

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: FCL078121	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED 10/09/2024
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

HERITAGE CARE HOME OF DIALS #2

**1685 CANAL ROAD
PEMBROKE, NC 28372**

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey on 10/09/24.	C 000		
C 103	10A NCAC 13G .0317 (b) Building Service Equipment 10A NCAC 13G .0317 Building Service Equipment (b) There shall be a central heating system sufficient to maintain 75 degrees F (24 degrees C) under winter design conditions. Built-in electric heaters, if used, shall be installed or protected so as to avoid hazards to residents and room furnishings. Unvented fuel burning room heaters and portable electric heaters are prohibited. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure the facility was free of hazards as evidence by allowing a resident to operate a portable electric heater in his room. The finds are: Observation of Resident room #2 during the initial tour on 10/09/24 at 9:30am revealed: -The resident was lying in his bed. -There was a portable electric heater operating on the floor next to the left wall, plugged into an outlet. Interview with the Resident in room #2 on 10/09/24 at 9:30am revealed: -A staff member purchased the heater for him. -He had the heater for about a week. -He was cold.	C 103	10A NCAC 13G.0317 Building Service Equipment Administrator removed the portable heater and explained to the resident and the staff how dangerous this is to have in rooms. Administrator will make weekly rounds to ensure that the building is free of all hazards.	11/15/24

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

TITLE

(X6) DATE

STATE FORM

6899

BSY711

If continuation sheet 1 of 5

Reviewed and Acknowledged 11/18/24 *Anna A. Hays*

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C 103	Continued From page 1 Interview with the personal care aide (PCA) on 10/09/24 at 11:48am revealed: -She purchased the portable electric heater for the Resident in room #2. -The resident in room #2 complained of being cold. -The Administrator was aware the heater was in the resident's room. Interview with the Administrator on 10/09/24 at 12:55pm revealed: -She did not know why the resident in room #2 had a heater in his room. -She was aware the portable electric heater was in resident's room #2. -She thought if the heater had automatically shut off, the resident could have it in his room.	C 103	10A NCAC 13G. 0904(c)(7) Nutrition and Food Service The Administrator consulted the doctor about this residents diet. The pcp wrote new diet order for regular diet instead of CCHO diet.	
C 270	10A NCAC 13G .0904 (c)(7) Nutrition And Food Service 10A NCAC 13G .0904 Nutrition And Food Service Menus in Family Care Homes: (7) The facility shall have a matching therapeutic diet menu for any resident's physician-ordered therapeutic diet for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to have matching therapeutic menus for food service staff guidance for 1 of 2 sampled residents (#2) with physician orders for Consistent Carbohydrate (CCHO) diet.	C 270	Administrator will check all residents diet sheets monthly to ensure the facility is following all diet orders 11/15/24	

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C 270	Continued From page 2 The findings are: Review of Resident #2's current FL-2 dated 10/01/24 revealed: -Diagnoses included history of chest pain, difficulty in walking, and prolonged Q-T interval on electrocardiography (ECG). -There was a diet order for Consistent Carbohydrate (CCHO) diet. Review of the facility's menus on 10/09/24 revealed there were no menus for a Consistent Carbohydrate (CCHO) diet. Interview with the personal care aide (PCA) on 10/09/24 at 12:51pm revealed: -She used the regular menu to serve Resident #2. -She did not know Resident #2 had a diet order for a Consistent Carbohydrate (CCHO) diet. -She did not know what to serve a resident with a diet order of CCHO. -The Administrator was responsible for ensuring the residents' diet orders list was updated. Interview with the Administrator on 10/09/24 at 12:55pm revealed: -The facility only offered regular and no concentrated sweets (NCS) menus. -She was responsible for ensuring the diet orders were up to date. -Resident #2 came back from the hospital with a diet order of CCHO. -She did not clarify the diet order when Resident #2 came back from the hospital.	C 270			
C 311	10A NCAC 13G .0909 Residents' Rights 10A NCAC 13G .0909 Resident Rights	C 311			

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C 311	Continued From page 3 A family care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: Based on observations and interviews, the facility to ensure residents were treated with consideration as evidence by the residents complaining of being too cold. The findings are: Observation of the thermostat during the initial tour on 10/09/24 at 9:35am revealed the temperature was 67 degrees Fahrenheit. Interview with a resident on 10/09/24 at 9:27am revealed: -She needed heat because she was cold. -She told the personal care aide (PCA) she was cold, and she gave her a blanket, but she wanted heat. Interview with a second resident on 10/09/24 at 9:35am revealed: -His room got cold. -He told staff he was cold, but they did not say anything or give him a blanket. Interview with a third resident on 10/09/24 at 9:42am revealed she told staff she was cold, and they did not answer her. Interview with the PCA on 10/09/24 at 11:42am revealed: -She controlled the thermostat. -The residents did not let her know they were cold. -She did not know why the thermostat was at 67	C 311	10A NCAC 13G .0909 Residents Rights 11/15/24 Administrator turned the thermostat from 67° to 75° and instructed to the staff to leave it on 75° at all times so that the residents does not get cold. The Administrator will make daily rounds to ensure that the thermostat is on 75° and make sure all residents are comfortable		

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C 311	Continued From page 4 degrees Fahrenheit because she normally kept it at 70 degrees. Interview with the Administrator on 10/09/24 at 12:55pm revealed: -The residents had not complained to her about being cold. -The temperature in the facility should be maintained at 75 degrees.	C 311			