care provider (PCP) on 09/11/25 at 10:57am revealed:
-Water temperatures varied throughout the facility.
-He did not think 126°F was hot enough to burn a resident.

_____

The facility failed to ensure that water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) and a maximum of 116°F related to sink temperatures of 126.9°F and 126.7°F in 2 residents' personal bathrooms and 1 shower temperature of 120.2°F located in a common shower room in the facility which is a special care unit (SCU). When skin is in contact with a water temperature of 125.6°F, this could result in a first degree burn in 45 seconds and a second degree burn in 1.5 minutes. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.

_____

The facility provided a Plan of Protection in

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D 113	Continued From page 16 accordance with G.S. 131D-34 received on 09/11/25 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 26, 2025.	D 113		
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 reviews, the facility failed to ensure a therapeutic diet was served as ordered for 2 of 3 sampled residents (#1, #2) with a texture modified diet. The findings are: Review of the facility's Daily Diet Modification Summary Report (therapeutic diet spreadsheet) for 09/11/25 revealed: -The breakfast menu included a fluffy baked omelet, breakfast ham, a donut, fresh fruit cup, cream of wheat, cheerios, orange juice, milk and coffee. -Bacon was not on the menu. Review of the facility's Daily Diet Modification Summary Report (therapeutic diet spreadsheet) for 08/29/25 revealed: -Bacon strips were to be omitted and substituted	D 310	All Dining personnel and Nursing Supervisors shall receive in-service training on providing residents with Therapeutic Diets when prescribed All Dining personnel shall receive in-service training on techniques and expectations for each diet the residents have been prescribed. The Dining Services Coordinator will generate and Daily Diet Modifier spreadsheet and make available to all Dining personnel. The Dining Services Coordinator will monitor the adherence of all Dining staff to the Brookdale standards with respect to therapeutic diets.	10/14/25

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with a sausage patty.
-The sausage patty was to be ground and served with gravy.

Review of the facility's Diet Manual provided by the Dietary Manager (DM) dated 2024 on 09/11/25 at 9:51am revealed under the heading Foods Allowed and Food to Avoid revealed bacon was not included in the texture modified diet due to its hard texture.

1. Review of Resident #1's current FL2 dated 05/30/25 revealed diagnoses included dementia, chronic kidney disease (CKD), Idiopathic peripheral autonomic neuropathy, and Parkinson's disease.

Review of Resident #1's record revealed:
-There was a diet order dated 07/15/25 for a texture modified diet with nectar thick liquids.
-There was a description reading "The texture modified diet is the regular diet modified to meet texture modified standards. It offers food that is moist and soft -solid. All meat and poultry are ground with the exception of small tender pieces of meat allowed in soups. It is expected that mixed textures are tolerated on this diet."

Observation of the breakfast meal service on 09/11/25 between 8:10am and 8:29am revealed:
-Resident #1 was served scrambled eggs, chopped bacon, a chopped cinnamon roll, thickened cranberry juice and thickened lemon water at 8:29am.
-Resident #1 ate all the food served except for the eggs and had no issues swallowing any of the food.

Based on observations, interviews and record reviews, Resident #1 was not interviewable.

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D 310	Continued From page 18 Refer to interview with a personal care aide (PCA) on 09/12/25 at 7:55am. Refer to interview with the medication aide (MA) on 09/12/25 at 10:13am. Refer to interview with the Health and Wellness Coordinator on 09/11/25 at 10:17am. Refer to interview with the Health and Wellness Director on 09/11/25 at 10:31am. Refer to interview with the Dietary Manager (DM) on 09/11/25 at 8:58am. Refer to interview with the Administrator on 09/11/25 at 9:03am. Refer to interview with the facility's contracted primary care provider (PCP) on 09/11/25 at 10:57am. 2. Review of Resident #2's current FL2 dated 04/08/25 revealed diagnoses included hyperlipidemia, hypothyroidism, major depressive disorder, and hypertension. Review of Resident #2's physician's orders dated 06/17/25 revealed there was an order for a texture modified diet. Observation of the breakfast meal service on 09/11/25 between 8:10am and 8:29am revealed: -Resident #2's private sitter sat with her. -Resident #2 was served scrambled eggs, chopped bacon, a chopped cinnamon roll, water and juice at 8:29am. -Resident #2 ate 75% of her food and had no issues swallowing any of the food.	D 310		

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D 310	Continued From page 19 Interview with Resident #2's private sitter on 09/12/25 at 8:12am revealed: -She had no concerns with Resident #2 being served bacon. -Bacon was Resident #2's favorite food. -Resident #2 never had issues swallowing the bacon. -Resident #2 did not like the sausage and spit it out. Based on observations, interviews and record reviews, Resident #2 was not interviewable. Refer to interview with a personal care aide (PCA) on 09/12/25 at 7:55am. Refer to interview with the medication aide (MA) on 09/12/25 at 10:13am. Refer to interview with the Health and Wellness Coordinator on 09/11/25 at 10:17am. Refer to interview with the Health and Wellness Director on 09/11/25 at 10:31am. Refer to interview with the Dietary Manager (DM) on 09/11/25 at 8:58am. Refer to interview with the Administrator on 09/11/25 at 9:03am. Refer to interview with the facility's contracted primary care provider (PCP) on 09/11/25 at 10:57am. _____ Interview with a personal care aide (PCA) on 09/12/25 at 7:55am revealed: -Residents #1 and #2 had never choked on their food.	D 310		

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D 310	Continued From page 20 -Resident #1 always had a cough whether he was eating or not. -Resident #2 sometimes coughed a lot whether she was eating or not. -Residents #1 and #2 had been served broken or chopped bacon for the past 2 months that she was aware of. -She attempted to inform the DM that residents on the texture modified diet were not supposed to have bacon, based on her knowledge from working at a previous facility. -The DM told her he was preparing the meals the way he was taught. -Serving bacon to residents on the texture modified diet posed the risk of choking or aspiration. Interview with a medication aide (MA) on 09/12/25 at 10:13am revealed: -Residents #1 and #2 were all served chopped bacon. -Neither Resident #1 or Resident #2 had issues swallowing bacon that she was aware of. Interview with the Health and Wellness Coordinator (HWC) in 09/11/25 at 10:17am revealed: -The DM was responsible for ensuring meals were prepared according to the diet order. -She provided a written nutrition tracker to the DM every Monday. -Resident #1 and Resident #2 had texture modified diets. -Texture modified diet food should have been cut up into small pieces so the resident could pick the food up. -The preparation of texture modified diet foods was described on the diet order. -She did not know what a therapeutic diet spreadsheet was.	D 310		

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D 310	Continued From page 21 -She was not aware residents on the texture modified diet could not have bacon. -She had nothing to do with dietary other than providing diet orders to the DM. Second interview with the HWC on 09/12/25 at 8:17am revealed neither Resident #1 or Resident #2 had swallowing issues while eating bacon that she was aware of. Interview with the Health and Wellness Director (HWD) on 09/11/25 at 10:31am revealed: -The DM was responsible for ensuring diets were prepared properly. -The DM knew how to prepare the diets because he had dietary training. -The DM had been at the facility longer than her, so she was unsure what training he had. -She provided copies of the diet orders to the DM. -She believed Resident #1 was on a mechanical soft diet and Resident #2 was on a texture modified diet. -A mechanical soft diet and a texture modified diet were the same. -She was not aware residents on the texture modified diet could not have bacon. -She did not know what a therapeutic diet spreadsheet was. -The residents on the texture modified diet receiving bacon posed a choking hazard. -She had no dietary involvement other than providing diet orders to the DM. Interview of the Dietary Manager (DM) on 09/11/25 at 8:58am revealed: -He substituted bacon for the ham on the menu. -He did not use the therapeutic diet spreadsheet to determine what to serve the residents. -He was not aware residents on the texture modified diet could not have bacon.	D 310		

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D 310	Continued From page 22 -He had been at the facility for 5 years and always served bacon to the residents on the texture modified diet. -He was not aware of the information in the facility's Diet Manual stating residents on the texture modified diet could not have bacon prior to today (09/11/25). -He understood the importance of using the therapeutic diet spreadsheet. -He was concerned that the residents could have choked. Interview with the Administrator on 09/11/25 at 9:03am revealed: -He was not aware residents in the texture modified diet were served bacon. -He was not aware residents on the texture modified diet were not supposed to have bacon. -He was not familiar with the residents' diets. -The DM was responsible for ensuring the diets were served correctly. -The DM was supposed to review with therapeutic diet spreadsheet and prepare the meals based on the spreadsheet. -Residents on the texture modified diet being served bacon posed the risk of aspiration or choking. Telephone interview with the facility's contracted primary care provider (PCP) on 09/11/25 at 10:57am revealed: -Resident #2 was on a texture modified diet. -He could not discuss the risk of serving bacon to a resident on a texture modified diet because the risk depended on each individual resident.	D 310		