Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
		FCL017022	B. WING		C 06/23/2021	
NAME OF P	ROVIDER OR SUPPLIER		RESS, CITY, STA			
D & H FAN	MILY CARE HOME	1111 YARB MILTON, N	OROUGH ROA C 27305	AD		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETE	
C 000	Initial Comments		C 000			
	The Adult Care Licens annual survey on Jun	sure Section conducted an e 23, 2021.				
C 283	10A NCAC 13G .0904 Service	4 (e-3) Nutrition And Food	C 283			
	10A NCAC 13G .0904	1 Nutrition And Food Service				
	Therapeutic Diets in F	Family Care Homes:				
	current listing of resid	maintain an accurate and ents with physician-ordered juidance of food service				
	facility failed to mainta listing of residents wit therapeutic diets for g	and record reviews, the ain an accurate and current h physician-ordered juidance of food service d residents with an order for				
	The findings are:					
		dent diet list posted in the t 8:07am revealed Resident g on a regular diet.				
	09/11/20 revealed: -Diagnoses included smitral regurgitation, m					

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

TITLE (X6) DATE

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STATEMENT OF DEFICIENCIES		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE	(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:	A. BUILDING:		COMPLETED		
						;	
		FCL017022	B. WING	<del>-</del>	06/2	23/2021	
NAME OF D	DOVIDED OD CURRUED	CTDEET AD	DDECC CITY CTA	TE 710 000E			
NAME OF PE	ROVIDER OR SUPPLIER	STREET AD	DRESS, CITY, STA	TE, ZIP CODE			
D & H EAN	MILY CARE HOME	1111 YAR	BOROUGH ROA	AD.			
Dania	MET CARE HOWLE	MILTON, N	1C 27305				
(X4) ID	SUMMARY ST.	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	١	(X5)	
PREFIX		Y MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD		COMPLETE	
TAG	REGULATORY OR I	LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPE	RIATE	DATE	
				DEFICIENCY)			
C 283	Cantinual Framera	- 1	C 283				
C 263	Continued From page	<b>∌</b> I	0 203				
	Telephone interview	with Resident #3's primary					
		on 06/23/21 at 3:26pm					
	revealed:	31 00/20/21 at 0.20pm					
		odium diet for Resident #3					
	because her blood pr						
		o on medication to lower her					
		e PCP wanted to also					
		p lower her blood pressure.					
	-Resident #3's blood	pressure had come down to					
	normal levels, but she still wanted the resident to						
	continue with a low so	odium diet.					
	-She expected the fac	cility to follow a diet order					
	and she thought the le	=					
	Resident #3 was carr						
		iod out by the lacinty					
	Interview with the Sur	pervisor-in-Charge (SIC) on					
	06/23/21 at 4:39pm re						
	I						
		ade the diet list and updated					
	it as needed.						
	-She did not know Resident #3 was on a low						
		the diet list had her list as					
	served regular diet.						
		ident #3 was on a low					
	sodium diet.						
	-If she had known Re	esident #3 was on a low					
	sodium diet, she wou	lld have prepared her a low					
	sodium diet.	• •					
	Interview with the Adr	ministrator on 06/23/21 at					
	4:42pm revealed:						
	-She updated the resi	ident diet liet when a					
		nange; she did not know the					
		~					
	last time the diet list h						
		esident #3 was on a low					
		ıght Resident #3 was on a					
	regular diet.						
	Based on observation	ո, record reviews and					

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interviewable.

interviews it was determined Resident #3 was not

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		
						С
FCL017022		B. WING	B. WING			
NAME OF P	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE	, ZIP CODE		
D & H FAI	MILY CARE HOME		RBOROUGH ROAD I, NC 27305			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID ID	PROVIDER'S PLAN OF	CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTI CROSS-REFERENCED TO T DEFICIENC	ON SHOULD BE HE APPROPRIATE	COMPLETE DATE
C 284	10A NCAC 13G .09 Service	04(e)(4) Nutrition and Food	C 284			
	Service (e) Therapeutic Die (4) All therapeutic of supplements and the	04 Nutrition and Food ets in Family Care Homes: diets, including nutritional lickened liquids, shall be by the resident's physician.				
	interviews, the facili therapeutic diet was	et as evidenced by: ons, record reviews, and ty failed to ensure a s served as ordered for 1 of 3 #3) who had an order for a				
	The findings are:					
	09/11/20 revealed: -Diagnoses include mitral regurgitation,					
	care provider (PCP revealed: -She had ordered a #3 because her blo-Resident #3 was a blood pressure but control her diet to h -Resident #3's blood normal levels, but s continue with a low	low sodium diet for Resident of pressure had gone up. Iso on medication to lower her the PCP wanted to also elp lower her blood pressure. It is pressure had come down to he still wanted the resident to sodium diet.				

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION  A. BUILDING:		(X3) DATE SURVEY COMPLETED	
					С	
		FCL017022	B. WING		06/2	3/2021
NAME OF P	ROVIDER OR SUPPLIER	STREET ADD	RESS, CITY, STA	TE, ZIP CODE		
D & H FAN	MILY CARE HOME		OROUGH ROA	AD		
	OLIMAN DV OT	MILTON, N		DDOWNERIO PLAN OF CORRECTION		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETE DATE
C 284	Continued From page	2 3	C 284			
	and she thought the low sodium order for Resident #3 was being followed by the facility					

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