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	HAL098027	A. BUILDING: _____ B. WING _____	R 02/10/2020

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 02/10/20.	{D 000}	RECEIVED MAR 20 2020 ADULT CARE LICENSURE SECTION RALEIGH	
{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) All food and beverage being procured, stored, prepared or served by the facility shall be protected from contamination. This Rule is not met as evidenced by: Based on observations, interviews, and record review, the facility failed to assure all food and beverage being served to residents were protected from contamination related to a wet pink, brown and black build-up substance in the facility's ice machine. The findings are: Observation of the ice machine on the assisted living side (AL) of the facility on 02/10/20 at 12:50pm revealed: -The ice bin was approximately 100% full of cubed ice. -The inside of the ice machine consisted of plastic and metal components that distributed the ice and had a wet pink, brown, and black substance that rested on the outside component onto the ice. -There was condensation along the inner upper walls, where the pink, brown, and black substance was located. -Water from the condensation was dripping down the inner walls onto the ice in the ice machine.	{D 283}	Ice machine was professionally cleaned on 2/11/2020 by [redacted]. We contracted for every 6 month deep clean with [redacted] on 2/17/2020. Ice machine is being cleaned weekly by kitchen staff. This is monitored monthly by Administrator or designee. 2/17/2020 D283 Addendum per Telephone with Ms. Frances on 03/27/20: The Administrator/ designee make physical Observations of Foods and Beverages Being Procured, Stored, Prepared or Served. DN RN (DN)	

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

Joe Ellen Administrator 3/13/2020

ATE FORM 6899 J8K012 If continuation sheet 1 of 12

* The Plan of Correction with Addendum was Reviewed and Accepted on 3/27/20. Refer to addendums on pages 1 and 6 of this Statement of deficiencies. 03/27/20 D.H. (DN)

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{D 283}	Continued From page 1 Observation on 02/10/20 at 11:31am revealed there was one ice machine in the facility for AL and special care unit (SCU). Observation on 02/10/20 at 12:06pm revealed 21 residents eating lunch and drinking a beverage with ice in cups. Review of facility's ice machine instruction manual revealed: -Maintenance procedures to clean the ice machine should occur every six months. -Areas around the ice machine should be cleaned as often as necessary to maintain cleanliness and efficient operation. -The cleaning procedures required special pumps and cleaning solutions and must be performed by qualified maintenance or service personnel. -The ice machine included technology that allowed the initiation and completion of a cleaning or sanitizing cycle at the flip of a switch. -The cleaning cycle would permit cleaning or sanitizing of all surfaces that came in contact with the water distribution system. -Periodic maintenance should be performed that included sanitizing the bin (the dispenser) and adjacent surface areas. Review of an invoice dated 06/13/19 from the facility's service vendor revealed the ice machine was serviced for not properly freezing and required cleaning. Interview with a dietary aide (DA) on 02/10/20 at 12:58pm revealed: -She and another staff had wiped down the inside of the ice machine with a cleaning solution and warm water last week. -All the ice was removed from the machine at the	{D 283}		

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{D 283}	Continued From page 2 time it was cleaned. -The ice machine was cleaned weekly. Interview with the Administrator/Dietary Manager (DM) on 02/10/20 at 1:20pm revealed: -A service vendor was responsible for cleaning the ice machine. -The service vendor would physically take the ice machine apart to be cleaned. -Staff did not remove parts to clean the ice machine. -She communicated verbally with staff on a weekly basis to prompt them to clean the ice machine. -There was no log for documenting when the ice machine was cleaned. Telephone interview with service vendor manager on 02/10/20 at 1:36pm revealed: -The contract with the facility had expired and they were no longer cleaning the ice machine. -The ice machine was last serviced by the service vendor on 06/14/19. -Staff at the facility should clean in between scheduled service cleanings. -Best practice would be to clean the ice machine every six months. -The machine had a self-cleaning cycle that should be utilized in between scheduled service calls. -The pink, brown, and black substance in the ice machine could be mold and potentially come in contact with the ice and residents at the facility could potentially ingest the pink, brown, and black substance. -There would be health concerns if ingested by the residents. -The pink, brown, and black substance wasn't normal and indicated the ice machine had not been cleaned properly.	{D 283}		

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{D 283}	Continued From page 3 Interview with the Maintenance Director on 02/10/20 at 2:39pm revealed: -He was not responsible for cleaning the ice machine in the facility. -A service vendor was responsible for cleaning the ice machine every 6 months. -The service vendor was responsible for flushing the tubing and lines of the ice machine. -There was no log for documenting when the ice machine was cleaned. -He thought the last time they had come to clean the ice machine was sometime in the summer (2019). -The service vendor instructed him during the last cleaning when a black substance appeared in the ice machine it was time for another cleaning to be performed. Interview with a second DA on 02/10/20 at 2:53pm revealed: -Cleaning the ice machine was mandatory and had to be cleaned weekly by kitchen staff. -Cleaning the ice machine was part of her kitchen training provided by the Dietary Manager. -She had wiped down the entire ice machine inside and outside of the machine last week with a cleaning solution. -The ice was completely emptied prior to cleaning the ice machine. -There was no log for documenting when the ice machine was cleaned. -She noticed a red substance while cleaning the ice machine, but removed it with the cleaning solution. A second interview with the Maintenance Director on 02/10/20 at 3:04pm revealed: -He had just emptied of all the ice from the ice machine.	{D 283}		

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{D 283}	Continued From page 4 -He was unsure of the next scheduled maintenance on the ice machine. -He would purchase ice for the facility until the ice machine was cleaned by the service vendor. Observation on 02/10/20 at 3:26pm revealed an ice pitcher on the medication cart on the AL. A third interview with the Maintenance Director on 02/10/20 at 3:29pm revealed: -He wasn't sure who placed the pitcher of ice on the medication cart but he would remove it. -He would let the Medication aides (MA's) know there were new bags of ice on the way. Interview with the Administrator/DM on 02/10/20 at 4:26pm revealed: -There was no policy for cleaning the ice machine. -There would be one in place effective today (02/10/20). -Lunch was the last time ice from the ice machine was served to residents that day (02/10/20). Interview with the Resident Care Coordinator (RCC) on 02/10/20 at 4:41pm revealed lunch that day (2/10/20) was the last time ice was served from the ice machine.	{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.	{D 310}		

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{D 310}	Continued From page 5 This Rule is not met as evidenced by: FOLLOW UP TO TYPE B VIOLATION The Type B Violation was abated. Non-compliance continues. Based on observations, interviews and record reviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 5 residents sampled, who had an order for honey thickened liquids (Resident #3). The findings are: Review of Resident #3's current FL-2 dated 02/10/20 revealed: -Diagnoses included chronic obstructive pulmonary disease (COPD), Parkinson's disease, dementia (vascular), gout and osteoarthritis. -There was an order for a no concentrated sweets pureed diet, honey thickened liquids and a supplemental nutritional shake three times a day with meals. -The resident was constantly disoriented. -The resident's current level of care was documented as special care unit (SCU). Review of Resident #3's Assessment and Care Plan dated 10/24/19 revealed: -The resident was always disoriented and had a significant memory loss, requiring direction. -The resident required staff supervision with eating. Review of the facility's undated "Diet Reference List" revealed Resident #3 was on a pureed diet with supplemental nutritional shakes three times a day with meals. Review of a second undated handwritten diet list	{D 310}	It is the policy of Wilson Assisted Living to prepare resident food and drink according to their physician's orders. Med Aides prepare thickened liquids for Residents per PCP orders. All Med Aides were in-serviced by the R.N. on how to properly thicken liquids on 3/2/2020. 3/2/2020 All new Med Aides have thickened liquid training by the R.N. upon hire. Dietary in-service was held on 2/21/2020 by Administrator pertaining to Therapeutic diets and thickened liquids. We order nectar and honey thickening packets weekly for proper mixing per physician orders. D310 Addendum per Telephone with MS. Fran Eths on 03/27/20: Record audits done on therapeutic diet orders and monthly by the Resident Care Coordinator (RCC) Meal Observations are done randomly every week by the RCC/ Administrator/Designee 03/27/20	

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{D 310}	Continued From page 6 revealed Resident #3 was on honey thickened liquids. Observation in the SCU dining room during Resident #3's lunch meal on 02/10/20 from 12:00pm - 12:35pm revealed: -At 12:00pm, there were two beverage containers with approximately 4 ounces of tea and water in a consistency observed to be pudding thick. -At 12:02pm, staff assisted the resident to the table in front of the prepared pudding thickened tea and water beverages. -At 12:03pm, the resident placed her finger in the pudding consistency tea and began eating the tea from her finger. -At 12:03pm, the resident was served her plated meal. -At 12:07pm, the resident picked up her tea beverage container, tilted the beverage container to her opened mouth and the pudding consistency tea would not move and stayed in place in the beverage container. -The resident looked at the beverage container, then placed the beverage container back on the table. -The resident was observed attempting to drink the tea intermittently throughout the meal. -At 12:15pm, staff served the resident a thickened nutritional supplement that was observed to be in a honey consistency. -At 12:35pm, the thickened nutritional supplement was observed clinging to the side of the beverage container and observed to have increased in thickness from a honey consistency to a pudding consistency. -The resident drank approximately 50% of the honey thickened nutritional supplement. Observation of Resident #3's thickened tea, water and nutritional supplement after the resident's	{D 310}		

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{D 310}	Continued From page 7 meal had ended on 02/10/20 at 12:47pm revealed: -The beverage container's used for Resident #3's thickened tea and water was repositioned with the opening of the beverage container in a down position. -The thickened tea and water in the beverage container stayed in the same position without any movement, staying in the same form and shape when the beverage container was in an upward position. -The beverage container used for Resident #3's thickened nutritional supplement was repositioned with the beverage container in a down position. -The thickened nutritional supplement had congealed into the formed shape of the beverage container and slid to the opening in one solid form. Interview with the cook on 02/10/20 at 11:39am revealed: -The facility used prepared thickening packets when residents had orders for thickened liquids. -The facility had nectar thickened packets but did not have honey thickened packets. -Dietary staff did not prepare Resident #3's honey thick beverages because the medication aides (MAs) were responsible for that. Observation of the liquid thickening agent available in the facility on 02/10/20 at 11:48am revealed: -There were 0.18-ounce packets of instant food and beverage thickening powder labeled on the front of the packet as "Nectar Consistency". -There were labeled directions on the back of the packet to add one packet of the thickening powder to 4 fluid ounces of liquid and to stir for 15 seconds, allowing 1-4 minutes for the liquid to	{D 310}		

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{D 310}	Continued From page 8 reach optimal thickness. -There were instructions in all capital letters that the beverage thickening powder may thicken over time. -There were instructions for nectar-like consistency to add one packet to 4 fluid ounces of liquid and spoon thick consistency to add two packets to 4 fluid ounces. -There were no instructions on the label for honey-like consistency. Observation of a MA on 2/10/20 at 2:50pm revealed: -The MA used a measuring cup to measure 4 ounces of lemonade. -The MA looked at the liquid poured into the measuring cup, but not at eye level. -The MA opened one packet of the instant food and beverage thickening powder labeled on the front of the packet as "Nectar Consistency". -The MA opened a second packet of the instant food and beverage thickening powder labeled on the front of the packet as "Nectar Consistency" and slowly poured approximately ½ of the packet into the liquid, then stirred the liquid for approximately 30 seconds. -The liquid was observed to be in a honey like consistency with small congealed segments noted in the liquid. Observation in In the dining room during Resident #3's snack on 02/10/20 at 2:55pm revealed: -The MA assisted the resident to drink the thickened lemonade from the cup. -The resident drank approximately ¾th of the lemonade. Interview with the MA on 02/10/20 at 3:06pm revealed: -She had worked at the facility for approximately	{D 310}		

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{D 310}	Continued From page 9 2 months. -She was trained by the Special Care Unit Coordinator (SCUC) on how to prepare the residents' ordered thickened liquids. -The facility also had written instructions for preparing the residents' ordered thickened liquids. -Resident #3's lemonade served today (02/10/20) looked a little thicker than honey thickened and thought it was more in the consistency of "applesauce". -She had not observed Resident #3 having any difficulty drinking her thickened beverages and the resident usually drank all her nutritional supplements. -The SCUC prepared Resident #3's beverages for the lunch meal today, (02/10/20). Interview with the SCUC on 02/10/20 at 3:08pm revealed: -She had worked in her current position for 2 years. -She prepared Resident #3's beverages for the lunch meal today, (02/10/20) by using one of the packets labeled as nectar consistency and then gradually added a second packet while stirring the liquid until a honey consistency was reached. -She had received training for preparing thickened liquids when she first started working at the facility but could not recall who trained her. -She prepared Resident #3's beverages around 11:45am today, (02/10/20). -There were written instructions how to mix honey thickened beverages in the kitchen. -She thought Resident #3's beverages thickening to a pudding consistency was related to a timing issue from the time the beverages were prepared, served and the meal completed. -She randomly observed the residents' meal service and had not noticed any concerns with	{D 310}		

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{D 310}	Continued From page 10 Resident #3's beverages and no staff had reported any concerns about the beverages becoming too thick or the resident not being not able to drink her beverages. Interview with a second cook on 02/10/20 at 4:05pm there was not any written instructions on how to prepare honey thickened beverages. Review of the facility's written instructions in a ringed binder provided by the MA that prepared Resident #3's snack and thickened lemonade on 02/10/20 revealed: -Resident #3's name was written on the form with "honey thickener" written beside the her name. -There were 2 other residents' names with "Nectar Thickener" written beside their names. -There was a front and back picture of the 0.18-ounce packets labeled as "Nectar Consistency" with the same labeled directions. Telephone interview with a Retail Sales Representative for the labeled company that manufactured the 0.18-ounce packets of instant food and beverage thickening powder labeled as "Nectar Consistency" on 02/10/20 at 3:40pm revealed: -It was important to follow the labeled instructions when thickening liquids to a physician ordered consistency. -The main ingredient in the thickening packets used by the facility was starch which allowed no room for error because the desired thickness could be thrown off easily if specific labeled instructions were not followed. -The safest and most accurate process to prepare honey thickened liquids would be to use packets labeled for the use of honey thick consistency or the use of a large container of a thickening agent with labeled directions with	{D 310}		

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{D 310}	Continued From page 11 different levels of desired thickness. Interview with the Administrator on 02/10/20 at 4:35pm revealed: -The MAs were trained to prepare Resident #3's honey thickened beverages using the packets of instant food and beverage thickening powder labeled as nectar consistency. -The facility used to buy both nectar and honey consistency packets, however, the facility currently only purchased nectar consistency because there were not many residents with an order for honey thickened liquids. -Resident #3 was currently the only resident that had an order for honey thickened liquids. -The facility also kept a large container of a thickening agent with labeled directions for different levels of thickness, however, she was just told this morning (02/10/20) the facility just "ran out". Telephone interview with the medical assistant with Resident #3's primary care provider (PCP) on 02/10/20 at 12:39pm revealed: -Resident #3 was on honey thickened liquids because of difficulty swallowing thin liquids. -Honey thickened liquids should be "pourable". -It was important for Resident #3 to be served honey thickened liquids and to be able to drink the liquids served to prevent dehydration. Based on observations, interviews and record reviews, it was determined Resident #3 was not interviewable.	{D 310}		