

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL055013	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 11/03/2023
NAME OF PROVIDER OR SUPPLIER HEATH HOUSE		STREET ADDRESS, CITY, STATE, ZIP CODE 919 WILMA SIGMON ROAD LINCOLNTON, NC 28092		
(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 and Lincoln County Department of Social Services conducted an annual survey on 11/01/23 through 11/03/23.	D 000		
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 therapeutic diets were served as ordered for 1 of 2 sampled residents (Resident # 6) who had a physician's order for nectar thick liquids. The findings are: Review of Resident #6's current FL2 dated 10/18/23 revealed: -Diagnoses included Senile Dementia of Lewy Body. -An order for nectar thickened liquids and chopped meats. Review of Resident #6's signed physician's orders dated 10/25/23 revealed a diet order for nectar thickened liquids and chopped meats. Review of the facility's therapeutic diet list on 11/01/23 revealed Resident #6 was ordered a ground diet with nectar thick liquids. Observation of the dining room on 11/02/23 from 10:24am to 10:25am revealed:	D 310		

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

TITLE

(X6) DATE

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D 310	Continued From page 1 -A resident was pouring drinks and handing out snacks from a snack cart for other residents to consume. -The snack cart had coffee, cranberry juice, popcorn, crackers and oatmeal pies. -Resident #6 was sitting in the dining room eating popcorn and taking a sip of cranberry juice. Interview with Resident #6 on 11/02/23 at 10:25 am revealed the cranberry juice he drank was not thickened but sometimes he drank nectar thick liquids. Interview with another resident on 11/02/23 at 10:28am revealed: -She handed out snacks and poured beverages on the mornings that she led devotions. -The kitchen staff put the snacks and beverages on the snack cart, and she did not request any nectar thick beverages from the kitchen staff. -She knew Resident #6 was supposed to drink nectar thick liquids but poured him a glass of regular cranberry juice because he liked to drink juice. Interview with the Dietary Manager (DM) on 11/02/23 at 10:30am revealed: -The kitchen staff put the snacks and beverages on the cart but kept the thickened beverages in the refrigerator to keep them cold. -Typically, a personal care attendant (PCA) would be in the dining room for snack time, and they would get thickened beverages for Resident #6 from the kitchen staff. -If snack time was during an activity, the Activity Director (AD) would request the thickened beverages from the kitchen staff. Interview with a personal care aide (PCA) on 11/02/23 at 12:44pm revealed:	D 310		

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D 310	Continued From page 2 -Activities staff usually did snack time , but if the activities staff were unable, they would ask a PCA to hand out snacks. -She knew Resident #6 was ordered thickened liquids. Interview with the AD on 11/02/23 at 3:31pm revealed: -Occasionally she served snacks if the activity was during snack time, then she gave residents the snack and beverage as part of the activity. -She would go to the DM and find out who had special diets or needed thickened liquids. -She thought two or three residents had thickened liquids and named Resident #6 as a person who received thickened liquids. -She was not in charge of snacks, the kitchen staff or the PCA's oversaw snacks. Interview with the Administrator on 11/03/23 at 12:58pm revealed: -His expected the residents to get the correct food and beverages based on their diet order. -The kitchen staff prepared the cart with snacks and beverages. -Generally, the PCA's passed out snacks and drinks. -The PCA's requested thickened beverages from the kitchen so they would be cold for the resident. -The AD was usually in the dining room during snack time. -Staff should not leave it up to a resident to know another resident's diet order. Attempted telephone interview with Resident #6's Primary Care Provider on 11/02/23 at 11:54am was unsuccessful.	D 310		