


Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 the Alexander County Department of Social Services completed an annual, follow up survey and complaint investigation from June 3, 2025 through June 12, 2025.	D 000		
D 067	<p>10A NCAC 13F .0305 (h)(4) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment</p> <p>(h) The requirements for outside entrances and exits are:</p> <p>(4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations, interviews, and record review, the facility failed to ensure 3 of 3 exit doors that were accessible to one resident (#11) who was disoriented and exhibited wandering behaviors, were equipped with sounding devices</p>	D 067	<p>10A NCAC 13 F .0305 (h)(4) Physical Environment met as evidenced by Door latches have been repaired and Door alarms installed at all resident entryways. Med Tech on shift will ensure alarms are on and operating appropriately daily. RCC will monitor weekly. Administrator or designee will monitor monthly and as needed.</p>	6/13/25

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Teresa Matos 	TITLE Administrator	(X6) DATE 7/24/25
--	------------------------	----------------------

Reviewed and acknowledged by MH on 7/29/2025

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	<p>Continued From page 1</p> <p>to alert staff when the exit doors were opened.</p> <p>The findings are:</p> <p>Review of the facility's current license effective 01/01/25 revealed the facility was licensed as an Adult Care Home with a capacity of 34.</p> <p>Review of the facility's current census on 06/03/25 revealed there were 33 residents residing in the facility.</p> <p>Observation of the facility exit doors, at intermittent times throughout the survey revealed:</p> <ul style="list-style-type: none"> -Several residents used the front entrance and two side exits to gather outside. -There was no audible sounding device heard when the front entrance/exit and two side doors were opened. <p>Observation of the facility's two side entrance/exit doors on 06/09/25 at 12:19pm and 3:50pm revealed:</p> <ul style="list-style-type: none"> -The front door of the facility had been functioning properly, locking, opening and closing as intended. -The alarm sensor at the top of the door had been secured with tape, preventing it from activating. - The left side exit door did not close properly and failed to latch securely when shut, there remained a half-inch gap, that prevented a complete seal, and the latch/lock assembly had been removed. -The left side exit alarm sensor appeared to be properly positioned on the left side exit door. -A half-inch gap prevented the door from fully closing, compromising the sensor's functionality. -The left side entrance/exit door did not shut all the way to engage the magnetic device on the alarm. 	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	<p>Continued From page 2</p> <ul style="list-style-type: none"> -The right-side exit door did not latch properly, and the outside door handle was hanging loosely and was nonfunctional and paper had been packed into the latch lock bolt assembly, obstructing its ability to engage correctly. -The right-side exit had tape over the door alarm sensor tape preventing it from working. -The alarm on the right-side door did not engage the magnetic device. -The two side doors did not lock or latch and did not have a working door latch. <p>Review of Resident #11's current FL2 dated 10/17/24 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included dementia, cardiomyopathy and acute stress reaction. -He was intermittently disoriented. -He was semi ambulatory and used a walker. -His level of care was assisted living. <p>Review of Resident #11's Resident Register revealed he was admitted on 11/8/24.</p> <p>Review of Resident #11's care plan dated 10/01/24 revealed:</p> <ul style="list-style-type: none"> -The care plan was from his former facility. -He had significant memory loss and must be redirected. -Safety and monitor daily was checked for seven days a week. -There was no documentation a care plan was completed after his admission to the current facility on 11/8/24. <p>Observation on 06/09/25 at 12:08pm revealed:</p> <ul style="list-style-type: none"> -Resident #11 was walking down the highway approximately 0.3 miles from the facility. -He was walking alone on the side of the road using his walker. -As the surveyor's car approached Resident #11, 	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	<p>Continued From page 3</p> <p>he moved his walker to the grassy side of the road.</p> <ul style="list-style-type: none"> -The temperature was 80 degrees outside according to the current weather report. -Resident #11 was wearing a long sleeved zipped up sweatshirt and long pants. -Resident #11 was stopped by the Adult Home Specialist (AHS) who was driving on the road behind the surveyor's car. <p>Interview with the Manager on 06/09/25 at 12:14pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #11 was not in the building. -There were not any alarms on the doors to notify staff if residents went outside. -Resident #11 would leave the facility approximately once per month, usually after his family has visited him. <p>Interview with the Administrator at 06/09/25 at 12:14pm revealed:</p> <ul style="list-style-type: none"> -She thought all residents were at the facility. -She did not know Resident #11 was seen by the survey team walking down the road. -When she first started approximately the first week in May 2025, she had told the Owner there should be alarms and locks on the doors. <p>Telephone interview with the AHS at 06/09/25 at 12:29pm revealed:</p> <ul style="list-style-type: none"> -She observed Resident #11 walking with his walker down the side of the highway 0.3 miles from the facility on 06/09/25 at 12:14pm. -She stayed with Resident #11 until Law Enforcement arrived. <p>Interview with a personal care aide (PCA) on 06/09/25 at 5:17pm revealed:</p> <ul style="list-style-type: none"> -She began working the night shift at the facility 	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	<p>Continued From page 4</p> <p>approximately eight months ago.</p> <ul style="list-style-type: none"> -Since she started at the facility, she had never heard any alarms when the doors were opened. -The locks were taken off because residents were locking other residents out of the facility. -Resident #11 needed to be watched closely because he wanted to return to his home and had a history of walking away from the facility. <p>Interview with a second PCA on 06/09/25 at 5:31pm revealed:</p> <ul style="list-style-type: none"> -She worked night shift at the facility for approximately four months. -She never heard any alarms on the doors and knew the doors did not lock. -She kept a close eye on Resident # 11 and a few other residents as they had a tendency to leave the facility. <p>Interview with the Manager on 06/10/25 at 9:43am revealed:</p> <ul style="list-style-type: none"> -She had been employed with the facility since January 2024. -When she began working in January 2024 the door alarms on the right hallway were functional. -The door alarms on the left side hallway never worked. -In the spring of 2024 someone put tape over the alarms, so the alarms were not functional. -There were no residents with elopement issues residing at the facility during that time. -The right-side hallway door could be locked but residents would lock each other out and a pull handle was installed. -The left-side hallway door never locked and used to have a handle with a doorknob but that broke off in January 2025 and now it is a pull handle. -She told the owner about the lock back in January 2025. 	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	<p>Continued From page 5</p> <p>Interview with the Administrator on 06/09/25 at 4:40pm and 06/10/25 at 11:22am revealed: -She began working at the facility on 04/28/25. - She gave a list to the Owner of things that needed to be done around the facility the first week of May 2025 and she alerted him about the locks and alarms. -The Owner told her he did not want the facility to have a locked unit. -She felt the doors should be able to be in working order so they would lock properly.</p> <p>Interview with the Owner on 06/10/25 at 11:03am revealed: -He was not made aware of doors not working. -He was made aware today 06/10/25 that sounding devices were necessary when the facility had a resident who was disoriented and exhibited wandering behaviors.</p> <p>_____</p> <p>The facility failed to ensure three of three exit doors were equipped with an audible sounding device when activated when at least one resident who is determined by a physician and observed by staff to be disoriented and exhibited wandering behavior. Facility staff were aware Resident #11 was disoriented and that the facility did not have sounding devices on 3 of 3 exit doors. Resident #11 was know to walk away from the facility. This resulted in Resident #11 who was intermittently disoriented and exhibited wandering behaviors, eloping from the facility without staff knowledge and was found walking along the road 0.3 miles from the facility. This failure resulted in serious neglect and constitutes a Type A1 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/25 for this violation.</p>	D 067		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 067	Continued From page 6	D 067		
D 072	<p>10A NCAC 13F .0305 (m) Physical Environment</p> <p>10A NCAC 13F .0305 Physical Environment</p> <p>(m) The requirements for outside premises are: (1) the outside grounds of new and existing facilities shall be maintained in a clean and safe condition. For the purpose of this Rule, "clean and safe condition" means free from debris, trash, uneven surfaces, and similar conditions as not to attract rodents and vermin and provide for safe movement throughout facility grounds. Creeks, ravines, ponds, pools, and other similar areas shall have safety protection. For the purpose of this Rule, "safety protection" means preventive measures, such as barriers, to block access to such areas; (2) if the facility has a fence around the premises, the fence shall not prevent residents from exiting or entering freely or have sharp edges, rusting posts, or other similar conditions that may cause injury; and (3) outdoor walkways and drives shall be illuminated by no less than five foot-candles of light at ground level.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations and interviews, the facility failed to ensure the outside grounds of the facility were maintained in a clean and safe condition</p>	D 072	<p>10A NCAC 13F .0305 (m) Physical Environment met as evidenced by all construction areas were immediately roped off with caution barriers, signs posted warning residents and visitors about the construction and the construction project completed. All holes have been filled and leveled, concrete repaired, rails re-installed and the project completed. Med tech to monitor future construction signage and barriers for safety daily, RCC to monitor weekly and Admin or designee to oversee monthly and as needed.</p>	6/13/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 072	<p>Continued From page 7</p> <p>related to a construction project for a new sewage pipe installation.</p> <p>The findings are:</p> <p>Observation of the front entrance of the facility on 06/03/25 at 9:15am revealed:</p> <ul style="list-style-type: none"> -A trench approximately 2-3 feet wide and 2 feet deep was observed in front of the entrance of the building where new plumbing piping was being installed directly where the railing connects to the front steps. -There was no barriers, or warnings signs indicating any hazards upon approach to the trench. -There was a slab of concrete right before the front steps that had been removed, and a black rug had been placed over the area. -There was a missing section of hand railing that connected to the remaining railing and the front porch. that was leaning against the porch, leaving the remaining railing unstable to hold onto. -The trench extended all the way to the right side of the facility, where white plastic pipes were exposed, along with other construction materials left unattended. <p>Observation of the front entrance of the facility on 06/04/25 at 8:17am revealed:</p> <ul style="list-style-type: none"> -A resident in a wheelchair was seen attempting to maneuver over the trench. -The resident encountered difficulty while passing over the trench at the front entrance of the facility, due to the obstruction, the resident had to exit his wheelchair and physically push it over the trench. <p>Observation of a resident on 06/04/25 at 2:31pm revealed:</p> <ul style="list-style-type: none"> -He walked along the right side of the building alongside the open trench to pick up a can on the 	D 072		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 072	<p>Continued From page 8</p> <p>far-right side of the building.</p> <p>-The resident walked around the building and came back and walked alongside the trench to place the can back on the far-right side of the building.</p> <p>Interview with a resident on 06/04/25 at 4:00pm revealed the resident was not informed about construction and was unaware of any signage to alert of a hazardous area.</p> <p>Interview with second resident on 06/04/25 at 4:05 pm revealed: -He had not been informed before or after the facility started construction. -He was not told to be "careful" or avoid the area.</p> <p>Interview with a third resident on 06/04/25 at 4:07 pm revealed: -He was not informed by staff about construction being done at the facility. -He was not informed about the trench in front of the facility. -Residents were never informed about changes being made at the facility.</p> <p>Interview with a personal care aide (PCA) on 06/05/25 at 1:46pm revealed: -The construction project started sometime last week. -The residents were allowed to enter and exit all entrances including the front and the right and left side. -She was not aware of instructions to prevent residents from using the front entrance.</p> <p>Interview with the Manager on 06/11/25 at 3:31 pm revealed: -She was not aware the area in front of the building was going to be dug up for construction</p>	D 072		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 072	<p>Continued From page 9</p> <p>work.</p> <p>-When she arrived on Monday 06/02/25 a large trench was dug along the outside of the front of the building.</p> <p>-The owner did not mention it or tell her to put up signs.</p> <p>Interview with the Administrator on 06/11/25 at 1:55 pm revealed:</p> <p>-When she was present at the facility on 05/30/25, there was no construction occurring.</p> <p>-She had no prior knowledge that any construction was planned.</p> <p>-Upon returning to the facility on 06/10/25 she was unaware of any communication provided to residents regarding the construction.</p> <p>-She expected the Manager to be responsible for handling such matters such as construction.</p> <p>Telephone interview with the owner on 06/04/25 at 5:10pm revealed:</p> <p>-A commercial septic line was being installed to avoid the septic system being clogged.</p> <p>-Residents normally would not go up and down the front steps and should only be on the front porch.</p> <p>-Residents were only allowed to exit on the right and left side of the building.</p> <p>_____</p> <p>The facility failed to ensure the outside grounds and entrance were maintained in a safe condition related to a construction project for a new sewage pipe installation that was being completed. The facility did not post signage or ensure access was restricted to residents or visitors entering or exiting the front entrance of the facility. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p>	D 072		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 072	Continued From page 10 The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED July 27, 2025.	D 072		
D 087	10A NCAC 13F .0306 (b)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (b) Each bedroom shall have the following furnishings in good repair and clean for each resident: (1) a bed equipped with a box spring and mattress or a bed frame with solid link springs with a foam mattress or a mattress designed to prevent sagging. A hospital bed equipped with all accessories required for use shall be arranged for as needed. A waterbed is allowed if requested by a resident and permitted by the facility. Each bed shall have the following: (A) at least one pillow with clean pillowcase; (B) a clean top and bottom sheet on the bed, with bed changed at least once a week and when soiled; and (C) clean bedspread and other clean coverings as needed. 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: TYPE A1 VIOLATION Based on interviews and observations, the facility	D 087	10A NCAC 13F .0306 (b)(1) Housekeeping and Furnishings met as evidenced by, all resident mattresses have been inspected and replaced as needed with mattress protectors applied. Fitted sheets, flat sheets and pillow cases have been replaced as needed per resident bed inspection. Patient care aide on shift will change bed linens three times a week on the resident assigned shower day and as needed, Med tech will monitor weekly and RCC will monitor monthly. Admin will oversee quarterly and as needed.	7/12/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 087	<p>Continued From page 11</p> <p>failed to ensure resident mattresses were free of rips, tears and holes and soiled linens and bedspreads were clean for 2 of 2 sampled residents (#6 and #7).</p> <p>The findings are:</p> <p>1. Review of Resident #6's current FL2 dated 9/24/24 revealed diagnoses included hypertension, depression and schizoaffective disorder.</p> <p>Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 10/04/24 -Resident #6 level of care was assisted living.</p> <p>Review of Resident #6's care plan dated 06/03/25 revealed he was independent with activities of daily living with the exception of assistance with grooming.</p> <p>Observation of Resident #6's bed on 06/03/25 at 9:42am and 10:37am revealed: -Resident #6's bedding consisted of a fitted sheet, pillow with pillowcase and a blanket. -The pillowcase was stained and discolored. -The fitted mattress sheet was soiled with dry dirt particles and had discolored areas with lines that appeared to be made by a green marking pen. -The mattress had multiple cracks in the outer lining of the mattress. -The mattress had more than 15 holes in the outer lining and the springs of the mattress were visible and extending through the mattress in at least four locations.</p> <p>Interview with Resident #6 on 06/03/25 at 9:42am revealed:</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 087	<p>Continued From page 12</p> <ul style="list-style-type: none"> -He had the same mattress since admission to the facility on 10/04/24. -He requested a new mattress multiple times, the most recent approximately a month ago, from the cook. -The cook said he would get him a new mattress but he never did. -The sheets have not been changed in over a month. -The Manager would not allow staff to go into his room. <p>Interview with a housekeeper on 06/10/25 at 9:52am revealed:</p> <ul style="list-style-type: none"> -All staff assisted with changing the residents' sheets on shower days and as needed. -All staff were expected to check the residents' mattresses during that time. -She noticed Resident #6's mattress had rips and holes on it a couple of weeks ago and reported it to the Manager, medication aide and the resident's guardian. <p>Interview with a second housekeeper on 06/10/25 at 9:58am revealed:</p> <ul style="list-style-type: none"> -The housekeepers and PCAs changed sheets on the resident's beds. - When staff performed laundry duties, they communicated if sheets were changed on the beds. -There was no log book or documentation related to when sheets were changed. <p>Interview with the Administrator on 06/11/25 at 12:48pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 did not like anyone to change the linens on his bed. -The PCAs and housekeeping were supposed to wipe the beds down every day. -Residents' bedding was to be changed and 	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 087	<p>Continued From page 13</p> <p>laundered every other day by rotation of hallways. -The PCAs and housekeeping were responsible for changing and laundering the sheets. -She thought she was told about Resident #6's mattress the second week after she was hired and made the Manager aware.</p> <p>Refer to interview with the Administrator on 06/11/25 at 2:10pm. 2. Review of Resident #7's current FL2 dated 03/12/25 revealed: -Diagnoses included paranoid schizophrenia, hypertension and gastroesophageal reflux disease.</p> <p>Review of Resident #7's Resident Register revealed: -Resident #7 was admitted to the facility on 02/04/25. -Resident #7's level of care was assisted living.</p> <p>Observation of Resident #7's mattress on 06/03/25 at 9:55am revealed: -A twin sized gray plastic mattress, approximately five inches in depth with three holes showing the webbing, approximately two inches in diameter. -The bottom and the top of the mattress were cracked with the inside foam showing.</p> <p>Interview with Resident #7 on 06/03/25 at 9:55am revealed: -She had three mattresses since admission on 02/04/25; none of them were new. -When she was admitted her family member emailed the Manager on 02/04/25 to ask for another mattress and 4 or 5 days later the staff brought one worse than the one on the bed that was needing to be replaced and she refused it. -About a month after she refused the last mattress, the staff brought the mattress she was</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 087	<p>Continued From page 14</p> <p>sleeping on now and gave her a quilt to put over the mattress so she would not feel the cracks. -Sometimes she felt the cracks in the mattress if the quilt slipped. -She would like a new mattress, but she did not think other residents' mattresses were any better.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed: -She did not know about Resident #7's mattress until she received the email from her family and could not remember when that was. -Resident #7 refused a mattress she found for her but could not remember when. -Resident #7 received another mattress and a quilt to put over the mattress because of the holes and cracks in it. -She did not know how bad the mattress was until it was pointed out during the survey.</p> <p>Refer to interview with the Administrator on 06/11/25 at 2:10pm.</p> <p>Interview with the Administrator on 06/11/25 at 2:10pm revealed: - Resident #7 reported to her about needing a new mattress sometime during the first week in May 2025. -She called the resident's guardian to inquire about purchasing new mattresses. -She was unaware that Resident #6 and #7 needed new mattresses. -The Administrator alerted the facility owner about contacting a medical equipment company to purchase new mattresses for Resident #6 and Resident #7. -The Administrator showed the owner the mattresses for Resident #6 and #7. -The owner told her that the Manager was supposed to order new mattress from a medical</p>	D 087		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	--

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 087	<p>Continued From page 15</p> <p>equipment company. -The Manager told the Administrator that she was "working on it."</p> <hr/> <p>The facility failed to replace worn and torn mattresses on residents beds resulting in residents sleeping on mattresses with exposed springs and holes in them for greater than 8 months without replacements. This failure resulted in serious neglect and constitutes a Type A1 violation.</p> <hr/> <p>The facility provided a plan of protection in accordance with G.S. 131-34 on 06/03/25 for this violation.</p> <p>THE CORRECTION DATE FOR THIS TYPE OF A1 VIOLATION SHALL NOT EXCEED JULY 12, 2025.</p>	D 087		
D 167	<p>10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation</p> <p>10A NCAC 13F .0507 Training On Cardio-Pulmonary Resuscitation Each adult care home shall have at least one staff person on the premises at all times who has completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, provided by the American Heart Association, American Red Cross, National Safety Council, American Safety and Health Institute or Medic First Aid, or by a trainer with documented certification as a trainer on these procedures from one of these organizations. The staff person trained according to this Rule shall have access at all times in the facility to a one-way valve pocket mask for use in performing</p>	D 167	<p>10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation met as evidenced by CPR class was held for all staff in need on 6/20/25 and another scheduled on 7/25/25 to cover new hires so that all staff is certified. RCC to monitor daily, Consultant RCC to monitor weekly and Administrator will oversee monthly and as needed to ensure facility compliance ongoing.</p>	7/25/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 167	<p>Continued From page 16</p> <p>cardio-pulmonary resuscitation.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on record reviews and interviews the facility failed to ensure at least one staff was on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, for 3 of 7 sampled staff (Staff B, Staff I and Staff K).</p> <p>The findings are:</p> <p>Observation on 06/05/25 at 6:10pm to 6:15pm revealed: -The Manager was leaving the facility. -Staff I and Staff K were personal care aides (PCAs) and the only staff on duty.</p> <p>1. Review of Staff B's personnel record revealed: -Staff B was hired on 06/01/17 as a medication aide (MA) and personal care aide (PCA). -Staff B's CPR certificate was dated 11/26/19.</p> <p>Review of time punches revealed Staff B was the only staff member on first shift on 03/22/25 and 03/23/25.</p> <p>Refer to interview with the former Administrator on 06/10/25 at 11:51am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Interview with the Administrator on 06/11/25 at 3:05pm.</p> <p>2. Review of Staff I's personnel record revealed:</p>	D 167		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 167	<p>Continued From page 17</p> <ul style="list-style-type: none"> -Staff I was hired at the facility as a PCA -There was documentation Staff I was hired as a PCA. -There was no documentation of a hire date for Staff I. -Staff I was issued a CPR certificate on 06/06/25. <p>Interview with Staff I on 06/05/25 at 6:12pm revealed her CPR certification was expired.</p> <p>Refer to interview with the former Administrator on 06/10/25 at 11:51am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Interview with the Administrator on 06/11/25 at 3:05pm.</p> <p>3. Review of Staff K's personnel record revealed:</p> <ul style="list-style-type: none"> -Staff K was hired on 04/03/25 as a MA. -Staff K was issued a CPR certificate on 06/07/25. -There was no documentation of prior CPR certification in Staff K's personnel file. <p>Interview with Staff K on 06/05/25 at 6:13pm revealed her CPR certification was expired.</p> <p>Refer to interview with the former Administrator on 06/10/25 at 11:51am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Interview with the Administrator on 06/11/25 at 3:05pm.</p> <p>_____</p> <p>Interview with the former Administrator on</p>	D 167		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 167	<p>Continued From page 18</p> <p>06/10/25 at 11:51am revealed: -The Manager was responsible for tracking CPR certifications. -She did not have access to the employee files; only the Manager and human resources (HR) had access. -She was not aware of staff working that had CPR certifications out of date.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed she informed the owner last year and a couple months ago that some staff needed a CPR class for recertification.</p> <p>Interview with the Administrator on 06/11/25 at 3:05pm revealed: -The Manager was responsible for ensuring staff were CPR certified and there was at least one staff member in the facility at all times with a current CPR certification. -The Manager was responsible for making sure personnel files were audited and staff were up to date on all of their training.</p> <p>[Refer to tag 194, 10A NCAC 13F .0608(a)(b) Staffing for a Facility With A Census of 21 Or More Residents (Type B Violation)].</p> <p>The facility failed to ensure three staff, Staff B, Staff I and Staff K had training on CPR and choking management in the last 24 months on first, second and third shifts for 17 of 42 shifts, resulting in no staff available to perform lifesaving measures in the event of an emergency. This failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation.</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/25 for</p>	D 167		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 167	Continued From page 19 this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/27/25.	D 167		
D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrato 10A NCAC 13F .0601 Management Of Facilities - General Administrator And Manager Responsibilities (a) Each adult care home shall have an administrator who is certified in accordance with Rule .1701 of this Subchapter. The administrator shall be responsible for the total operation and management of the facility to assure that all care and services are provided to maintain the health, safety, and welfare of the residents in accordance with all applicable local, state, and federal regulations and codes. The administrator shall also be responsible to the Division of Health Service Regulation and the county department of social services for complying with the rules of this Subchapter. The co administrator, when there is one, shall share equal responsibility with the administrator for the operation of the home and for meeting and maintaining the rules of this Subchapter. The term "administrator" also refers to co administrator where it is used in this Subchapter.	D 176	10A NCAC 13F .0601 (a) Management of Facilities-General Administrator and Manager Responsibilities met as evidenced by, Facility ownership has terminated all previous inter-facility management and replaced with new management, including rehiring the previous Certified Administrator, previous RCC as a Consultant RCC and staff RCC. RCC shall monitor daily to ensure the facility day to day operations and management of the facility. Consultant RCC shall also ensure operation and management of the facility weekly and Administrator will ensure all operations and management of the facility monthly and as needed.	6/13/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 20</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on record reviews and interviews, the Administrator and former Administrator failed to ensure the overall management and day to day operations of the facility to meet and maintain rules related to physical environment, housekeeping and furnishings, resident rights, medication administration, health care, controlled substances, reporting to the health care personnel registry, training on cardiopulmonary resuscitation, staffing with a census of 21 or more, accurately documenting medications, activities, transportation of residents to appointments, assessment, care plan and reporting of incidents and accidents.</p> <p>The findings are:</p> <p>Review of the facility's license revealed: -The facility's license was effective 01/01/25 through 12/31/25 for a capacity up to 34 residents and type was listed as zero for Alzheimer's/Dementia.</p> <p>Review of the facility's census on 06/03/25 revealed there were 33 residents residing in the facility.</p> <p>Interview with the Adult Home Specialist on 06/03/25 at 8:45am revealed: -The current Administrator started at the end of April 2025. -The current Administrator took personal leave the week prior to the survey entry date of 06/03/25.</p> <p>Interview with the Dietary Manager upon arrival at</p>	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	--

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 21</p> <p>the facility on 06/03/25 at 9:00am revealed he thought the Administrator was still on personal leave and did not know if she was coming back.</p> <p>Interviews with the Manager on 06/03/25 at 9:10am and 9:30am revealed: -She was the Business Office Manager (BOM), Residential Care Coordinator (RCC), Medication Aide Supervisor, Activities Director (AD) and the Transportation Coordinator. -She was not sure if the Administrator would be working but would get in touch with someone to let them know State Surveyors were in the facility. -She called the former Administrator to come to the facility to assist her and she should be at the facility in about four hours.</p> <p>Interview with the former Administrator on 06/03/25 2:20pm revealed: -"For now", she was the "acting Administrator" for the facility. -A new Administrator was hired a month ago but she was not sure of her status.</p> <p>Interview with the former Administrator on 06/05/25 at 10:10am revealed: -She was responsible for the overall management of the facility since June of 2024. -When she was contacted by the Manager about the missing narcotics around 04/08/25 or 04/09/25, she did not tell them to notify the local law enforcement because she did not have all the details. -She did not complete an investigation into the missing narcotics because the Owner hired a Consultant to complete the investigation. -She was not aware of any concerns with missing controlled substances until the incident on 04/08/25. -She said the Manager contacted her regarding</p>	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 22</p> <p>the missing narcotics and thought it was either 04/08/25 or 04/09/25 but could not remember the date.</p> <p>-She was not aware of the residents who had missing medications.</p> <p>-There was nothing else immediately put into place by her but knew the pharmacy was involved.</p> <p>-She knew three staff were involved but did not know the third staff's name but knew she was a MA.</p> <p>-She did not complete the 24-hour report or the 5-day investigative report and was not told to do so.</p> <p>-Today 06/05/25 she faxed a new report to the health care personnel registry because the alleged staff were not included in the report.</p> <p>-She only reported one staff member at the direction of the two alleged staff members (the Manager and the MA) and she never read the investigation report.</p> <p>-She should of come to the facility when this was reported to her immediately but knew someone else was doing the investigation.</p> <p>-She never had access to any of the emails for the facility.</p> <p>-The staff would call the Owner before calling her because that was what the Owner wanted.</p> <p>Interview with the Manager on 06/04/25 at 4:43pm revealed:</p> <p>-The Administrator that was hired 3-4 weeks ago had worked about two and half weeks out of the four weeks.</p> <p>-The former Administrator had been overseeing the facility as the Acting Administrator since about 09/01/24 until the Owner recently hired a replacement the end of April 2025.</p> <p>-The former Administrator would come to the facility about once a week.</p>	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 23</p> <p>-Since 09/01/24 she was "all alone to handle the responsibilities."</p> <p>Interview with the former Administrator on 06/04/25 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -She started at this facility on 06/22/24 to train with the facility's Administrator at that time who was leaving in September 2024. -This individual was currently the Facility Consultant. -She was still working as the Administrator at other family care homes owned by the same owner of this facility. -She came to this facility two to three days a week for about a month and then one day a week and was available by phone. -She was available to staff by telephone if she was not at this facility. <p>Telephone interview with the Facility Consultant on 06/04/25 at 2:41pm revealed:</p> <ul style="list-style-type: none"> -She had worked at this facility from 2007 until September 2024. -When she started in 2007 she was a personal care aide (PCA) and advanced her way up to be the Administrator. -She was hired by the Owner to complete an investigation regarding missing narcotics at the facility. -He wanted to have an external representative who was familiar with the facility to conduct the investigation. -The investigation was from 04/08/25 to 04/14/25. -Two staff members were listed as alleged staff regarding diversion of drugs. -When she started the investigation, she asked the Owner and the Manager for the controlled substance count sheets (CSCS), but they could not be found. -She advised the Owner to suspend the Manager 	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 24</p> <p>during the investigation and if he did not want to suspend the Manager she should not continue to administer medications to resident.</p> <ul style="list-style-type: none"> -The Owner did not want to suspend the Manager because of lack of medication staff. -She spoke to law enforcement regarding the allegation but had not heard back from them. <p>Telephone interview with the owner on 06/04/25 at 5:19pm revealed:</p> <ul style="list-style-type: none"> -The current Administrator that was hired a few weeks ago was taking personal leave but may return to work soon. -He hired the Facility Consultant in April 2025 to complete an investigation regarding an allegation related to staff members and missing controlled substance because he wanted an outside party to complete the investigation. -The Facility Consultant used to be the Administrator when he bought the building in 2023 and she worked in the facility for several years. -It was the third time there was a concern with missing narcotics. -The first time was in December 2024 when the Manager threw away narcotics and replaced them. -The second time a medication aide (MA) was suspected of taking pills and ingesting them per another MA between October 2024 and January 2025. -The third time the Manager admitted to accidentally throwing away two cards of narcotics in April 2025. -The Manager and the former Administrator were responsible for submitting the 24-hour and five-day report to the Health Care Personnel Registry. -He had a copy of both reports on his "drive" (a cloud-based storage system). 	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 25</p> <p>-He opened them to make sure they were filed but had not reviewed them.</p> <p>Interview with the Manager on 06/09/25 at 9:00am, 1:02pm and 3:55pm revealed:</p> <ul style="list-style-type: none"> -The Administrator that started the end of April 2025 was present in the facility (06/09/25). -She did not know if the Administrator hired in April 2025 was an active Administrator. -She was never informed when work was happening at the facility. -She was not informed regarding the construction the week of 05/26/25 when the front of the building was going to be dug up and new plumbing piping installed. -The area where the piping was to be installed was not blocked off to ensure residents safety and felt it was a fall risk. -She was the only person in management beginning 8/31/24 with no one in the facility to train her. -She was not able to transport people to their appointments because she would not be in compliance with the staffing requirements so people could not get to their appointments. <p>Interview with the current Administrator on 06/09/25 at 9:45am revealed that she was the Administrator now and we could give all necessary correspondence to her.</p> <p>Interview with the Manager on 06/10/25 at 9:43am revealed:</p> <ul style="list-style-type: none"> -The former Administrator became the acting Administrator in September 2024. -The former Administrator was just a phone call away but would only help with paperwork and she came about once per week and she sometimes did a video call but it was not the same as having someone here for hands on training. 	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 26</p> <ul style="list-style-type: none"> - She became the Business Office Manager in September 2024 along with being responsible for the duties of the Residential Care Coordinator, Activities Director and Transportation Coordinator. -She told the Owner she needed help on multiple occasions and "begged" to bring back the Facility Consultant who used to work as the Administrator when the Owner bought the facility. -She did not know anything about the job descriptions but was expected to do the hiring, issue the drug test for new employees and human resources (HR) would do the criminal background checks. -HR was in another country (India). <p>Interview with the former Administrator on 6/11/2025 at 10:15 am revealed:</p> <ul style="list-style-type: none"> -Staff were responsible for taking residents to their appointments. -She was not aware of the residents' missed appointments. -The Manager did not make her aware of the residents' missed appointments and did not keep her informed about anything going on in the facility. <p>Interview with the Owner on 06/11/25 at 11:10am revealed:</p> <ul style="list-style-type: none"> -The Administrator was hired on 04/28/25. -Her certificate was not posted because he would like to give her a month to make sure she will stay. <p>Interview with the Administrator on 06/11/25 at 3:15pm and 4:55pm revealed:</p> <ul style="list-style-type: none"> -She did not think the former Administrator had much involvement with things at the facility. -She told the Owner of several things needed to be put in place, for example the alarms on the 	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 27</p> <p>doors.</p> <p>-The Owner or home office did all the hiring, and she would like to be included in that process to make sure the potential new employees were a good match with the current staff.</p> <p>Interview with the Owner on 06/12/25 at 11:44am revealed the Manager was no longer employed at the facility because she withdrew funds from resident accounts for her own personal use and used the facilities debit card resulting in overdrafts.</p> <p>Non-compliance was identified at a violation level in the following rule areas:</p> <ol style="list-style-type: none"> 1. Based on observations, interviews, and record review, the facility failed to ensure 3 of 3 exit doors that were accessible to one resident (#11) who was disoriented and exhibited wandering behaviors, were equipped with sounding devices to alert staff when the exit doors were opened. [Refer to tag 067, 10A NCAC 13F .0305(h)(4) Physical Environment (Type A1 Violation)]. 2. Based on observations and interviews, the facility failed to ensure the outside grounds of the facility were maintained in a clean and safe condition related to a construction project for a new sewage pipe installation. [Refer to tag 072, 10A NCAC 13F .0305(m) Physical Environment (Type B Violation)]. 3. Based on interviews and observations, the facility failed to ensure resident mattresses were free of rips, tears and holes and soiled linens and bedspreads were clean for 2 of 2 sampled residents (#6 and #7). [Refer to tag 087, 10A NCAC 13F .0306(b)(1) Housekeeping and Furnishings (Type A1 	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 28</p> <p>Violation)].</p> <p>4. Based on record reviews and interviews the facility failed to ensure at least one staff was on the premises at all times who completed within the last 24 months a course on cardio-pulmonary resuscitation and choking management, including the Heimlich maneuver, for 3 of 7 sampled staff (Staff B, Staff I and Staff K). [Refer to tag 167, 10A NCAC 13F .0507 Training on Cardio-Pulmonary Resuscitation (Type B Violation)].</p> <p>5. Based on interviews, record reviews and observations, the facility failed to ensure referral and follow-up for 4 of 6 sampled residents (#1, #4, #5 and #11) related to a resident who had an order for physical and occupational therapy (Resident #1), ensuring a resident attended his infectious disease appointments with his Primary Care Provider (PCP) (Resident #4), notifying the PCP regarding elevated blood pressures (Resident #5) and of exit seeking behaviors (Resident #11). [Refer to tag 273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation)].</p> <p>6. Based on observations and interviews and record reviews, the facility failed to ensure resident's rights were maintained for all residents related to privacy when an audio and visual surveillance system was operational in all common areas and recorded residents' and visitors' conversations and related to the care and services needed for 2 of 2 residents (#6 & #7) whose mattresses had rips, tears and holes in them and were not in good condition upon admission or replaced when needed.[Refer to tag 338, 10A NCAC 13F .0909 Resident Rights (Type A1 Violation)].</p>	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	<p>Continued From page 29</p> <p>7. The facility failed to administer medications as ordered for 6 of 6 sampled resident related to medications for pain (#1), hypertension, stroke prevention, chronic pain, fluid retention, low iron levels, elevated blood sugar levels, gout, restless leg syndrome (#2), sleep (#3), and anxiety (#4, #5, #10). [Refer to tag 358, 10A NCAC 13F .1004(a) Medication Administration (Type B Violation)].</p> <p>8. Based on observations, interviews, and record reviews, the facility failed to ensure a readily available record that reconciled the receipt, administration, and disposition of controlled medications for 5 of 6 sampled residents (#1, #2, #3, #5 and #10) related to a Schedule II controlled pain reliever (#1, #2, and #3), a Schedule IV controlled anti-anxiety medication (#3, #5 and #10), and a Schedule IV controlled insomnia medication (#3). [Refer to tag 392, 10A NCAC 13F .1008(a) Controlled Substances (Type B Violation)].</p> <p>9. Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours for 3 of 3 sampled staff (A, B & L) related to allegations of drug diversion and failed to submit to HCPR a 5-working day investigation report. This failure was detrimental to the safety, health, and welfare of the residents and constitutes a Type B Violation. [Refer to tag 438, 10A NCAC 13F .1205 Health Care Personnel Registry (Type B Violation)].</p> <p>_____</p> <p>The Administrator failed to ensure the overall management, operations and implementation of policies of the facility to maintain substantial compliance with the rules and statutes governing adult care homes as related to physical</p>	D 176		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 176	Continued From page 30 environment, housekeeping and furnishings, resident rights, medication administration, health care, controlled substances, reporting alleged staff to the to health care personnel registry, training on cardiopulmonary resuscitation, adequate staffing with a census of 21 or more, accurately recording medications, activities, transportation, assessment, care plan and reporting of incidents and accidents. The Administrator's failure to ensure responsibility for the overall operation, administration, management, and supervision of the facility resulted in serious neglect of the residents which constitutes a Type A1 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/25 for this Violation. THE CORRECTION DATE FOR THIS TYPE A1 VIOLATION SHALL NOT EXCEED July 12, 2025.	D 176		
D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities With A Census Of 21 10A NCAC 13F .0608 Staffing for Facilities With A Census Of 21 Or More Residents (a) Each facility with a census of 21 or more residents shall have staff on duty to meet the needs of the residents. (b) In addition to the requirement in Paragraph (a) of this Rule, each facility with a census of 21 or more residents shall comply with the following staffing requirements: (1) On first shift and second shift, the total aide duty hours shall be at least: (A) 16 hours of aide duty for facilities with a census of 21 to 40 residents.	D 194	10A NCAC 13F .0608 (a)(b) Staffing for Facilities with Census of 21 or more Residents met as evidenced by facility has hired adequate staff in facility for the maximum census capacity of 34. Staff were in-serviced regarding lunch breaks and overall attendance. Med Techs will endure all shifts are staffed to census ratio at minimum daily. RCC will ensure schedule reflects adequate coverage weekly. Administrator or designee will ensure staff to resident ratio is correct monthly and as needed.	7/24/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 31</p> <p>(B) 20 hours of aide duty for facilities with a census of 41 to 50 residents.</p> <p>(C) 24 hours of aide duty for facilities with a census of 51 to 60 residents.</p> <p>(D) 28 hours of aide duty for facilities with a census of 61 to 70 residents.</p> <p>(E) 32 hours of aide duty for facilities with a census of 71 to 80 residents.</p> <p>(F) 36 hours of aide duty for facilities with a census of 81 to 90 residents.</p> <p>(G) 40 hours of aide duty for facilities with a census of 91 to 100 residents.</p> <p>(H) 44 hours of aide duty for facilities with a census of 101 to 110 residents.</p> <p>(I) 48 hours of aide duty for facilities with a census of 111 to 120 residents.</p> <p>(J) 52 hours of aide duty for facilities with a census of 121 to 130 residents.</p> <p>(K) 56 hours of aide duty for facilities with a census of 131 to 140 residents.</p> <p>(L) 60 hours of aide duty for facilities with a census of 141 to 150 residents.</p> <p>(M) 64 hours of aide duty for facilities with a census of 151 to 160 residents.</p> <p>(N) 68 hours of aide duty for facilities with a census of 161 to 170 residents.</p> <p>(O) 72 hours of aide duty for facilities with a census of 171 to 180 residents.</p> <p>(P) 76 hours of aide duty for facilities with a census of 181 to 190 residents.</p> <p>(Q) 80 hours of aide duty for facilities with a census of 191 to 200 residents.</p> <p>(R) 84 hours of aide duty for facilities with a census of 201 to 210 residents.</p> <p>(S) 88 hours of aide duty for facilities with a census of 211 to 220 residents.</p> <p>(T) 92 hours of aide duty for facilities with a census of 221 to 230 residents.</p> <p>(U) 96 hours of aide duty for facilities with a</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 33</p> <p>sampled from 03/21/25 through 04/03/25.</p> <p>The findings are:</p> <p>Review of the facility's current license issued by the Division of Health Service Regulation effective January 1, 2025, revealed the facility was licensed for a capacity of 34 beds for an Adult Care Home.</p> <p>Observation during the initial tour on 06/03/24 at 9:00am revealed the facility was not sprinklered for fire suppression.</p> <p>Review of the facility's census for 03/21/25 to 04/03/25 revealed there were 33 to 34 residents which required 16 aide duty hours on first shift and second shift, and 16 aide duty hours on third shift.</p> <p>Review of the facility's residents receiving Personal Care Services (PCS) revealed:</p> <ul style="list-style-type: none"> -A total of 29 residents received PCS. -There were 4 of 5 sampled residents who received PCS. -There were 4 of 5 sampled residents who required extensive assistance with toileting. -There were 3 of 5 sampled residents who required extensive assistance with bathing, grooming and dressing. -There was 1 of 5 sampled residents who was totally dependent with grooming. <p>1. Review of the facility's census for 03/21/25 to 04/03/25 revealed there were 33 to 34 residents which required 16 aide duty hours on first shift.</p> <p>Review of the employee time punch detail report dated 03/21/25 revealed there was a total of 14.57 aide duty hours provided on first shift with a</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 34</p> <p>shortage of 1.43 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/22/25 revealed there was a total of 8 aide duty hours provided on first shift with a shortage of 8 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/23/25 revealed there was a total of 7.5 aide duty hours provided on first shift with a shortage of 8.5 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/29/25 revealed there was a total of 12 aide duty hours provided on first shift with a shortage of 4 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/30/25 revealed there was a total of 12 aide duty hours provided on first shift with a shortage of 4 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 04/01/25 revealed there was a total of 10 aide duty hours provided on first shift with a shortage of 6 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 04/03/25 revealed there was a total of 14.5 aide duty hours provided on first shift with a shortage of 1.5 aide duty hours.</p> <p>Refer to interview with a personal care aide (PCA) on 06/03/25 at 9:20am.</p> <p>Refer to interview with a second PCA on 06/03/25 at 11:20am.</p> <p>Refer to interview with the Manager on 06/11/25 at 9:50am.</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 35</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>Refer to interview with the Owner on 06/11/25 at 10:55am.</p> <p>2. Review of the facility's census for 03/21/25 to 04/03/25 revealed there were 33 to 34 residents which required 16 aide duty hours on second shift.</p> <p>Review of the employee time punch detail report dated 03/21/25 revealed there was a total of 8 aide duty hours provided on second shift with a shortage of 8 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/22/25 revealed there was a total of 6 aide duty hours provided on second shift with a shortage of 10 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/23/25 revealed there was a total of 6.18 aide duty hours provided on second shift with a shortage of 9.82 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/24/25 revealed there was a total of 13.92 aide duty hours provided on second shift with a shortage of 2.08 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/25/25 revealed there was a total of 11.73 aide duty hours provided on second shift with a shortage of 4.27 aide duty hours.</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 36</p> <p>Review of the employee time punch detail report work calendar dated 03/26/25 revealed there was a total of 15.54 aide duty hours provided on second shift with a shortage of 1.02 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/27/25 revealed there was a total of 8.95 aide duty hours provided on second shift with a shortage of 7.05 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/28/25 revealed there was a total of 14 aide duty hours provided on second shift with a shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/29/25 revealed there was a total of 14 aide duty hours provided on second shift with a shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 03/30/25 revealed there was a total of 14 aide duty hours provided on second shift with a shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 04/01/25 revealed there was a total of 11 aide duty hours provided on second shift with a shortage of 5 aide duty hours.</p> <p>Review of the employee time punch detail report work calendar dated 04/03/25 revealed there was a total of 14.96 aide duty hours provided on second shift with a shortage of 1.04 aide duty hours.</p> <p>Refer to interview with a personal care aide (PCA) on 06/03/25 at 9:20am.</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 37</p> <p>Refer to interview with a second PCA on 06/03/25 at 11:20am.</p> <p>Refer to interview with the Manager on 06/11/25 at 9:50am.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>Refer to interview with the Owner on 06/11/25 at 10:55am.</p> <p>3. Review of the facility's census for 03/21/25 to 04/03/25 revealed there were 33 to 34 residents which required 16 aide duty hours on third shift.</p> <p>Review of the employee time punch detail report dated 03/21/25 revealed there was a total of 12.95 aide duty hours provided on third shift with a shortage of 3.05 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/22/25 revealed there was a total of 12.3 aide duty hours provided on third shift with a shortage of 3.7 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/23/25 revealed there was a total of 15 aide duty hours provided on third shift with a shortage of 1 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/24/25 revealed there was a total of 15 aide duty hours provided on third shift with a shortage of 1 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/25/25 revealed there was a total of 14.77 aide duty hours provided on third shift with</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 38</p> <p>a shortage of 1.23 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/26/25 revealed there was a total of 13 aide duty hours provided on third shift with a shortage of 3 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/27/25 revealed there was a total of 8 aide duty hours provided on third shift with a shortage of 8 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/28/25 revealed there was a total of 13.88 aide duty hours provided on third shift with a shortage of 2.12 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/29/25 revealed there was a total of 13.95 aide duty hours provided on third shift with a shortage of 2.05 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/30/25 revealed there was a total of 14 aide duty hours provided on third shift with a shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report dated 03/31/25 revealed there was a total of 13 aide duty hours provided on third shift with a shortage of 3 aide duty hours.</p> <p>Review of the employee time punch detail report dated 04/01/25 revealed there was a total of 14 aide duty hours provided on third shift with a shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report dated 04/02/25 revealed there was a total of 14 aide duty hours provided on third shift with a</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 39</p> <p>shortage of 2 aide duty hours.</p> <p>Review of the employee time punch detail report dated 04/03/25 revealed there was a total of 14 aide duty hours provided on third shift with a shortage of 2 aide duty hours.</p> <p>Refer to interview with a personal care aide (PCA) on 06/03/25 at 9:20am.</p> <p>Refer to interview with a second PCA on 06/03/25 at 11:20am.</p> <p>Refer to interview with the Manager on 06/11/25 at 9:50am.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>Refer to interview with the Owner on 06/11/25 at 10:55am.</p> <p>Interview with a personal care aide (PCA) on 06/03/25 at 9:20am revealed there was never less than two staff on duty in the facility that she knew of.</p> <p>Interview with a second PCA on 06/03/25 at 11:20am revealed:</p> <ul style="list-style-type: none"> -She came in at 6:00am when she was scheduled to work and checked on the residents to ensure they were in their beds and were dry. -If they needed assistance with toileting or needed changed, she assisted them. -After she did her rounds, she started housekeeping duties until around 12:00pm. -After her lunch break, she did PCA duties until she left at 6:00pm. -When she worked weekends, she performed housekeeping duties. 	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	<p>Continued From page 40</p> <p>-She made rounds on residents every two hours throughout her workday, whether she was doing housekeeping duties or PCA duties.</p> <p>Interview with the Manager on 06/11/25 at 9:50am revealed:</p> <p>-The owner was responsible for making the schedule.</p> <p>-There was always at least two staff in the facility at all times.</p> <p>-She lived within 500 feet from the facility and if a staff member called out or had to leave, she would fill in, if she was not on duty.</p> <p>-The Human Resource (HR) department was not in the facility, and they adjusted her time punches down to 86.66 hours per pay period because she was salary.</p> <p>-The HR department adjusted the time punches of any staff member that did not clock out for their breaks.</p> <p>-Third shift staffs' punches were adjusted at the end of the shift and therefore the time punches often appeared like staff left at 5:00am when they were still in the facility working.</p> <p>-She provided to survey staff the time sheets the HR department had provided but would reach out to HR to see if she could get an unadjusted report.</p> <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed:</p> <p>-She began working as the Administrator on 04/28/25.</p> <p>-She thought the Manager was responsible for the schedule.</p> <p>-There were always two care staff members in the building.</p> <p>Interview with the Owner on 06/11/25 at 10:55am revealed:</p>	D 194		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 194	Continued From page 41 -He was responsible for the schedule. -The HR department made adjustments to the time reports to take out staff breaks and that was why it looked like there was no staff in the building at times. -There was always two staff members in the building. -He was trying to get a new time punch report from HR without the adjustments.	D 194		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. The assessment instrument established by the Department shall include the following: (1) resident identification and demographic	D 253	10A NCAC 13F .0801 (a)(b) Resident Assessment met as evidenced by, new management have been trained on the assessment tool. All resident charts are being audited for completion of all missing documents. Residents missing pre-assessments will undergo a documented post assessment and documented assessment will be kept in resident chart. Med techs to monitor daily, RCC to monitor weekly and Administrator to oversee monthly and as needed.	7/12/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 24</p> <p>information;</p> <p>(2) current diagnoses;</p> <p>(3) current medications;</p> <p>(4) the resident's ability to self-administer medications;</p> <p>(5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating;</p> <p>(6) mental health history;</p> <p>(7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background;</p> <p>(8) mood and behaviors;</p> <p>(9) nutritional status, including specialized diet or dietary needs;</p> <p>(10) skin integrity;</p> <p>(11) memory, orientation and cognition;</p> <p>(12) vision and hearing;</p> <p>(13) speech and communication;</p> <p>(14) assistive devices needed; and</p> <p>(15) a list of and contact information for health care providers or services used by the resident.</p> <p>The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicare/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.</p>	D 253		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 43</p> <p>This Rule is not met as evidenced by: Based on observation, record reviews and interviews, the facility failed to complete a resident assessment for 3 of 6 sampled residents within 30 days following admission to the facility (#3, #5, #11) and annually thereafter (#3) and failed to accurately assess a residents psychosocial well-being and physical functioning in activities of daily living (#5).</p> <p>The findings are:</p> <p>1. Review of Resident #3's current FL2 dated 01/16/25 revealed: -Diagnoses included coronary artery disease, schizoaffective disorder and hypertension. -He was semi-ambulatory. -He was continent of bladder and bowel.</p> <p>Review of Resident #3's Resident Register revealed he was admitted to the facility on 08/12/16.</p> <p>Review of Resident #3's Care Plan dated 06/03/25 revealed: -Resident #3 exhibited wandering and disruptive behaviors, was verbally and physically abusive and suicidal. -Resident #3 required extensive assistance with toileting and grooming. -The care plan was signed by Resident #3's Primary Care Provider (PCP) on 06/03/25.</p> <p>Review of Resident #3's record revealed the previous care plan for Resident #3 was signed by the PCP on 08/24/23.</p>	D 253		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 44</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed: -Because the facility did not have a Resident Care Coordinator it was her responsibility to ensure care plans were completed annually. -She thought Resident #3 had a Care Plan completed in 2024, but she could not find it.</p> <p>Attempted telephone interviews with Resident #3's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>2. Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, hyperlipidemia and asthma. -He was Ambulatory.</p> <p>Review of Resident #5's Resident Register revealed he was admitted on 11/01/24.</p> <p>a. Review of his record revealed there was no Resident Assessment and care plan completed within 30 days after Resident #5's admission on 11/01/24.</p> <p>b. Review of Resident #5's current care plan signed on 06/03/25 revealed: -There was no assessment date listed at the top of report or type of assessment. -There was no mental health and social history completed. -Limited ability was checked under ambulation/locomotion. -Toileting, ambulation, bathing, dressing grooming</p>	D 253		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 45</p> <p>and personal hygiene were documented as extensive assistance. -Transferring was documented as limited assistance.</p> <p>Review of Primary Care Provider (PCP) visit note dated 01/17/25 revealed 'patient was stable and does not need assistance with ADL's or Instrumental ADLs.'</p> <p>Observation of Resident #5 from 06/03/25 through 06/12/25 revealed: -He walked independently throughout the facility. -He walked to the shower to take a shower independently</p> <p>Interview with Resident #5 on 06/03/25 10:30am revealed he took care of his own personal care needs and did not require assistance from staff.</p> <p>Interview with a (PCA) on 06/05/25 at 1:46pm revealed Resident #5 did not require any assistance from staff for any personal care tasks.</p> <p>_____</p> <p>Interview with the former Administrator 06/10/25 at 11:51am revealed: -She signed the assessment and care plan on 06/03/25 for Resident #5. -She did not assess Resident # 5 the Manager entered the information, and she signed it.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>3. Review of Resident #11's current FL2 dated 10/17/24 revealed: -Diagnoses included dementia, cardiomyopathy and acute stress reaction. -He was intermittently disoriented.</p>	D 253		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 46</p> <ul style="list-style-type: none"> -He was semi ambulatory and used a walker. -There was no documentation related to wandering behavior. -Level of care was assisted living. <p>Review of Resident #11's Resident Register revealed he was admitted on 11/8/24.</p> <p>Review of Resident #11's care plan dated 10/01/24 revealed:</p> <ul style="list-style-type: none"> -The care plan was from his former facility. -He had significant memory loss and must be redirected. -Safety and monitor daily was checked for seven days a week. <p>Review of Resident #11's record revealed there was no current care plan.</p> <p>Interview with the Manager on 06/11/25 at 4:00pm revealed:</p> <ul style="list-style-type: none"> -She did not completed a new assessment and care plan for Resident #11. -She did not think she needed to complete a new care plan since he was admitted from a sister facility. <p>Telephone interview with the former Administrator on 06/10/25 at 11:51am revealed:</p> <ul style="list-style-type: none"> -Resident #11 used to live at her facility where she was the Administrator. -When Resident #11 was admitted on 11/08/24 to his current facility she was the acting Administrator for both his old facility and this facility. -She completed Resident #11's assessment and care plan dated 10/01/24 when he lived at her other facility. -She moved Resident #11 from her facility to this current facility because he had exit seeking 	D 253		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 253	<p>Continued From page 47</p> <p>behaviors and felt he needed awake staff during the night.</p> <p>Interview with the Administrator on 06/11/25 at 3:15pm revealed: -She was going to be doing a new assessment and care plan for Resident #11. -She could not explain why one had not been done. -She did not think the former Administrator had much involvement with things at the facility.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>_____</p> <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed: -She began working as the Administrator on 04/28/25. -She was responsible for ensuring resident care plans were completed annually. -Prior to her being hired, the Manager was responsible for ensuring care plans were completed annually.</p>	D 253		
D 262	<p>10A NCAC 13F .0802 (e) Resident Care Plan</p> <p>10A NCAC 13F .0802 Resident Care Plan</p> <p>(e) The facility shall assure that the care plan for each resident who is under the care of a provider of mental health, developmental disabilities or substance use services includes instructions regarding how to contact that provider, including emergency and after-hours contacts. Whenever significant behavioral changes described in Rule .0801(c)(1)(D) of this Section are identified, the facility shall refer the resident to a provider of</p>	D 262	<p>10A NCAC 13F .0802 (e) Resident Care Plan met as evidenced by, All resident charts audited for completion of all missing documents and assessments. Residents missing Care Plans have undergone an assessment and the form completed. After physician review, will be filed in the resident chart. RCC will monitor daily, Consultant RCC will monitor weekly and Administrator will oversee monthly and as needed.</p>	7/12/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 262	<p>Continued From page 48</p> <p>mental health, developmental disabilities or substance use services in accordance with Rule .0801(d) of this Section.</p> <p>This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure a care plan of a resident who was under the care of a mental health provider included instructions regarding how to contact that provider including emergency and after-hour contacts for 1 of 10 residents (#5).</p> <p>The findings are:</p> <p>Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, hyperlipidemia and asthma. -Resident #5 had a history of self-injurious behavior.</p> <p>Review of Resident #5's Resident Register revealed he was admitted on 11/01/24.</p> <p>Review of his current assessment and care plan signed 06/03/25 revealed: -There was no assessment date listed at the top of report or type of assessment. -Mental Health and Social history were left blank. -Under the section 'Resident currently receiving Mental Health services, name of contact agency person and agency were left blank.</p> <p>Review of a Licensed Health Professional Support (LHPS) assessment dated 04/21/25 revealed: Resident #5 was recently hospitalized from</p>	D 262		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 262	<p>Continued From page 49</p> <p>02/28/25 through 03/14/25 for self-injurious behavior.</p> <p>Telephone interview with the behavior health provider on 06/09/25 at 11:30am revealed she was currently seeing Resident #5 and saw him on 06/03/25.</p> <p>Interview with the former Administrator 06/10/25 at 11:51am revealed: -She signed the assessment and care plan on 06/03/25 for Resident #5. -Resident #5's care plan was filled out by the Manager.</p> <p>Interview with the Administrator on 06/11/25 at 5:48pm revealed the Manager was responsible for filling out the care plan.</p> <p>Attempted interview with the Manager on 06/12/25 was unsuccessful.</p>	D 262		
D 273	<p>10A NCAC 13F .0902(b) Health Care</p> <p>10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents.</p> <p>This Rule is not met as evidenced by: TYPE A2 VIOLATION</p> <p>Based on interviews, record reviews and observations, the facility failed to ensure referral and follow-up for 4 of 6 sampled residents (#1, #4, #5 and #11) related to a resident who had an order for physical and occupational therapy (Resident #1), a resident who missed 8 of his</p>	D 273	<p>10A NCAC 13F .0902(b) Health Care met as evidenced by all orders and referral appointments have been consulted with PCP and appointments checked on to ensure they are scheduled. Facility put an appointment book in place and utilize a dry erase appointment calendar to inform all staff regarding monthly scheduled appointments and transportation plans. PCP has been consulted to frequent the facility bi-monthly and available through telemedic with PCP provided tablet for stat reporting and visit needs. PCP also to revisit any PT, OT, ST orders from previous provider for necessity. Residents who facility cannot meet their needs have been issued discharge notice or immediately discharged to an appropriate care level setting assessed by the PCP. Med tech to monitor daily, RCC updates transport book and calendar weekly and Administrator or designee oversees monthly and as needed.</p>	7/12/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 50</p> <p>infectious disease appointments with his Infectious Disease Provider (Resident #4), notifying the PCP regarding elevated blood pressures (Resident #5) and exit seeking behaviors (Resident #11).</p> <p>The findings are:</p> <p>1. Review of Resident #1's current FL2 dated 06/03/25 revealed: -Diagnoses included traumatic brain injury, chronic pain syndrome, diabetes, and impulse control disorder. -Resident #1 was intermittently disoriented. -Resident #1 was ambulatory.</p> <p>Review of Resident #1's Resident Register revealed an admission date of 09/16/19.</p> <p>Review of Resident #1's PCP order dated 02/27/25 revealed an order for physical therapy (PT) for unsteady gait, , occupational therapy (OT) related to activities of daily living and speech therapy (ST) related to difficulty swallowing.</p> <p>Telephone interview with the Program Director with the facility's contracted rehabilitation agency on 06/09/25 at 3:40pm revealed: -A referral for Resident #1 for PT, OT and ST was never received in their office. -Referrals were usually received by the PCP's by electronic prescription. -The referral should have been caught when the facility staff reviewed the PCP's progress notes.</p> <p>Interview with the Manager on 06/09/25 at 3:55pm revealed: -She was not aware of the PT, OT and ST order dated 02/27/25 for Resident #1. -She was responsible for reviewing the progress</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 51</p> <p>notes.</p> <ul style="list-style-type: none"> -She overlooked the PT, OT and ST orders for Resident #1. -She was never told to do any audits of the progress notes. <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #1 had a referral for PT, OT and ST that was never followed up on by the facility. -Orders were to be sent by the PCP by email to the facility's contracted rehabilitation agency. <p>Attempted telephone interviews with Resident #1's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>2. Review of #4's current FL2 dated 05/27/24 revealed:</p> <ul style="list-style-type: none"> -Diagnoses included communicable disease, hypertension, insomnia, dementia, schizophrenia and major depression. -Resident #4's level of care was assisted living. -Resident #4 was disoriented. -Resident #4 was ambulatory with a history of wandering behavior. <p>Review of Resident #4's Resident Register revealed:</p> <ul style="list-style-type: none"> -He was admitted to the facility on 10/15/18. -His responsible party was a family member. <p>Telephone interview with a staff member with Resident #4's PCP office on 06/05/25 at 1:52 pm revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not come to his appointment on 03/31/25. -Staff from the office contacted the facility Manager and she was aware that he missed his appointment. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 52</p> <ul style="list-style-type: none"> -The facility Manager rescheduled the appointment for 04/15/25. -The facility Manager stated she would make contact if the appointment needed to be canceled or rescheduled. -Staff from her office sent a fax with missed appointment dates to the facility Manager. <p>Telephone interview with a second staff member with Resident #4's PCP office on 06/06/25 revealed:</p> <ul style="list-style-type: none"> -It was important for Resident #4 to attend appointments because his communicable disease blood levels need to be monitored. -Elevated communicable disease blood levels could lead to pneumonia and death if untreated. -If Resident #4 continued to miss appointments, they would have to stop prescribing his medications. <p>Telephone interview with a third staff member with Resident #4's PCP office on 06/06/25 revealed:</p> <ul style="list-style-type: none"> -It was important to monitor Resident #4's communicable disease blood levels because if levels continued to be elevated, he would require Salvage therapy (a treatment used when conventional approaches were no longer effective). -If Resident #4's communicable disease blood levels were not monitored, elevated levels could lead to cancer, vision loss, severe infections, gut issues, and death. -Resident #4 did not show up for his last appointment on 05/28/25. <p>Review of a fax from Resident #4's PCP office received on 06/05/25 revealed:</p> <ul style="list-style-type: none"> -Resident #4 did not show up for his appointment on 11/06/24. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 53</p> <ul style="list-style-type: none"> -The PCP called the facility on 11/06/24 at 11:05am regarding Resident #4's missed appointment on 11/06/24. -There was no answer from the facility and a message was left. -The PCP called the facility on 11/11/2024 at 10:35am, spoke with staff at the facility and rescheduled Resident #4's appointment he missed for 12/03/24. -The PCP called the facility on 12/18/24 at 4:16pm regarding the resident being a no show on 12/03/24 and spoke with the manager; the appointment was rescheduled for 01/13/25 at 9:00 am which was also a no show. -The PCP called the facility on 01/13/25 at 2:25 pm and there was no answer and left a message. -The PCP called the facility on 01/17/25 at 9:58 am and left a second message. -The PCP called the facility on 02/03/25 at 4:22 pm and spoke to the manager and rescheduled an appointment for 02/12/25 at 9:30 am for which Resident #4 was a no show. -The PCP documented Resident #4 had not attended an appointment since 06/04/24. -The PCP contacted the facility on 03/31/25 and spoke with the Manager who said she was aware of Resident #4's missed appointments and said there were barriers she could not overcome to get him to his appointments. -The PCP expressed importance of Resident #4 attending his medical appointments. -The Manager rescheduled Resident #4's appointment for 04/15/25 at 10:00am which was a no show. -The PCP called the facility on 4/17/25 and the phone was not answered. -The PCP called the facility on 04/21/25 at 3:14pm and spoke to a staff member; the PCP asked to speak with the Manager and requested she call the PCP back. 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 54</p> <ul style="list-style-type: none"> -The PCP called the facility on 04/25/25 at 3:14pm and spoke with a medication aide (MA) and rescheduled Resident #4's appointment for 04/29/25 at 10:30am for which Resident #4 did attend. -Resident #4 attended his appointment on 06/04/25. -Resident #4 missed eight appointments from 11/06/24-06/06/25 due to transportation issues. <p>Interview with the Manager on 06/11/25 at 3:31pm revealed:</p> <ul style="list-style-type: none"> -She was responsible for the transportation calendar. -The van did not work for approximately the last 8 months. -The Owner asked her to look for someone in the area to repair it but she did not have the time to do it. <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed:</p> <ul style="list-style-type: none"> -She knew the van was not working and thought the Manager was working on it. -She was not aware of any appointments missed due to the van not working. <p>3. Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, hyperlipidemia and asthma.</p> <p>Review of Resident #5's former Primary Care Provider (PCP) progress note dated 04/22/25 revealed:</p> <ul style="list-style-type: none"> -There was an order to check blood pressure two times per week and record on the electronic Medication Administration Record (eMAR). -Notify the PCP if systolic blood pressure (SBP) 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 55</p> <p>(the top number in a blood pressure reading) is greater than 150 or less than 100 and diastolic blood pressure (DBP) (the lower number in a blood pressure reading) is greater than 100 or less than 50.</p> <p>Review of Resident #5's May 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry to check blood pressure two times per week and notify the PCP if SBP was greater than 150 or less than 100 and DBP was greater than 100 or less than 50. -On 05/08/25, the blood pressure was documented as 151/80 and there was no documentation the PCP was notified. -On 05/22/25, the blood pressure was documented as 151/90 and there was no documentation the PCP was notified. -On 05/29/25, the blood pressure was documented as 155/79 and there was no documentation the PCP was notified. <p>Review of Resident #5's progress notes revealed no documentation of notification was made to the PCP for elevated blood pressures.</p> <p>Interview with a medication aide (MA) on 06/11/25 at 5:43pm revealed:</p> <ul style="list-style-type: none"> -She did not recall if she notified the PCP regarding Resident #5's blood pressure being elevated. -The facility had so many changes in PCPs, it was hard to remember. <p>Interview with the Manager on 06/09/25 at 9:43am revealed:</p> <ul style="list-style-type: none"> -They did not have the need to contact the PCP for Resident #5. -She or the MAs could alert the PCP if needed. -All notifications to the current PCP were on-line 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 56</p> <p>and there was no phone number to call. -There was no documentation of notification to the PCP regarding Resident #5's blood pressure.</p> <p>Interview with the Manager on 06/11/25 at 4:00pm revealed the MA who took Resident #5's blood pressure was responsible for notifying the PCP.</p> <p>Telephone interview with Resident #5's former PCP on 06/09/25 at 12:01pm revealed: -She wrote the order to check the blood pressure two times weekly. -She was not contacted regarding Resident #5's blood pressures but was not the PCP at that time in May 2025. -There were no documented notes in the triage system or under Resident #5's name related to the elevated blood pressure. -The PCP should have been contacted or a notification in the triage system sent as the blood pressure parameters were in place for a reason. -Risks involved with elevated blood pressure could be headache and dizziness.</p> <p>4. Review of Resident #11's current FL2 dated 10/17/24 revealed: -Diagnoses included dementia, cardiomyopathy and acute stress reaction. -He was intermittently disoriented. -He was semi ambulatory and used a walker. -Level of care was assisted living.</p> <p>Review of Resident #11's Resident Register revealed he was admitted on 11/8/24.</p> <p>Review of the facility's undated policy on identification and Supervision of Wandering Resident Policy revealed: -The wandering risk assessment shall be</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 57</p> <p>completed as part of the pre-screen assessment, upon admission if the pre-screen is more than 72 hours old and annually thereafter unless a change in status occurs that would warrant a new assessment.</p> <p>-Change in status shall include but was not limited to the following: (1) Readmission, (2) New diagnosis of dementia and /or Alzheimer, (3) change in cognitive status -increased confusion.</p> <p>Review of Resident #11's care plan dated 10/01/24 revealed:</p> <p>-The care plan was from his former facility.</p> <p>-He had significant memory loss and must be redirected.</p> <p>-Safety and monitor daily was checked for seven days a week.</p> <p>-There was no documentation a care plan was completed after his admission to the current facility on 11/8/24.</p> <p>Observation on 06/09/25 at 12:08pm revealed:</p> <p>-Resident #11 was walking down the highway approximately 0.3 miles from the facility.</p> <p>-He was walking alone on the side of the road using his walker.</p> <p>-As the surveyor's car approached Resident #11, he moved his walker to the grassy side of the road.</p> <p>-Resident #11 was wearing a long sleeved zipped up sweatshirt and long pants.</p> <p>-Resident #11 was stopped by the Adult Home Specialist (AHS) who was driving on the road behind the surveyor's car.</p> <p>-Review of a current weather report revealed the temperature outside was 80 degrees.</p> <p>Interview with a personal care aide (PCA) on 06/09/25 at 5:17pm revealed:</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 58</p> <ul style="list-style-type: none"> -She began working night shift at the facility approximately eight months ago. -Resident #11 was one she had to watch closely because he would try to leave because he thought he was going home. <p>Interview with another PCA on 06/09/25 at 1:10pm revealed:</p> <ul style="list-style-type: none"> -Resident #11 would go out walking when he got mad. -Staff were supposed to make the Manager aware when Resident #11 got mad or upset. -Staff were checking on Resident #11 every hour but after he left today someone was to be with him at all times, which was going to be difficult. -She was sent to get Resident #11 today (06/09/25) and when she got to him along the road, he would not get in her car and go with her. <p>Telephone interview with Resident #11's responsible party on 06/12/25 at 8:49am revealed:</p> <ul style="list-style-type: none"> -She visited Resident #11 over the weekend on 06/07/25. -She was aware that at times Resident #11 tried to leave the facility. -She was kept informed with his care but was not notified regarding him walking down the road on Monday (06/09/25). <p>Interview with the Manager on 06/09/25 at 12:14pm revealed:</p> <ul style="list-style-type: none"> -Resident #11 would leave the facility approximately one time a month. -Resident #11 would do this after a family visit and his family had just visited him this past weekend on 06/07/25. -Resident #11 would leave the facility to look for his family. -She thought that she had mentioned Resident 	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 59</p> <p>#11 should be in a special care unit to one of the PCP's but she could not recall.</p> <p>Observation on 06/12/25 at 12:52pm of Resident #11 by the state surveyor revealed he was standing in the road with his walker approximately 300 feet from the facility.</p> <p>Observation on 06/12/25 at 12:59pm of Resident #11 revealed: -Resident #11 was standing in the road with his walker approximately 300 feet from the facility. -The Administrator's car was blocking the road and she was talking to Resident #11.</p> <p>Observation of Resident #11 on 06/12/25 at 1:20pm revealed he was walking near the left side entrance heading towards the door.</p> <p>Interview with the Administrator on 06/12/25 at 12:53pm revealed she was not aware Resident #11 had eloped from the facility on 06/12/25.</p> <p>Interview with the Administrator on 06/12/25 at 1:25pm revealed: -She tried to get Resident #11 to return to the facility today, 06/12/25, but he refused. -She called his family member who spoke with Resident #11 on the telephone, and he had agreed to return to the facility.</p> <p>Telephone interview with the former Administrator on 06/10/25 at 11:51am revealed: -She was the Administrator for another facility but oversaw this facility as well. -Resident #11 used to reside at the other facility. -Resident #11 had exit seeking behaviors. -Resident #11 was transferred to this facility because she felt he needed awake staff who did not sleep at night.</p>	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 273	<p>Continued From page 60</p> <p>Telephone interview with Resident #11's PCP on 06/12/25 at revealed: -She had only been to the facility one time on 06/03/25. -She had not seen Resident #11, however he was on the schedule to be seen on 06/17/25. -His last PCP visit was in April 2025. -She did not see any notes in triage regarding exit seeking behaviors.</p> <p>_____</p> <p>The facility failed to ensure referral and follow up for a resident who had a physician's order for physical, speech, and occupational therapy (#1), a resident who missed 8 of 9 appointments to monitor his communicable disease blood levels which could have resulted in cancer, vision loss, severe infections, gut issues and death (#4), and for a resident, who had dementia and exit seeking behaviors (#11) with no referral to his physician. This failure resulted in a substantial risk for serious physical harm to the residents and constitutes a Type A2 Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/12/25 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED 07/12/25.</p>	D 273		
D 280	<p>10A NCAC 13F .0903(c) Licensed Health Professional Support</p> <p>10A NCAC 13F .0903 Licensed Health Professional Support</p> <p>(c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and</p>	D 280	<p>10A NCAC 13F .0903(c) Licensed Health Professional Support met as evidenced by Facility management met with RenCare LHPS nurse to inform any and all reportables to date regarding changes to be documented in the LHPS and ensure all residents had been assessed by RenCare LHPS nurse. Med tech to monitor daily, RCC to monitor weekly and Administrator to oversee monthly and as needed.</p>	7/24/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 280	<p>Continued From page 61</p> <p>evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following:</p> <ol style="list-style-type: none"> (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. <p>This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to ensure 1 of 5 sampled residents (Resident #3) with the tasks of monitoring of blood glucose levels and medication administration through injections had a Licensed Health Professional Support (LHPS) review completed quarterly by an appropriate licensed health professional.</p> <p>The findings are:</p> <p>Review of Resident #3's current FL2 dated 01/16/25 revealed diagnoses included schizoaffective disorder, hypertension and coronary artery disease.</p> <p>Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed:</p>	D 280	<p>changes to be documented in the LHPS. Med tech to monitor daily, RCC to monitor weekly and Administrator to oversee monthly and as needed.</p>	
-------	---	-------	---	--

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 280	<p>Continued From page 62</p> <ul style="list-style-type: none"> -There was documentation Resident #3 was out of the facility from 03/06/25 to 03/10/25 and from 03/16/25 to 03/17/25. -There was an entry for Freestyle Libre 2 sensor (a sensor for monitoring blood sugar readings) apply one sensor to upper arm or stomach every 14 days. -There was documentation on 03/21/25 at 8:00am a Freestyle Libre 2 sensor was placed on Resident #3's arm or stomach. -There was an entry for insulin lispro (a fast acting insulin to lower blood sugar levels) 100unit/ml, inject per sliding scale before meals; fingerstick blood sugar (FSBS) 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 351-400 = 10 units, and 401-450 = 12 units. -There was documentation insulin lispro was administered 22 instances from 03/01/25 and 03/30/25. -There was an entry for lantus insulin (a long acting insulin to lower blood sugar levels) 100units/ml, inject 50 units daily. -There was documentation lantus insulin 50 units was administered 26 instances from 03/01/25 to 03/31/25. <p>Review of Resident #3's April 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was documentation Resident #3 was out of the facility from 04/12/25 to 04/22/25. -There was an entry for Freestyle Libre 2 sensor, apply one sensor to upper arm or stomach every 14 days. -There was documentation on 04/04/25 at 8:00am a Freestyle Libre 2 sensor was placed on Resident #3's arm or stomach. -There was an entry for insulin lispro 100unit/ml, inject per sliding scale before meals; fingerstick blood sugar (FSBS) 151-200 = 2 units, 201-250 = 4 units, 251-300 = 6 units, 301-350 = 8 units, 	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 280	<p>Continued From page 63</p> <p>351-400 = 10 units, and 401-450 = 12 units with a discontinue date of 04/22/25.</p> <p>-There was documentation insulin lispro was administered 8 instances between 04/01/25 and 04/22/25.</p> <p>-There was an entry for lantus insulin 100units/ml, inject 50 units daily.</p> <p>-There was documentation lantus insulin 50 units was administered 20 instances from 04/01/25 to 04/30/25.</p> <p>Review of Resident #3's May 2025 eMAR revealed:</p> <p>-There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25.</p> <p>-There was an entry for Freestyle Libre 2 sensor, apply one sensor to upper arm or stomach every 14 days with a discontinue date of 04/22/25.</p> <p>-There was documentation on 04/02/25 a Freestyle Libre 2 sensor was placed on Resident #3's arm or stomach.</p> <p>-There was an entry for lantus insulin 100units/ml, inject 50 units daily.</p> <p>-There was documentation lantus insulin 50 units was administered 30 instances from 05/01/25 to 05/30/25.</p> <p>Review of Resident #3's record revealed:</p> <p>-The most current LHPS was dated 05/23/25 and included personal care tasks documented as medication administration through injections and collecting and testing of finger stick blood sugars (FSBS).</p> <p>-The previous LHPS review was dated 11/18/24 and included personal care tasks documented as medication administration through injections and collecting and testing of FSBS.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed:</p>	D 280		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 280	<p>Continued From page 64</p> <p>-A Registered Nurse (RN) came to the facility monthly to complete LHPS reviews.</p> <p>-She kept track of when each resident's quarterly LHPS review needed completed.</p> <p>-In March of 2025, there was a virus in the facility, and she thought that was the reason Resident #3's LHPS review was not completed when due.</p> <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed:</p> <p>-She began working as the Administrator on 04/28/25.</p> <p>-She was responsible for ensuring resident LHPS reviews were completed quarterly.</p> <p>-Prior to her being hired, the Manager was responsible for ensuring LHPS reviews were completed quarterly.</p>	D 280		
D 317	<p>10A NCAC 13F .0905 (d) Activities Program</p> <p>10A NCAC 13F .0905 Activities Program (d) There shall be at least 14 hours of a variety of planned group activities per week that include activities that promote socialization, physical interaction, group accomplishment, creative expression, increased knowledge, and learning of new skills.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to implement an activity calendar for all residents, reflecting 14 hours per week of a variety of planned group activities.</p> <p>The findings are:</p> <p>Review of the facility's census on 06/03/25 revealed there were 33 residents.</p>	D 317	<p>10A NCAC .0905(d) Activities Program met as evidenced by facility hired a Certified Activity Director on 6/13/24. Facility staff were in-serviced on the importance of and rule regarding activity documentation and occurrence. All staff will assist with activities on each shift as directed by the Activity Director. Med tech will ensure activities are conducted daily, RCC will ensure weekly and Administrator or designee will monitor monthly and as needed.</p>	6/13/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 317	<p>Continued From page 65</p> <p>Observations of the activity board across from the day room on 06/03/25 at 9:10am revealed:</p> <ul style="list-style-type: none"> - There was an activity calendar posted for May (with no year reflected on the calendar). -There was a picture of flowers on 05/01/25 with no activities listed for that day. -There were three separate activities per day listed on the calendar for 05/02/25 - 05/30/25. -Activities included devotions, cards, cornhole, story time, music, coloring and darts. -There were no scheduled times for the activities reflected on the calendar. -There was a picture posted at the bottom of the calendar listing May "fun facts." - Devotions were listed as an activity for every day of the month except 05/01/25. <p>Observations of the activity board across from the day room on 06/09/25 at 10:25am revealed:</p> <ul style="list-style-type: none"> -There was an activity calendar posted for June (with no year reflected on the calendar). -There was nothing listed in the space for the day of 06/01/25. - There were three separate activities per day listed on the calendar for 06/02/25 - 06/30/25. - Activities included bingo,devotions, cards, cornhole, story time, molding clay, music, coloring and darts. -There were no scheduled times for the activities reflected on the calendar. -There was a picture posted at the bottom of the calendar listing June "fun facts." -Devotions are listed as an activity for every day of the month except 06/01/25. <p>Observation of activities during the survey period form 06/03/25 through 06/12/25 revealed:</p> <ul style="list-style-type: none"> -On 06/09/25 at 11:15am the housekeeper and PCA were doing an activity of ball darts with two residents on the male hallway. 	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 317	<p>Continued From page 66</p> <ul style="list-style-type: none"> -Devotions were observed everyday conducted by a resident. -Music was played on a speaker in hallways. -No other activities on the calendar were observed. <p>Interview with a resident on 06/04/25 at 9:33am revealed:</p> <ul style="list-style-type: none"> -There were no activities being done here. - The Pastor had devotions with the residents every day in the Day Room. -The Pastor was a resident who resided at the facility. - We do not do all of the activities that were listed on the calendar. <p>Interview with a second resident on 06/09/25 at 1:35pm revealed:</p> <ul style="list-style-type: none"> -The facility had activities a couple times per week, with devotions every day. -Activities include corn hole, bowling with plastic balls, Bingo and exercises which consist of walking outside around the building. <p>Interview with the housekeeper on 06/09/25 at 1:57pm revealed:</p> <ul style="list-style-type: none"> -She and one of the PCAs played ball darts with the residents earlier today. -A night shift PCA sometimes had activities with the residents but there was no set schedule or times for when the activities were done. -Activities were done with the residents whenever the staff had time. <p>Interview with the Manager on 06/09/25 at 2:05pm revealed:</p> <ul style="list-style-type: none"> -She posted the June 2025 Activity Calendar today and had not had a chance to organize it because of the survey team being at the facility. -She was not aware the Activity Calendar had to 	D 317		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 317	Continued From page 67 reflect the times of the activities. Interview with the Administrator on 06/11/25 at 3:05pm revealed: -The Manager was the Activity Director. -The Manager informed her she was taking an Activity Director class but she did not know when the course would be completed. -She was currently enrolled in an Activity Director class. -She had not been the Administrator for this facility long but intended to fix the Activity program for the residents. -The PCAs and Housekeeper were conducting some activities with the residents. Interview with the Manager on 06/11/25 at 3:31pm revealed she did not have time for activities and did not think activities had been done for the last two months except for a resident who was the Pastor doing 10:30am devotions.	D 317		
D 321	10A NCAC 13F .0906(a) Other Resident Care And Services 10A NCAC 13F .0906 Other Resident Care And Services (a) Transportation. The administrator shall assure the provision of transportation for the residents of adult care homes to necessary resources and activities, including transportation to the nearest appropriate health facilities, social services agencies, shopping and recreational facilities, and religious activities of the resident's choice. The resident shall not be charged any additional fee for this service. Sources of transportation may include community resources, public systems, volunteer programs, family members as well as facility vehicles.	D 321	10A NCAC 13F .0906(a) Other Resident Care and Services met as evidenced by, the facility van has been repaired and is back in working order. Residents have also been registered with Medicaid transportation where applicable for assistance with transportation needs both personal and medical. Med tech to monitor daily, RCC to monitor weekly and Administrator to oversee monthly and as needed.	6/22/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	--

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 321	<p>Continued From page 68</p> <p>This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure transportation was available to transport residents to medical appointments resulting in 1 of 5 sampled residents (#4) not having transportation to medical appointments.</p> <p>The findings are:</p> <p>Review of #4 current FL2 dated 05/27/24 revealed: -Diagnoses included a communicable disease, hypertension, insomnia, dementia, schizophrenia, and major depression. -Resident #4's level of care was assisted living. -Resident #4 was disoriented. -Resident #4 was ambulatory with a history of wandering behaviors.</p> <p>Review of Resident #4's Resident Register revealed he was admitted to the facility on 10/15/18.</p> <p>Review of Resident #4's medical record revealed: -Resident #4 missed appointments with his communicable disease care primary care provider (PCP) on 05/28/25, 04/15/25, 03/31/25, 02/12/25, 01/13/25, 12/03/24 and 11/26/24.</p> <p>Interview with the Manager on 6/5/2025 at 1:17pm revealed: -Residents were transported to appointments by either the facility van, public transportation, private paid insurance providers or staff. -Public transportation did not always arrive to transport the residents to their appointments. -When staff transported the residents to their</p>	D 321		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 321	<p>Continued From page 69</p> <p>appointments, they used their own private vehicles.</p> <p>-If there were not enough staff in the building to transport, other staff who were not scheduled for the day were called to come in, or a backup transportation was contacted as a last result.</p> <p>-The facility had a van but the van had been out of service since January 2025.</p> <p>Interview with the Manager on 6/9/2025 at 1:02 pm revealed:</p> <p>-There were only two MAs in the building on his appointment days so she could not send one of the MAs out of the facility.</p> <p>-The local DSS Medicaid Transportation scheduled one worker on Mondays to assist with facility transports.</p> <p>Telephone interview with the communicable disease PCP on 06/06/25 revealed:</p> <p>-Communicable disease blood levels were to be monitored monthly.</p> <p>-If Resident #4's levels were not monitored and were high he could require Salvage therapy (an approach used when treatment does not respond to standard therapies).</p> <p>-The missed appointments with Resident #4 not being monitored could lead to vision loss, severe infections, cancer, gut issues and death.</p> <p>Interview with the Administrator on 6/10/2025 at 12:40 pm revealed:</p> <p>-She spoke to the Owner of the facility during the first week in May and was told the Manager was getting the facility van repaired.</p> <p>-She had to focus on learning the software for the medications.</p> <p>-All staff were in change of transporting residents to their appointments.</p> <p>-She was not aware residents had been missing</p>	D 321		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 321	<p>Continued From page 70</p> <p>appointments. -She would check the calendar to make sure residents were attending their appointments.</p> <p>Interview with the former Administrator on 6/11/2025 at 10:15 am revealed: -Staff should be taking residents to their appointments. -She was not aware of the residents missed appointments. -The manager did not make her aware of the resident's missed appointments and didn't keep her in the loop about anything going on in the facility.</p> <p>Interview with the Administrator and Manager on 6/11/2025 at 12:48 pm revealed: -The facility van had not been operational for seven months. -A tire company should have been contacted to repair the van. -They forgot to contact the tire company.</p>	D 321		
D 338	<p>10A NCAC 13F .0909 Resident Rights</p> <p>10A NCAC 13F .0909 Resident Rights An adult 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.</p> <p>This Rule is not met as evidenced by: TYPE A1 VIOLATION</p> <p>Based on observations and interviews and record reviews, the facility failed to ensure resident's rights were maintained for all residents related to privacy when an audio and visual surveillance</p>	D 338	<p>10A NCAC 13F .0909 Resident Rights met as evidenced by all staff were in-serviced by the Western Region Ombudsman on 7/1/25. Facility ownership developed consents for Audio and visual surveillance for the residents and/or guardians to sign. All residents and guardians have been presented with the consents for signatures. RCC to monitor daily, Consulting RCC to monitor weekly and Admin to monitor monthly and ass needed. Facility ownership to amend the admission paperwork to include the new consent.</p>	7/12/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 71</p> <p>system was operational in all common areas and recorded residents' and visitors' conversations and related to the care and services needed for 2 of 2 residents (#6 & #7) whose mattresses had rips, tears and holes in them and were not in good condition upon admission or replaced when needed.</p> <p>The findings are:</p> <ol style="list-style-type: none"> 1. Interview with the Manager on 06/03/25 at 9:00am upon entrance to the facility revealed all common areas and several of the offices were equipped with video and audio surveillance. <p>Observations of the facility on 06/06/25 through 06/12/25 revealed cameras were located at the entrances and exits, in the day room, dining room, hallways, medication room and two of the offices.</p> <p>Observation on 06/04/25 at 4:25pm revealed signage posted at the front of the building, at the left and right entrances and exits of the building read "warning 24 hour video surveillance private property no trespassing".</p> <p>Observation of the video and audio surveillance system on the owners cell phone on 06/10/25 at 5:10pm revealed the voices of the survey team could be heard in the dining room on 06/10/25 at 9:05am.</p> <p>Review of a resident's record on 06/11/25 revealed there was no documentation signed by either the resident or responsible party consenting to video and audio surveillance of the resident inside or outside of the facility.</p> <p>Review of a second resident's record on 6/11/25</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 72</p> <p>revealed there was no documentation of consent signed by either the resident or their responsible party consenting to video and audio surveillance of the resident inside or outside of the facility.</p> <p>Interview with a resident on 06/09/25 at 4:57pm revealed she did not agree with being recorded by audio or video while she was living at the facility.</p> <p>Interview with the Owner revealed on 06/10/25 at 5:00pm revealed:</p> <ul style="list-style-type: none"> -He purchased the facility in August of 2023. -He thought there was an existing video and audio surveillance system installed when he purchased the building. -He put in a new system that provided video and audio surveillance in March of 2025. -He was unsure if the residents gave consent for video and audio surveillance or if any consents were in the resident records. <p>2. Review of the facility's Housekeeper Job Responsibilities revealed:</p> <ul style="list-style-type: none"> -Maintain the self-respect, personal dignity, and physical safety of each resident. -Thoroughly clean all resident room areas. <p>a. Review of Resident #7's current FL2 dated 03/12/25 revealed diagnoses included paranoid schizophrenia, hypertension and gastroesophageal reflux disease.</p> <p>Review of Resident #7's Resident Register revealed:</p> <ul style="list-style-type: none"> -Resident #7 was admitted to the facility on 02/04/25. -Resident #7's level of care was assisted living. <p>Observation of Resident #7's mattress on</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 73</p> <p>06/03/25 at 9:55am revealed: -A twin sized gray plastic mattress, approximately five inches in depth with three holes showing the webbing, approximately two inches in diameter. -The bottom and the top of the mattress were cracked with the inside foam showing.</p> <p>Interview with Resident #7 on 06/03/25 at 9:55am revealed: -She had three mattresses since admission on 02/04/25. -When she was admitted her family member emailed the Manager to ask for another mattress and 4 or 5 days later the staff brought one in worse than what was on her bed that was needed to be replaced but she refused it. -About a month after she refused the last mattress, the staff brought the mattress she was sleeping on now and gave her a quilt to put over the mattress so she would not feel the cracks and tears. -Sometimes she felt the cracks and tears on the mattress if the quilt slipped. -She would like a new mattress, but she thought other residents' mattresses were not any better.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed: -She did not know about Resident #7's mattress until she received the email from her family and could not remember when that was. -Resident #7 refused a mattress she found for her but could not remember when. -Resident #7 received another mattress and a quilt to put over her mattress but she did not know who the staff member was who brought it in to her. -She did not know how bad the mattress was until it was pointed out during the survey.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 74</p> <p>Refer to interview with a second housekeeper on 06/10/25 at 9:58am.</p> <p>Refer to interview with the Administrator on 06/11/25 at 12:48pm,</p> <p>Refer to interview with the Administrator on 06/11/25 at 2:10pm.</p> <p>b. Review of Resident #6's current FL2 dated 9/24/2024 revealed diagnoses included hypertension, depression, and schizoaffective disorder.</p> <p>Review of Resident #6's Resident Register revealed: -Resident #6 was admitted to the facility on 10/04/24 -Resident #6's level of care was assisted living.</p> <p>Observation of Resident #6's bed on 06/03/25 at 9:42am and 10:37am revealed: -Resident #6's bedding consisted of a fitted sheet, pillow with pillowcase and a blanket. -The pillowcase appeared stained and discolored. -The fitted mattress sheet was soiled with dry dirt particles and had discolored areas with lines that appeared to be made by a green marking pen. -Resident #6's mattress had multiple cracks in the outer lining of the mattress. -The mattress had more than 15 holes in the outer lining and the springs of the mattress were visible and extending through the mattress in a minimum of four locations.</p> <p>Interview with Resident #6 on 6/3/2025 at 9:42 revealed: -He had the same mattress since admission to the facility on 10/04/24. -He requested a new mattress from the cook but he has never received one.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 75</p> <p>-The Manager did not allow staff to go into the resident's room.</p> <p>Interview with the Housekeeper on 6/10/2025 at 9:52 am revealed:</p> <p>-All staff assist with changing the resident's sheets on shower days and as needed.</p> <p>-All mattresses were checked during that time.</p> <p>-All rooms needed new mattresses.</p> <p>-She noticed Resident #6's mattress "a couple of weeks ago" and reported it to the Manager, medications aide and guardian.</p> <p>Interview with a second housekeeper on 6/10/2025 at 9:58 am revealed:</p> <p>-She and the PCAs changed the sheets on the resident's beds.</p> <p>-Staff that were performing laundry duty would communicate when sheets had been changed on the beds.</p> <p>-The facility did not keep a log book or documentation when sheets were changed.</p> <p>Refer to interview with a second housekeeper on 06/10/25 at 9:58am.</p> <p>Refer to interview with the Administrator on 06/11/25 at 12:48pm,</p> <p>Refer to interview with the Administrator on 06/11/25 at 2:10pm.</p> <p>_____</p> <p>Interview with the Housekeeper on 6/10/2025 at 9:52 am revealed:</p> <p>-All staff assist with changing the resident's sheets on shower days and as needed.</p> <p>-Mattresses are checked during this time.</p> <p>-All rooms need new mattresses.</p> <p>-Housekeeper noticed Resident #6's mattress "a couple of weeks ago" and reported it to the</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	<p>Continued From page 76</p> <p>Manager, medication aide and "guardian."</p> <p>Interview with a second housekeeper on 6/10/2025 at 9:58 am revealed:</p> <ul style="list-style-type: none"> -The housekeeper and PCAs change the sheets on the residents' beds. -Staff assigned to laundry duties would communicate if sheets were changed on the residents' beds. -The facility did not keep a log book or documentation as to when sheets were being changed. <p>Interview with the Administrator on 06/11/2025 at 12:48pm revealed:</p> <ul style="list-style-type: none"> -Resident #6 did not like anyone changing his bed. -His family member laundered his sheets for him. -The PCAs and housekeeping were to wipe the beds down every day. -PCAs and housekeeping were responsible for changing and laundering the sheets. <p>Interview with the Administrator on 06/11/25 at 2:10pm revealed:</p> <ul style="list-style-type: none"> -She called the resident's guardian to inquire about purchasing him a new mattress. -She was unaware that Resident #6 needed a new mattress. <p>_____</p> <p>The facility failed to ensure residents' right to privacy was maintained for all residents related to the use of video with audio surveillance at entrances and exits, in the day room, dining room and hallways. Resident and visitors conversations were heard on audio recordings. Residents had not consented to video and audio surveillance and did not want their conversations recorded. This failure resulted in serious neglect and constitutes a Type A1 Violation.</p>	D 338		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 338	Continued From page 77 The facility provided a plan of protection in accordance with GS. 131D-34 on June 12, 2025 for the violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED July 12, 2025.	D 338		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: TYPE B VIOLATION The facility failed to administer medications as ordered for 6 of 6 sampled resident related to medications for pain (#1), hypertension, stroke prevention, chronic pain, fluid retention, low iron levels, elevated blood sugar levels, gout, restless leg syndrome (#2), sleep (#3), and anxiety (#4, #5, #10). The findings are: Review of the facility's undated Medication Administration policy revealed: -Documentation will be provided by staff who administers medication and performs treatments	D 358	10A NCAC 13F .1004(a) Medication Administration met as evidenced by all MAR have been audited for compliance. All narcotics have been returned to the locked narcotic box located on the Med Cart. Med techs have been in-serviced with a 15hr Medication Administration class by the LHPS nurse and separately in-serviced by Administrator and RCC regarding appropriate counting and reporting procedure. Facility consulted with RenCare to ensure the pharmacy quarterly audits would continue. Med tech to ensure compliance daily, RCC to ensure weekly and Admin or designee to oversee monthly and as needed.	6/30/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 78</p> <p>on the Medication Administration Record (MAR). -Omission and refusals of medications or treatments and the reason for the omissions will be documented on the MAR.</p> <p>1. Review of Resident #1's current FL2 dated 06/03/25 revealed diagnoses included chronic pain syndrome, diabetes type 2, traumatic brain injury, impulse control disorder and hypertension.</p> <p>Review of Resident #1's Resident Register revealed he was admitted 09/16/19.</p> <p>Review of Resident #1's physician's order dated 02/23/25 revealed an order for hydrocodone-acetaminophen (a medication used to treat severe pain) 10-325mg one tablet three times daily.</p> <p>Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily. -There was no documentation hydrocodone-acetaminophen 10-325mg was administered on 03/03/25 at 6:00am and 12:00pm, on 03/05/25 at 6:00am and 12:00pm, on 03/13/25 at 12:00pm, on 03/16/25 at 6:00am, 12:00pm, and 6:00pm, on 03/18/25 at 6:00am, and 12:00pm, on 03/20/25 at 12:00pm, on 03/22/25 at 12:00pm, and 6:00pm, on 03/23/25 at 6:00am, and 12:00pm, on 03/26/25 at 6:00am, on 03/30/25 at 6:00am and 12:00pm and on 03/31/25 at 12:00pm. -There was no documentation on the March 2025 eMAR why hydrocodone-acetaminophen 10-325mg one tablet three times daily was not administered on 03/03/25, 03/05/25, 03/13/25,</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 79</p> <p>03/16/25, 03/18/25, 03/20/25, 03/22/25, 03/23/25, 03/26/25, 03/30/25 and 03/31/25. -There were 19 of 93 opportunities hydrocodone-acetaminophen 10-325mg was not administered.</p> <p>Review of Resident #1's April 2025 eMAR from April 1 through April 9 revealed: -There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily. -There was no documentation hydrocodone-acetaminophen 10-325mg was administered on 04/01/25 at 6:00am and 12:00pm, on 04/02/25 at 6:00pm, on 04/05/25 at 6:00am, 12:00pm and 6:00pm, on 04/06/25 at 6:00am, 12:00pm and 6:00pm and 04/09/25 at 6:00am and 12:00pm. -There was an order to discontinue hydrocodone-acetaminophen on 04/09/25 at 5:00pm. -There were 9 of 27 opportunities hydrocodone-acetaminophen 10-325mg was not administered.</p> <p>Observation of medications on hand on 06/04/25 at 11:20am for Resident #1 revealed there was no hydrocodone-acetaminophen 10-325mg on hand because it was discontinued on 04/09/25.</p> <p>Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/05/25 at 10:25am revealed: -Resident #1 had an order for hydrocodone-acetaminophen 10-325mg one tablet three times daily for chronic pain ordered 02/23/25. -On 02/26/25, 90 tablets of hydrocodone-acetaminophen 10-325mg were dispensed for Resident #1.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 80</p> <ul style="list-style-type: none"> -On 03/27/25, 90 tablets of hydrocodone-acetaminophen 10-325mg were dispensed for Resident #1. -Audits were completed quarterly by a Pharmacist. -The audits consisted of looking at orders, and discontinued medication. -If a resident did not receive hydrocodone-acetaminophen, it could cause an increase in pain. -Hydrocodone-acetaminophen 10-325mg was discontinued on 04/09/25. <p>Interview with Resident #1 on 06/06/25 at 10:45am revealed:</p> <ul style="list-style-type: none"> -He did not know what medications he took and never refused his medications. -He thought he received what he was supposed to get. -Sometimes his medications would help him and sometimes they would not. <p>Interview with a medication aide (MA) on 06/04/25 at 8:30am revealed:</p> <ul style="list-style-type: none"> -She gave medications when she was scheduled to work. -There was a time sometime in March or April when the MAs administered Resident #1's medications, and it would not sync on the eMAR. -She told the Administrator and Manager, and the Manager said she was working on the issue with the Pharmacy. -Resident #1 never refused his medications when she was the MA. -She did not know if audits were completed or not. -The facility did not use control count sheets for narcotics and did not know why as she was told this when she began about a year ago. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 81</p> <p>Interview with the Manager on 06/09/25 at 3:55pm and 06/11/25 at 3:31pm revealed:</p> <ul style="list-style-type: none"> -She was not aware Resident #1 had missed so many hydrocodone-acetaminophen. -She was aware the hydrocodone-acetaminophen was discontinued sometime in April 2025 because the PCP and pharmacy felt someone was taking some of the narcotics. -She did not do any audits because she was never told to. -Resident #1 would have told her if he was not getting his medications and he was always the first resident in the morning to receive his medications. <p>Attempted telephone interviews with Resident #1's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>2. Review of Resident #4's current FL2 dated 05/27/24 revealed diagnoses included communicable disease, hypertension, insomnia, dementia, schizophrenia, and major depression.</p> <p>Review of Resident #4's Resident Register revealed he was admitted on 10/15/18.</p> <p>Review of Resident #4's Primary Care Provider's (PCP) order dated 12/02/24 revealed hydroxyzine (a medication to treat anxiety) 25mg one tablet by mouth on Monday, Wednesday and Friday.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 82</p> <p>Review of the Resident's #4 March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydroxyzine 25mg one tablet on Monday, Wednesday and Friday. -There was no documentation hydroxyzine 25mg one tablet was administered on Wednesday, 03/26/25. -There was 1 of 31 opportunities hydroxyzine 25mg was documented as not administered on 03/26/25. <p>Observation on 06/06/25 at 10:15am of Resident #4's medication on hand revealed there were two tablets of hydroxyzine 25mg on 06/06/25 at 10:15am.</p> <ul style="list-style-type: none"> -Telephone interview with the Pharmacist at the facility's contracted pharmacy on 06/06/25 at 12:25pm revealed: -On 03/05/25 the Pharmacy dispensed 12 tablets of hydroxyzine 25mg for Resident #4. -On 04/01/25 the Pharmacy dispensed 12 tablets of hydroxyzine 25mg for Resident #4. -On 05/01/25 the Pharmacy dispensed 12 tablets of hydroxyzine 25mg for Resident #4. -From 03/30/25 through 04/08/25 the pharmacy visited the facility due to a complaint of overstock of medications. <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 83</p> <p>3. Review of Resident #2's current FL2 dated 01/16/25 revealed diagnoses included type 2 diabetes, gout, restless leg syndrome, below the knee amputation of left leg, and stroke affecting the left side.</p> <p>a. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for hydrocodone-acetaminophen (a medication for chronic pain) 5-325mg one tablet twice daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily with a start date of 02/12/25. -There was no documentation hydrocodone-acetaminophen 5-325mg one tablet was administered at 6:00am on 03/05/25, 03/06/25, 03/18/25, 03/23/25 to 03/24/25, 03/26/25, 03/30/25 and at 6:00pm on 03/16/25, 03/22/25, and 03/24/25 with no explanation. -There was documentation on 03/26/25 at 4:10pm, on 03/27/25 at 2:15pm and on 03/28/25 at 9:20am and 4:48pm hydrocodone-acetaminophen 5-325mg one tablet was not administered due to Resident #2 refusing the medication. -There were 14 of 62 opportunities hydrocodone-acetaminophen 5-325mg was documented as not administered. <p>Review of Resident #2's April 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for hydrocodone-acetaminophen 5-325mg, one tablet twice daily at 6:00am/7:00am and 6:00pm/7:00pm with a start date of 02/12/24 and a stop date of 04/17/25. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 84</p> <p>-There was no documentation hydrocodone-acetaminophen 5-325mg, one tablet was administered at 6:00am on 04/01/25, 04/05/25 and 04/06/25 and at 6:00pm/7:00pm on 04/02/25 04/05/25 and 04/06/25 with no explanation.</p> <p>-There was no documentation hydrocodone-acetaminophen 5-325mg one tablet twice daily was administered at 7:00am from 04/08/25 to 04/17/25 and at 7:00pm from 04/09/25 to 04/16/25 and the entry was circled with no explanation.</p> <p>-There was documentation on 04/08/25 at 8:41am hydrocodone-acetaminophen 5-325mg one tablet was not administered due to Resident #2 refusing the medication.</p> <p>-There was documentation on 04/09/25 at 7:05am and 6:16pm hydrocodone-acetaminophen 5-325mg was not administered due to "on order/waiting on pharmacy".</p> <p>-There was documentation on 04/10/25 at 7:08am and 6:14pm and on 04/11/25 at 7:11am and 5:33pm hydrocodone-acetaminophen 5-325mg was not administered due to "awaiting clarification".</p> <p>-There was documentation on 04/12/25 at 6:59am and 5:48pm, on 04/13/25 at 7:20am and 5:31pm, on 04/14/25 at 6:35am and 5:06pm, on 04/15/25 at 6:57am and 5:24pm on 04/16/25 at 7:15am and 5:13pm and on 04/17/25 at 6:05am hydrocodone-acetaminophen 5-325mg was not administered due to "awaiting prescription from provider to be sent to pharmacy".</p> <p>-There were 6 of 60 opportunities hydrocodone-acetaminophen 5-325mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications available on hand for Resident #2</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 85</p> <p>revealed there were no hydrocodone-acetaminophen 5-325mg tablets available for administration as the medication was discontinued on 04/17/25.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed: -Hydrocodone-acetaminophen 5-325mg 60 tablets were dispensed for Resident #2 on 02/27/25 and 03/17/25. -The pharmacy received a verbal order from Resident #2's Primary Care Provider (PCP) on 04/17/25 to discontinue Resident #2's hydrocodone-acetaminophen 5-325mg one tablet twice daily.</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could experience increased pain if he did not receive hydrocodone-acetaminophen 5-325mg as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 86</p> <p>b. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for Tresiba 100units/ml (a medication to treat elevated blood sugar levels) 52 units daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Tresiba 100 units/ml inject 52 units daily. -There was no documentation Tresiba 100 units/ml 52 units was administered daily at 6:00am on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 with no explanation. -There were 7 of 31 opportunities Tresiba 52 units was documented as not administered.</p> <p>Review of Resident #2's April 2025 eMAR revealed: -There was an entry for Tresiba 100 units/ml inject 52 units daily. -There was no documentation Tresiba 100 units/ml 52 units was administered at 6:00am on 04/01/25, 04/05/25 and 04/06/25. -There were 3 of 30 opportunities Tresiba 52 units was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there was Tresiba 100 units/ml available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed Tresiba 100 units/ml, 5 pens containing 3mls each, were dispensed for Resident #2 on 02/24/25 and 04/01/25.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 87</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could experience elevated blood sugar levels if he did not receive Tresiba 100 units/ml 52 units daily as ordered</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>c. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for aspirin 81mg (a medication to prevent stroke) one tablet daily</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for aspirin 81mg one tablet daily with a start date of 04/30/24. -There was no documentation aspirin 81mg one tablet daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25 and 03/26/25 with no explanation. -There were 6 of 31 opportunities aspirin 81mg was documented as not administered. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 88</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 9 tablets of aspirin 81mg available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed: -Resident #2's aspirin 81mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month. -Aspirin 81mg 31 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 05/01/25.</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have an increased risk of a heart attack if he did not receive aspirin 81mg one tablet daily as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>d. Review of Resident #2's physician's orders</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 89</p> <p>dated 01/16/25 revealed there was an order for atorvastatin (a medication to lower cholesterol) 10mg one tablet every evening.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for atorvastatin 10mg one tablet every evening. -There was no documentation atorvastatin 10mg one tablet every evening was administered on 03/16/25, 03/22/25, 03/24/25 with no explanation. -There were 3 of 31 opportunities atorvastatin 10mg was documented as not administered. <p>Review of Resident #2's April 2025 eMAR revealed</p> <ul style="list-style-type: none"> -There was an entry for atorvastatin 10mg one tablet every evening. -There was no documentation atorvastatin 10mg one tablet every evening was administered on 04/02/25, 04/05/25 and 04/06/25 with no explanation. -There were 3 of 30 opportunities atorvastatin 10mg was documented as not administered. <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 10 tablets of atorvastatin 10mg available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's atorvastatin 10mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month. -Atorvastatin 10mg 31 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 90</p> <p>05/01/25.</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have an increased risk of a heart attack if he did not receive atorvastatin 10mg one tablet every evening as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>e. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for diltiazem extended release (ER) (a medication to treat high blood pressure) 240mg one tablet daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for diltiazem ER 240mg one tablet daily with a start date of 02/18/25. -There was no documentation diltiazem ER 240mg one tablet daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 with no explanation. 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 91</p> <p>-There were 7 of 31 opportunities diltiazem ER 240mg was documented as not administered.</p> <p>Review of Resident #2's April 2025 eMAR revealed</p> <p>-There was an entry for diltiazem ER 240mg one tablet daily.</p> <p>-There was no documentation diltiazem ER 240mg one tablet daily was administered on 04/01/25, 04/05/25 and 04/06/25 with no explanation.</p> <p>-There were 3 of 30 opportunities diltiazem ER 240mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 9 tablets of diltiazem ER 240mg available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <p>-Resident #2's diltiazem ER 240mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month.</p> <p>-Diltiazem ER 240mg 28 tablets were dispensed for Resident #2 on 02/17/25.</p> <p>-Diltiazem ER 240mg 31 tablets were dispensed for Resident #2 on 03/05/25, 04/01/25 and 05/01/25.</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have an increased risk of a stroke or heart attack if he did not receive diltiazem ER 240mg one tablet daily as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 92</p> <p>revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>f. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for Eliquis (a medication to prevent blood clots) 5mg one tablet twice daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for Eliquis 5mg one tablet twice daily. -There was no documentation Eliquis 5mg one tablet twice daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 at 6:00am with no explanation. -There was no documentation Eliquis 5mg one tablet twice daily was administered on 03/16/25, 03/22/25, and 03/24/25 at 6:00pm with no explanation. -There were 10 of 62 opportunities Eliquis 5mg was documented as not administered. <p>Review of Resident #2's April 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for Eliquis 5mg one tablet 	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 93</p> <p>twice daily.</p> <p>-There was no documentation Eliquis 5mg one tablet twice daily was administered on 04/01/25, 04/05/25, and 04/06/25 at 6:00am and on 04/02/25, 04/05/25 and 04/06/25 at 7:00pm with no explanation.</p> <p>-There were 6 of 60 opportunities Eliquis 5mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 19 tablets of Eliquis 5mg available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <p>-Resident #2's Eliquis 5mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month.</p> <p>-Eliquis 5mg 62 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 05/01/25.</p> <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have an increased risk of a blood clot if he did not receive Eliquis 5mg one tablet twice daily as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 94</p> <p>06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>g. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for ferrous sulfate (an iron supplement) 325mg one tablet daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ferrous sulfate 325mg one tablet daily. -There was no documentation ferrous sulfate 325mg one tablet daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 with no explanation. -There were 7 of 31 opportunities ferrous sulfate 325mg was documented as not administered.</p> <p>Review of Resident #2's April 2025 eMAR revealed: -There was an entry for ferrous sulfate 325mg one tablet daily. -There was no documentation ferrous sulfate 325mg one tablet daily was administered on 04/01/25, 04/05/25 and 04/06/25 with no explanation. -There were 3 of 30 opportunities ferrous sulfate 325mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 9 tablets of ferrous sulfate 325mg available for administration.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 95</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed: -Resident #2's ferrous sulfate 325mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month. -Ferrous sulfate 325mg 31 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 05/01/25.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>h. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for furosemide (a medication for fluid retention) 20mg one tablet daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 20mg one tablet daily. -There was no documentation furosemide 20mg</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 96</p> <p>one tablet daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 with no explanation. -There were 7 of 31 opportunities furosemide 20mg was documented as not administered.</p> <p>Review of Resident #2's April 2025 eMAR revealed: -There was an entry for furosemide 20mg one tablet daily. -There was no documentation furosemide 20mg one tablet daily was administered on 04/01/25, 04/05/25 and 04/06/25 with no explanation. -There were 3 of 30 opportunities furosemide 20mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 9 tablets of furosemide 20mg available for administration.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>i. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 97</p> <p>metformin (a medication to lower blood sugar) 500mg one tablet twice daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for metformin 500mg one tablet twice daily. -There was no documentation metformin 500mg one tablet twice daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 at 6:00am with no explanation. -There was no documentation metformin 500mg one tablet twice daily was administered on 03/16/25, 03/22/25, and 03/24/25 at 6:00pm with no explanation. -There were 10 of 62 opportunities metformin 500mg was documented as not administered. <p>Review of Resident #2's April 2025 eMAR revealed:</p> <ul style="list-style-type: none"> -There was an entry for metformin 500mg one tablet twice daily. -There was no documentation metformin 500mg one tablet twice daily was administered on 04/01/25 at 6:00am and 04/02/25 at 6:00pm with no explanation. -There was no documentation metformin 500mg one tablet twice daily was administered on 04/05/25 and 04/06/25 at 6:00am and 6:00pm with no explanation. -There were 6 of 60 opportunities metformin 500mg was documented as not administered. <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 19 tablets of metformin 500mg available for administration.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 98</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <ul style="list-style-type: none"> -Resident #2's metformin 500mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month. -Metformin 500mg 62 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 05/01/25. <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have elevated blood sugar levels if he did not receive metformin 500mg one tablet twice daily as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>j. Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for ropinirole (a medication for restless leg syndrome) 0.25mg one tablet daily.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 99</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for ropinirole 0.25mg one tablet daily. -There was no documentation ropinirole 0.25mg one tablet daily was administered on 03/05/25, 03/06/25, 03/18/25, 03/23/25, 03/24/25, 03/26/25 and 03/30/25 at 6:00am with no explanation. -There were 7 of 31 opportunities ropinirole 0.25mg was documented as not administered.</p> <p>Review of Resident #2's April 2025 eMAR revealed: -There was an entry for ropinirole 0.25mg one tablet daily with a start date of 04/30/24. -There was no documentation ropinirole 0.25mg one tablet daily was administered on 04/01/25, 04/05/25 and 04/06/25 at 6:00am with no explanation. -There were 3 of 30 opportunities ropinirole 0.25mg was documented as not administered.</p> <p>Observation on 06/06/25 at 10:38am of medications on hand for Resident #2 revealed there were 9 tablets of ropinirole 0.25mg available for administration.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed: -Resident #2's ropinirole 0.25mg was "cycle-filled" and the facility should begin dispensing from the monthly bubble packs around the 15th of each month. -Ropinirole 0.25mg 31 tablets were dispensed for Resident #2 on 02/02/25, 03/05/25, 04/01/25 and 05/01/25.</p> <p>Telephone interview with a Pharmacist with the</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 100</p> <p>facility's contracted pharmacy on 06/11/25 at 11:59am revealed Resident #2 could have increased restless leg symptoms if he did not receive ropinirole 0.25mg one tablet daily as ordered.</p> <p>Interview with Resident #2 on 06/11/25 at 1:40pm revealed he was unsure what medications he took and did not know why they were prescribed.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>4. Review of Resident #3's current FL2 dated 01/16/25 revealed diagnoses included coronary artery disease and benzodiazepine dependence.</p> <p>a. Review of Resident #3's physician orders dated 12/02/24 revealed an order for zolpidem (a medication to treat sleeplessness) 5mg one tablet at bedtime along with zolpidem 10mg for a total dose of 15mg.</p> <p>Review of Resident #3's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for zolpidem 5mg one tablet daily at bedtime along with zolpidem 10mg one tablet. -Zolpidem 5mg one tablet was documented as</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 101</p> <p>administered daily at bedtime except on 05/02/25, 05/03/25, 05/05/25, 05/06/24 and 05/08/25 due to waiting on pharmacy/awaiting clarification and on 05/30/25 and 05/31/25 due to the resident being out of the facility.</p> <p>-There were 5 of 29 opportunities zolpidem 5mg was documented as not administered.</p> <p>Observation of medications on hand for Resident #3 on 06/06/25 at 10:38am revealed there was a bubble pack with zolpidem 5mg seven tablets remaining with a dispensed date of 06/05/25.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <p>-Zolpidem 5mg seven tablets were dispensed for Resident #3 on 04/30/25 and 05/08/25.</p> <p>-Zolpidem 5mg one tablet was dispensed for Resident #3 on 05/06/25.</p> <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>b. Review of Resident #3's physician orders dated 12/02/24 revealed an order for zolpidem 10mg one tablet at bedtime along with zolpidem 5mg for a total dose of 15mg.</p> <p>Review of Resident #3's May 2025 eMAR</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 102</p> <p>revealed:</p> <ul style="list-style-type: none"> -There was an entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet. -Zolpidem 10mg one tablet was documented as administered daily at bedtime except on 05/03/25, 05/05/25, 05/06/24 and 05/08/25 due to waiting on pharmacy/awaiting clarification and on 05/30/25 and 05/31/25 due to the resident being out of the facility. -There were 4 of 29 opportunities zolpidem 10mg was documented as not administered. <p>Observation of medications on hand for Resident #3 on 06/06/25 at 10:38am revealed there was a bubble pack with zolpidem 10mg seven tablets remaining with a dispense date of 06/05/25.</p> <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/06/25 at 1:02pm revealed:</p> <ul style="list-style-type: none"> -Zolpidem 10mg seven tablets were dispensed for Resident #3 on 04/30/25 and 05/08/25. -Zolpidem 10mg one tablet was dispensed for Resident #3 on 05/06/25. <p>Attempted telephone interviews with Resident #2's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>5. Review of Resident #10's current FL2 dated</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 103</p> <p>01/16/25 revealed diagnoses included chronic obstructive pulmonary disease, dementia and major depressive disorder.</p> <p>a. Review of Resident #10's physician orders dated 12/02/24 revealed an order for lorazepam (a medication to treat anxiety) 1mg one tablet twice daily.</p> <p>Review of Resident #10's March 2025 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There was an entry for lorazepam 1mg one tablet twice daily. -Lorazepam one tablet was documented as administered twice daily except at 6:00am on 03/03/25, 03/05/25, 03/06/25, 03/16/25 and at 6:00pm on 03/16/25 with no explanation. -There were 5 of 62 opportunities lorazepam 1mg was documented as not administered. <p>Telephone interview with a representative with the facility's contracted pharmacy on 06/11/25 at 11:59am revealed:</p> <ul style="list-style-type: none"> -Lorazepam 1mg sixty tablets were dispensed for Resident #10 on 01/02/25, 02/02/25 and 03/17/25. -Resident #10 could have increased anxiety or agitation if she did not receive lorazepam 1mg one tablet twice daily as ordered. <p>Interview with Resident #10 on 06/11/25 at 1:50pm revealed she received medication for anxiety but could not recall a time she had not received it.</p> <p>Attempted telephone interviews with Resident #10's PCP on 06/11/25 at 3:20pm and 06/12/25 at 10:14am were unsuccessful.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 104</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>6. Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, hyperlipidemia and asthma. -There was an order for clonazepam 1mg twice daily.</p> <p>Review of Resident #5's signed physician orders dated 12/02/24 revealed there was an order for clonazepam (a medication used to treat anxiety) 1mg, one tablet three times daily.</p> <p>Review of Resident #5's hospital discharge report revealed: -Resident #5 was admitted to the hospital from 02/28/25 through 03/13/25. -There was an order change for clonazepam 1mg twice daily with a start date of 03/12/25.</p> <p>Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 1mg, one tablet three times daily to be given at 6:00am, 12:00pm, and 6:00pm with a start date of 12/18/24. -There was no documentation clonazepam 1mg was administered on 02/05/25 at 6:00am and</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 105</p> <p>6:00pm, 02/06/25 at 6:00am and 6:00pm, 02/07/25 at 12:00pm and 6:00pm, 02/15/25 at 12:00pm, 02/18/25 at 12:00pm, 02/24/25 at 6:00am and 12:00pm, 02/26/25 at 6:00am and 12:00pm.</p> <p>-There were 12 of 84 opportunities clonazepam 1mg was not documented as administered.</p> <p>Review of Resident #5's April 2025 eMAR revealed:</p> <p>-There was an entry for clonazepam 1mg, one tablet two times daily to be given at 6:00am and 6:00pm with a start date of 03/12/25.</p> <p>-There was documentation clonazepam 1mg was not administered 04/24/25-04/30/25 two times daily at 6:00am and 6:00pm with a comment "waiting on pharmacy to fill prescription".</p> <p>-There were 14 of 60 opportunities clonazepam 1mg was not documented as administered.</p> <p>Review of Resident #5's May's 2025 eMAR revealed:</p> <p>-There was an entry for clonazepam 1mg, one tablet two times daily to be given at 6:00am, and 6:00pm with a start date of 03/12/25 through 05/09/25.</p> <p>-There was documentation clonazepam 1mg was not administered 05/01/25-05/09/25 with a comment "waiting on pharmacy to fill prescription".</p> <p>-There were 18 of 18 opportunities clonazepam 1mg was not documented as administered.</p> <p>Observation on 06/06/25 at 10:15am of Resident #5's medications on hand revealed:</p> <p>-There were 13 clonazepam 1mg tablets available for administration.</p> <p>-The facility received 14 clonazepam 1mg tablets on 06/05/25.</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 106</p> <p>Interview with Resident #5 on 06/03/25 at 10:30am revealed: -He knew there were some problems with not getting his clonazepam in February 2025 but was not sure of the details. -He was hospitalized 02/28/25 through 03/14/25 for cutting his arm with a piece of coffee cup he had broken.</p> <p>Interview with the Manager on 06/11/25 at 4:00 pm revealed: -She was certain that Resident #5 was administered clonazepam in February 2025 but for some reason was showing up as not administered. -Usually if the medication was administered late it would show up as blank.</p> <p>Telephone call with a representative with the facility's contracted pharmacy on 06/09/25 at 12:50pm revealed: -On 11/29/24 a telephone prescription from the PCP was received on 11/29/24 for clonazepam 1mg three times a day with five refills. -On 12/16/24 a prescription was filled with a quantity of 90 tablets -On 01/10/25 a prescription was filled with a quantity of 90 tablets. -On 02/26/25 a prescription was filled with a quantity of 90 tablets. -There was no fill history for March 2025. -On 05/09/25 clonazepam 1mg was filled with a quantity of 12 tablets. -On 05/15/25 clonazepam 1mg was filled with a quantity of 14 tablets. -On 05/22/25 clonazepam 1mg was filled with a quantity of 14 tablets. -On 05/29/25 clonazepam 1mg was filled with a quantity of 14 tablets. -On 06/05/25 clonazepam 1mg was filled with a</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 107</p> <p>quantity of 14 tablets.</p> <p>-Resident #5 medications were on monthly fill cycles but as of 05/09/25 it was on weekly fill cycle.</p> <p>-Resident #5 could have increased behaviors and anxiety when he missed his clonazepam.</p> <p>Telephone call with Resident # Primary 5's previous Primary Care Provider (PCP) on 06/09/25 at 1:09pm revealed:</p> <p>-Resident #5 could have increased anxiety and an increase in behavior if missing large doses or multiples doses of his clonazepam.</p> <p>-She was aware Resident #5 would refuse his clonazepam at times but Resident #5 reported to her that he was taking it.</p> <p>Refer to interview with a medication aide (MA) on 06/04/25 at 8:30am.</p> <p>Refer to interview with the Manager on 06/11/25 at 3:31pm.</p> <p>Refer to interview with the Administrator on 06/11/25 at 1:55pm.</p> <p>Interview with a medication aide (MA) on 06/04/25 at 8:30am revealed:</p> <p>-She administered medications when she was on duty.</p> <p>-There was a time sometime in March 2025 or April 2025 when the MAs administered medications, but it would not sync on the eMAR.</p> <p>-She told the Administrator and Manager, and the Manager stated she was working on the issue with the Pharmacy.</p> <p>-She did not know if audits were completed or not.</p> <p>Interview with the Manager on 06/11/25 at</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	<p>Continued From page 108</p> <p>3:31pm revealed: -She was aware there were blank documentation areas on the residents' eMARs. -The Administrator sent the medication laptop to the pharmacy in April 2025 to resolve the issue. -She thought all residents' were receiving their medication even when there were blank areas in the eMAR. -If they were blank it usually was because medications were administered late. -She did not do any audits because she was never told to.</p> <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed: -She was informed by the MAs that there were blank medication administration documentation areas on residents' eMARs and the MAs thought it was due to an internet or laptop syncing issue. -She informed pharmacy of the issue and returned the medication administration laptop to them. -Since receiving the new laptop from the pharmacy, she had not noticed blank documentation areas. -There were no chart audits completed since she began working at the facility, but she planned to start having them completed monthly.</p> <p>The facility failed to ensure medications were administered as ordered for Resident #1 related to a narcotic pain medication, for Resident #2 related to medications for hypertension, stroke prevention, chronic pain, fluid retention, low iron levels, elevated blood sugar levels, gout, restless leg syndrome, for Resident #3 related to sleeplessness, and for Residents #4, #5 and #10 related to medications for anxiety. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B</p>	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 358	Continued From page 109 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/27/25.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by:	D 367	10A NCAC 13F .1004(j) Medication Administration met as evidenced by All MARs have been audited for compliance and accuracy. All medication staff in-serviced with 15hr Medication Administration class and Documentation class. Med techs to ensure compliance and accuracy daily, RCC to monitor weekly, Administrator to oversee monthly and as needed.	6/30/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 367	<p>Continued From page 110</p> <p>Based on interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 2 of 6 residents (#1, #3) related to inaccurate documentation of a medication used to treat mild to moderate pain (#1), and medications to lower blood pressure, treat mental illness, lower cholesterol, for sleeplessness, constipation, anxiety, memory loss, allergy symptoms, muscle spasms, pain, enlarged prostate, depression, lower blood sugar levels and a thyroid hormone replacement (#3)</p> <p>The findings are:</p> <p>Review of the facility's undated Medication Administration Policy revealed:</p> <ul style="list-style-type: none"> -Documentation would be provided by staff who administered medications to the residents on the Medication Administration Record (MAR). -Staff will provide documentation on the MAR after observing the residents taking the medications and before administration to another resident. <p>1. Review of Resident #1's current FL2 dated 06/03/25 revealed diagnoses included chronic pain syndrome, diabetes type 2, traumatic brain injury, impulse control disorder, and hypertension.</p> <p>Review of Resident #1's Resident Register revealed he was admitted on 09/16/2019.</p> <p>a. Review of Resident #1's signed physician's order dated 02/23/25 revealed an order for hydrocodone-acetaminophen 10-325mg one tablet three times daily for chronic pain.</p> <p>Review of Resident #1's March 2025 electronic medication administration record (eMAR)</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 367	<p>Continued From page 111</p> <p>revealed:</p> <p>-There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily.</p> <p>-There was no documentation hydrocodone-acetaminophen 10-325mg was administered on 03/03/25 at 6:00am and 12:00pm, on 03/05/25 at 6:00am and 12:00pm, on 03/13/25 at 12:00pm, on 03/16/25 at 6:00am, 12:00pm, and 6:00pm, on 03/18/25 at 6:00am, and 12:00pm, on 03/20/25 at 12:00pm, on 03/22/25 at 12:00pm, and 6:00pm, on 03/23/25 at 6:00am, and 12:00pm, on 03/26/25 at 6:00am, on 03/30/25 at 6:00am and 12:00pm and on 03/31/25 at 12:00pm.</p> <p>-There was no documentation why hydrocodone-acetaminophen 10-325mg one tablet three times daily was not administered on 03/03/25, 03/05/25, 03/13/25, 03/16/25, 03/18/25, 03/20/25, 03/22/25, 03/23/25, 03/26/25, 03/30/25 and 03/31/25.</p> <p>Review of Resident #1's April 2025 eMAR revealed:</p> <p>-There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily.</p> <p>-There was no documentation hydrocodone-acetaminophen 10-325mg was administered on 04/01/25 at 6:00am and 12:00pm, on 04/02/25 at 6:00pm, on 04/05/25 at 6:00am, 12:00pm and 6:00pm, on 04/06/25 at 6:00am, 12:00pm and 6:00pm and 04/09/25 at 6:00am and 12:00pm.</p> <p>-There was an order to discontinue hydrocodone-acetaminophen 10-325mg on 04/09/25 at 5:00pm.</p> <p>Interview with a medication aide (MA) on 06/04/25 at 8:30am revealed:</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 367	<p>Continued From page 112</p> <ul style="list-style-type: none"> -She administered medications when she was scheduled to work. -There was a time in March or April the MAs would administer medication, and it would not sync on the eMAR. -She told the Administrator and Manager of the facility, and the Manager stated she was working on the issue with the Pharmacy. -She did not know if audits were completed or not. <p>Interview with the Manager on 06/09/25 at 3:55pm and 06/11/25 at 3:31pm revealed:</p> <ul style="list-style-type: none"> -She was not aware there were 11 days in March 2025 and five days in April 2025 when Resident #1's medications were not documented as administered. - The medications were given because Resident #1 would let the MA know if he did not receive them. -She did not do any audits because she was never told too. <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed she did not know Resident #1's hydrocodone-acetaminophen was not documented as administered.</p> <p>2. Review of Resident #3's current FL2 dated 01/16/25 revealed diagnoses included schizoaffective disorder, benzodiazepine dependence and opioid dependence.</p> <p>Review of Resident #3's April 2024 electronic medication administration record (eMAR) revealed:</p> <ul style="list-style-type: none"> -There were medications documented as administered to Resident #3 when he was out of 	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 367	<p>Continued From page 113</p> <p>the facility.</p> <p>-There was documentation on each of the medication entries that the medication was "suspended" from 04/09/25 to 04/14/25 because the resident went home with family for the week.</p> <p>-For example, oxycodone-acetaminophen (a medication to treat severe pain) 7.5-325mg one tablet was documented administered to Resident #3 two times on 04/09/25 and three times daily from 04/10/25 to 04/12/25 when he was out of the facility.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed:</p> <p>-She "suspended" Resident #3's eMAR in the eMAR software sometime in April 2025, but she was unsure when it was.</p> <p>-When a resident's eMAR was "suspended" in the eMAR software the eMAR should not show up during the medication pass.</p> <p>-Resident #3's eMAR was not "suspended" in the eMAR software correctly, making his eMAR visible in the eMAR software during the medication pass.</p> <p>-She accidentally documented medications were administered to Resident #3 when he was not in the facility because she was not paying attention.</p> <p>Interview with the Administrator on 06/11/25 at 1:55pm revealed:</p> <p>-If medication aides (MA) were correctly administering medications, there should not be documentation that medications were administered to a resident who was out of the facility.</p> <p>-When a resident was out of the facility, depending on how the resident was documented out of the facility, in the eMAR system, a blank area may appear on the eMAR but it should not show a medication was administered.</p>	D 367		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>10A NCAC 13F .1008 (a) Controlled Substances</p> <p>10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on observations, interviews, and record reviews, the facility failed to ensure a readily available record that reconciled the receipt, administration, and disposition of controlled medications for 5 of 6 sampled residents (#1, #2, #3, #5 and #10) related to a Schedule II controlled pain reliever (#1, #2, and #3), a Schedule IV controlled anti-anxiety medication (#3, #5 and #10), and a Schedule IV controlled insomnia medication (#3).</p> <p>The findings are:</p> <p>Review of the facility's undated Controlled Substance policy revealed: -Documentation of controlled substances would be maintained by the facility and available for review. -The record of documentation would be kept in the resident's record.</p> <p>1. Review of Resident #2's current FL2 dated 01/16/25 revealed diagnoses included below the knee amputation of left leg and stroke affecting the left side.</p>	D 392	<p>10A NCAC 13F .1008(a) Controlled Substances met as evidenced by All carts have been audited to ensure all narcotics have a corresponding narcotic sign out sheet. All medication staff in-serviced on narcotic sheets and how to intake/disposition narcotic medications as well as to turn in all completed narcotic sheets daily to RCC for review. Med staff will follow facility policy for dispositioned medications. RCC will review narc sheets and disposition sheets weekly and as needed then turn them in to Administrator for review. Administrator will oversee monthly and as needed.</p>	6/30/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 115</p> <p>Review of Resident #2's physician's orders dated 01/16/25 revealed there was an order for hydrocodone-acetaminophen (a medication for chronic pain) 5-325mg one tablet twice daily.</p> <p>Review of Resident #2's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily. -Hydrocodone-acetaminophen 5-325mg one tablet was documented as administered 48 of 62 opportunities from 03/01/25 to 03/31/25.</p> <p>Review of Resident #2's April 2025 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 5-325mg one tablet twice daily. -The entry was discontinued on 04/17/25. -Hydrocodone-acetaminophen 5-325mg one tablet was documented as administered 9 of 33 opportunities between 04/01/25 and 04/17/25.</p> <p>Review of Resident #2's record revealed there were no controlled substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>2. Review of Resident #3's current FL2 dated</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 116</p> <p>01/16/25 revealed diagnoses included schizoaffective disorder, benzodiazepine dependence and opioid dependence.</p> <p>a. Review of Resident #3's physician orders dated 12/02/24 revealed an order for diazepam 5mg one tablet three times a day for anxiety.</p> <p>Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for diazepam 5mg one tablet three times daily. -There was documentation Resident #3 was out of the facility from 03/06/25 to 03/10/25 and from 03/16/25 to 03/17/25. -Diazepam 5mg one tablet was documented as administered 68 of 68 opportunities from 03/01/25 to 03/31/25.</p> <p>Review of Resident #3's April 2025 eMAR revealed: -There was an entry for diazepam 5mg one tablet three times daily. -There was documentation Resident #3 was out of the facility from 4/12/25 to 04/22/25 and from 04/09/25 to 04/14/25. -Diazepam 5mg one tablet was documented as administered 51 of 51 opportunities from 04/01/25 to 04/30/25.</p> <p>Review of Resident #3's May 2025 eMAR revealed: -There was an entry for diazepam 5mg one tablet three times daily. -There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25. -Diazepam 5mg one tablet was documented as administered 81 of 87 opportunities from 05/01/25 to 05/30/25.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 117</p> <p>Review of Resident #3's June 2025 eMAR revealed: -There was an entry for diazepam 5mg one tablet three times daily. -There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25. -Diazepam 5mg was documented as administered 2 of 5 opportunities from 06/01/25 to 06/03/25.</p> <p>Review of Resident #3's record revealed there were no controlled substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>b. Review of Resident #3's physician orders dated 12/02/24 revealed an order for zolpidem (used to treat insomnia) 10mg one tablet at bedtime along with zolpidem 5mg for a total dose of 15mg.</p> <p>Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed: -There was documentation Resident #3 was out of the facility from 03/06/25 to 03/10/25 and from 03/16/25 to 03/17/25. -There was an entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet with a stop date of 03/04/25.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 118</p> <p>-Zolpidem 10mg one tablet was documented as administered 3 of 3 opportunities from 03/01/25 to 03/03/25.</p> <p>-There was a second entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet with a start date of 03/03/25.</p> <p>-Zolpidem 10mg one tablet was documented as administered 23 of 23 opportunities on the second entry from 03/04/25 to 03/3/25.</p> <p>Review of Resident #3's April 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet.</p> <p>-Zolpidem 10mg one tablet was documented as administered 21 of 21 opportunities from 04/01/25 to 04/12/25 and from 04/22/25 to 04/30/25.</p> <p>-There was documentation Resident #3 was out of the facility from 04/12/25 to 04/22/25.</p> <p>Review of Resident #3's May 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet.</p> <p>-Zolpidem 10mg one tablet was documented as administered 25 of 29 opportunities from 05/01/25 to 05/29/25.</p> <p>-There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25.</p> <p>Review of Resident #3's June 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 10mg one tablet daily at bedtime along with zolpidem 5mg one tablet.</p> <p>-Zolpidem 10mg one tablet was not documented as administered 1 of 1 opportunity on 06/02/25</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 119</p> <p>due to the resident refused.</p> <p>-There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25.</p> <p>Review of Resident #3's record revealed there were no controlled substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>c. Review of Resident #3's physician orders dated 12/02/24 revealed an order for zolpidem 5mg one tablet at bedtime along with zolpidem 10mg for a total dose of 15mg.</p> <p>Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed:</p> <p>-There was an entry for zolpidem 5mg one tablet daily at bedtime along with zolpidem 10mg one tablet.</p> <p>-Zolpidem 5mg one tablet was documented as administered 26 of 26 opportunities from 03/01/25 to 03/31/25.</p> <p>-There was documentation Resident #3 was out of the facility from 03/06/25 to 03/10/25 and from 03/16/25 to 03/17/25.</p> <p>Review of Resident #3's April 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 5mg one tablet daily at bedtime along with zolpidem 10mg one</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 120</p> <p>tablet.</p> <p>-Zolpidem 5mg one tablet was documented as administered 21 of 21 opportunities from 04/01/25 to 04/30/25.</p> <p>-There was documentation Resident #3 was out of the facility from 04/12/25 to 04/22/25.</p> <p>Review of Resident #3's May 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 5mg one tablet daily at bedtime along with zolpidem 10mg one tablet.</p> <p>-Zolpidem 5mg one tablet was documented as administered 24 of 29 opportunities from 04/01/25 to 04/29/25.</p> <p>-There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25.</p> <p>Review of Resident #3's June 2025 eMAR revealed:</p> <p>-There was an entry for zolpidem 5mg one tablet daily at bedtime along with zolpidem 10mg one tablet.</p> <p>-Zolpidem 5mg one tablet was documented as administered 0 of 1 opportunity on 06/02/25 as the resident refused.</p> <p>-There was documentation Resident #3 was out of the facility from 05/30/25 to 06/01/25.</p> <p>Review of Resident #3's record revealed there were no controlled substance count sheets (CSCS) available for review.</p> <p>Refer to interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 121</p> <p>Refer to telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>d. Review of Resident #3's physician orders dated 12/02/24 revealed an order for oxycodone-acetaminophen (used to help control pain) 7.5-325mg one tablet three times a day.</p> <p>Review of Resident #3's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for oxycodone-acetaminophen 7.5-325mg one tablet three times daily. -Oxycodone-acetaminophen 7.5-325mg was documented as administered 53 of 78 opportunities from 03/01/25 to 03/31/25. -There was documentation Resident #3 was out of the facility from 03/06/25 to 03/10/25 and from 03/16/25 to 03/17/25.</p> <p>Review of Resident #3's April 2025 eMAR revealed: -There was an entry for oxycodone-acetaminophen 7.5-325mg one tablet three times daily with a start day of 12/18/24 and a stop date of 04/03/25. -Oxycodone-acetaminophen 7.5-325mg one tablet was documented as administered 2 of 8 opportunities from 04/01/25 to 04/03/25. -There was a second entry for oxycodone-acetaminophen 7.5-325mg one tablet three times daily with a start date of 04/03/25 and a stop date of 04/30/25. -Oxycodone-acetaminophen 7.5-325mg one tablet was documented as administered 44 of 62 opportunities on the second entry from 04/03/25 to 04/30/25. -There was documentation Resident #3 was out of the facility from 04/12/25 to 04/22/25.</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 122</p> <p>Review of Resident #3's record revealed there were no controlled substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>3. Review of Resident #10's current FL2 dated 01/16/25 revealed diagnoses included dementia and major depression disorder.</p> <p>Review of Resident #10's physician's orders dated 12/02/24 revealed there was an order for lorazepam 1mg, one tablet twice daily for anxiety.</p> <p>Review of Resident #10's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 1mg one tablet twice daily with a start date of 08/10/24 and a stop date 03/18/25. -Lorazepam 1mg one tablet was documented as administered 29 of 34 opportunities from 03/01/25 to 03/18/25. -There was a second entry for lorazepam 1mg one tablet twice daily with a start date of 03/18/25. -Lorazepam 1mg one tablet was documented as administered 28 of 28 opportunities from 03/18/25 to 03/31/25.</p> <p>Review of Resident #10's controlled substance</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 123</p> <p>count sheet (CSCS) dated 01/23/25 revealed: -The CSCS was for lorazepam 1mg with direction to take one tablet twice daily for anxiety. -The label indicated 60 tablets were dispensed. -The first administration date was 03/24/25 at 6:00am. -There was documentation lorazepam 1mg one was signed out at 6:00am and 6:00pm from 03/24/25 through 03/28/25. -There was documentation lorazepam 1mg one tablet was signed out on 03/28/25 at 6:00pm and 50 tablets remained. -The next sign out for lorazepam 1 mg tablet was documented on 03/29/25 at 6:00am and 39 tablets remained.</p> <p>Interview with the Manager on 06/11/25 at 3:31pm revealed: -During the time of the error on 03/29/25 at 6:00pm, on Resident #10's CSCS dated 01/23/25, the facility was doing the narcotic count in the electronic eMAR system. -She had been filling in the paper CSCS to try and "catch up" the paper CSCSs and no one was counting off with the paper CSCS at that time.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>4. Review of Resident #5's current FL2 dated 03/12/25 revealed: -Diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 124</p> <p>obstructive pulmonary disease, hypertension, hyperlipidemia and asthma. -There was an order for clonazepam (a medication used to treat anxiety) 1 mg twice daily.</p> <p>Review of Resident #5's signed physician orders dated 12/02/24 revealed there was an order for clonazepam 1mg, one tablet three times daily.</p> <p>Review of Resident #5's hospital discharge report revealed: -Resident #5 was admitted to the hospital on 02/28/25 through 03/13/25. -There was an order change for clonazepam 1mg twice daily with a start date of 03/12/25.</p> <p>Review of Resident #5's February 2025 electronic medication administration record (eMAR) revealed: -There was an entry for clonazepam 1mg, one tablet three times daily. -Clonazepam 1mg one tablet was documented as administered 72 of 84 opportunities from 02/01/25 to 02/28/25.</p> <p>Review of Resident #5's March 2025 eMAR revealed: -There was an entry for clonazepam 1mg one tablet three times daily with a start date of 12/18/24 and a discontinue date of 03/14/25. -There was documentation clonazepam 1 mg tablet continued to be administered through 6:00pm on 03/15/25. -Clonazepam 1mg one tablet was documented as administered 6 of 42 opportunities from 03/01/25 to 03/15/25. -There was a second entry for clonazepam 1mg, one tablet twice daily with a start date of 03/12/25. -Under the second entry, clonazepam 1mg one</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 125</p> <p>tablet was documented as administered 36 of 38 opportunities from 03/14/25 to 03/31/25. -There was documentation the resident was out of the facility from 03/06/25 to 03/13/25.</p> <p>Review of Resident #5's April 2025 eMAR revealed: -There was an entry for clonazepam 1mg one tablet twice daily. -Clonazepam 1mg one tablet was documented as administered 46 of 60 opportunities from 04/01/25 to 04/30/25.</p> <p>Review of Resident #5's May 2025 eMAR revealed: -There was an entry for clonazepam 1mg one tablet twice daily with a stop date of 05/09/25 -Clonazepam 1mg one tablet was not documented as administered 17 of 17 opportunities from 05/01/25 to 05/09/25. -There was a second entry for clonazepam 1mg one tablet twice daily with a start date of 05/09/25. -On the second entry, clonazepam 1mg one tablet was documented as administered 44 of 45 opportunities from 05/09/25 to 05/31/25.</p> <p>Review of Resident #5's June 2025 eMAR revealed: -There was an entry for clonazepam 1mg one tablet twice daily. -Clonazepam 1mg one tablet was documented as administered 5 of 5 opportunities from 06/01/25 to 06/03/25.</p> <p>Review of Resident #5's record revealed there were no control substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 126</p> <p>06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>5. Review of Resident #1's current FL2 dated 06/03/25 revealed diagnoses included chronic pain syndrome and diabetes type 2.</p> <p>Review of Resident #1's physician's order dated 02/23/25 revealed an order for hydrocodone-acetaminophen (used to control pain) 10-325mg one tablet three times daily.</p> <p>Review of Resident #1's March 2025 electronic medication administration record (eMAR) revealed: -There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily. -There was documentation hydrocodone-acetaminophen 10-325mg one tablet was administered 74 of 93 opportunities from 03/01/25 to 03/31/25.</p> <p>Review of Resident #1's April 2025 eMAR revealed: -There was an entry for hydrocodone-acetaminophen 10-325mg one tablet three times daily. -There was documentation hydrocodone-acetaminophen 10-325mg one tablet three times daily was discontinued on 04/09/25. -There was documentation hydrocodone-acetaminophen 10-325mg one</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 127</p> <p>tablet was administered 16 of 27 opportunities from 04/01/25 to 04/09/25.</p> <p>Review of Resident #1's record revealed there were no control substance count sheets (CSCS) available for review.</p> <p>Refer to the interview with the Manager on 06/05/25 at 9:08am.</p> <p>Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am.</p> <p>Refer to the telephone interview with the Facility Consultant on 06/04/25 at 2:41pm.</p> <p>_____ Interview with the Manager on 06/05/25 at 9:08am revealed:</p> <ul style="list-style-type: none"> -The facility switched to using the eMAR system for keeping count of controlled substances around April 2025. -She was unable to find the handwritten CSCS prior to April 2025. -She was not able to provide a readily available accounting of controlled substances from the eMAR system. <p>Telephone interview with a Pharmacist with the facility's contracted pharmacy on 06/04/25 at 11:15am revealed:</p> <ul style="list-style-type: none"> -When controlled substances were dispensed to the facility, a CSCS was sent with the medication to keep track of the count. -There were several instances of concerns for drug diversion at the facility beginning around December 2024. -Because of drug diversion concerns, new delivery procedures were put into place at the facility around the end of January 2025. 	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 392	<p>Continued From page 128</p> <p>-The facility began using the eMAR system for controlled substance logging in April 2025. -She thought the eMAR system was able to print a CSCS report for controlled medications.</p> <p>Telephone interview with the Facility Consultant on 06/04/25 at 2:41pm revealed: -She was hired by the Owner to complete an investigation regarding missing narcotics at the facility. -The investigation was from 04/08/25 to 04/14/25. -When she started the investigation she asked the Owner and the Manager for the CSCS but they were not available and could not be found.</p> <p>_____</p> <p>The facility failed to ensure there was a readily retrievable and accurate record of controlled substances maintained for Resident #3 related to oxycodone-acetaminophen 7.5-325mg, diazepam 5mg, and zolpidem 10mg, for Resident #1 related to hydrocodone-acetaminophen 10-325mg, for Resident #2 related to hydrocodone-acetaminophen 5-325mg, for Resident #5 related to clonazepam 1mg and for Resident #10 related to lorazepam 1mg. This failure resulted in risk of drug diversion and residents not receiving their controlled substances. This failure was detrimental to the health, safety and welfare of the residents and constitutes a Type B Violation.</p> <p>_____</p> <p>The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/06/25 for this violation.</p> <p>CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/27/25</p>	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438 D 438	<p>Continued From page 129</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry</p> <p>10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.</p> <p>This Rule is not met as evidenced by: TYPE B VIOLATION</p> <p>Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) report within 24 hours for 3 of 3 sampled staff (A, B & L) related to allegations of drug diversion and failed to submit to HCPR a 5-working day investigation report.</p> <p>The findings are:</p> <p>Review of a 24-hour Health Care Personnel Registry (HCPR) Initial Allegation Report revealed:</p> <ul style="list-style-type: none"> -The contact person for the report was listed as Staff A, (The Manager) and the former Administrator. -There was no documentation of the type of allegation. -The date the facility became aware of the incident was documented as 04/08/25 at 3:00pm. -The allegation description read: "noticed two cards of missing narcotics, facility filed a police report and had started an internal investigation, interviewed medication aides (MA) and staff as we conducted drug screens on staff members during process." -There were no accused employees listed on the report. 	D 438 D 438	<p>10A NCAC 13F .1205 Health Care Personnel Registry met as evidenced by, facility administrator turned in all incorrect and missing HCPR reports, 24 hour and 5-day reports. RCC will monitor daily for any needed reports, RCC consultant will monitor weekly and Administrator will oversee and ensure monthly and as needed.</p>	6/30/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	<p>Continued From page 130</p> <ul style="list-style-type: none"> -Two residents were listed in the report. -The field Accused Individual Information was blank. -The field Reasonable Suspicion of a Crime was blank. -The incident was reported to the local police department on 04/09/25 at 3:30pm. -The report was signed by Staff A on 04/09/25. <p>Review of the facility's fax confirmation sheet revealed the 24-hour report was faxed to HCPR on 04/10/25 at 3:17pm.</p> <p>Review of a 5-Day HCPR Investigation Report revealed:</p> <ul style="list-style-type: none"> -The contact person was Staff A and the (former)Administrator. -The field Allegation/Incident Type was blank. -The field Incident Resulted in Physical Injury/Harm was marked "no". -The field Mental Anguish lasting 5 days or more was marked "no". -The field Accused Individual Information was blank. -The field Witness Information was blank. -The field Resident Information was blank. -The Facility Provider/Investigator was listed as the Facility Consultant. -The field Allegation substantiated was marked "no". -The field Accused individuals employment terminated was marked "no". -It was documented the incident was not reported to the local County Department of Social Services. -It was documented there was no reasonable suspicion of a crime. -The incident was reported to the local law enforcement on 04/09/25 at 3:00pm. -It was documented that the Accused was not 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	<p>Continued From page 131</p> <p>charged.</p> <ul style="list-style-type: none"> -The field Witness(es) was left blank. -The Summary of Facility Investigation was documented as attached to the report. -The Investigation Summary timeline was from 04/08/25 through 04/14/25. -There was camera footage available for review from 03/28/25 through 04/14/25. -Investigative video review report for Staff B read in part; Staff B pulling medications without using the eMAR, left pulled narcotics in cups on top of cart without label and not behind two locks, popped a pill into her hand and threw it in the trash, took pre-pulled pills and appeared to throw in trash. -Investigative video review report for Staff A read in part; Staff A advising Staff B of medicine on the cart to consume in the medication room from resident packs for Staff B's personal illness, medications were not narcotics, throwing the pill from cup to trash while talking to a resident but confirmed it was paper trash. -There were no narcotic sheets for review. -The Facility Consultant interviewed a representative from the facility's contracted pharmacy who had concerns regarding Staff A and missing narcotics on multiple occasions. -When Staff A was questioned, she stated she had thrown the pills away by mistake. -Staff A admitted to accidentally throwing away narcotics in December 2024 and March 2025. -Staff A reported to the Facility Consultant she had concerns about Staff B and Staff L. -Staff B admitted to taking pills out of a medication cup and throwing them in the trash after punching them from the medication card by mistake. -Staff B reported to the Facility Consultant that Staff L "stole pills when she was there and thought the pills were gone since then." 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	<p>Continued From page 132</p> <ul style="list-style-type: none"> -Staff L was no longer employed by the facility . -The report was signed by Staff A on 04/14/25. <p>Telephone interview with a representative from the HCPR on 06/04/25 at 9:35am revealed:</p> <ul style="list-style-type: none"> -A 24-hour Report was received on 04/10/25 at 10:17am. -There were no alleged staff and no perpetrator on the report, so it was "screened out." -The 24-hour Report was in the Complaint Intake Unit. (A division within NC Health Service Regulation which enters complaints for a facility.) -A 5-day Investigation Report was not received from the facility. <p>Interview with Staff A, Manager, on 06/4/25 at 10:43am revealed:</p> <ul style="list-style-type: none"> -She could not find the fax confirmation report for the 5-Day Investigation Report. -She reviewed a list of previously fax journal reports and realized the 5-day Investigation report did not go through as the line was busy and she did not confirm if it was successfully transmitted. <p>Telephone interview with the Facility Consultant on 06/04/25 at 2:41pm revealed:</p> <ul style="list-style-type: none"> -She worked at the facility from 2007 until August of 2024. -She was hired by the Owner to complete the investigation related to the alleged drug diversion. -Both staff A and B were the listed staff regarding diversion of drugs. -Staff A admitted to throwing away narcotics. -Nothing warranted Staff B to be suspended and the only concern she had with Staff B was she popped medacaitons without using the eMAR and taking pills out of the dispensing cup and throwing them into the trash. -Staff B told the Facility Consultant she had 	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	<p>Continued From page 133</p> <p>popped it out by mistake so she threw it away. -She was not responsible for submitting the 24-Hour Report or the 5-day Investigation Report because the Owner told her Staff A, the Manager, or the former Administrator would complete the reports.</p> <p>Interview with the former Administrator on 06/04/25 at 3:41pm revealed: -She started at the facility on 06/22/24 to train with the existing Administrator (Facility Consultant). -She thought the Facility Consultant had completed the investigation. -No one had asked her to complete and submit the 24-Hour or 5-Day Investigation Report.</p> <p>Telephone interview with the Owner on 06/04/25 at 5:19pm revealed: -Staff A and the former Administrator were responsible for filling out and submitting the 24-Hour Initial Allegation Report. -Staff A filled out the 5-day Investigation Report and the former Administrator assisted. -He was not aware that Staff A and Staff B were not listed on the report. -He was not aware that the 5-day Investigation Report was not sent in to the HCPR. -He had a copy of both reports on his "drive" (a cloud-based storage system). -He opened them to make sure they were filed but had not reviewed them.</p> <p>Review of a second 24-Hour Initial Allegation Report and 5-Day Investigative Report revealed: -It was completed and signed by the former Administrator on 06/04/25. -It was faxed to HCPR on 06/05/25. -Staff L was reported on both reports but Staff A and Staff B were not.</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	<p>Continued From page 134</p> <p>-Staff A was documented as the "Facility/Provider Investigator" on the 5 day investigative report.</p> <p>Interview with the former Administrator on 06/05/25 at 10:10am revealed:</p> <p>-She had been overseeing the building since June of 2024.</p> <p>-She had experience with submitting reports to HCPR.</p> <p>-She had not read the 5-Day Investigation Report completed by the Facility Consultant.</p> <p>-She had not spoken with the Owner regarding the investigation.</p> <p>-She reported Staff L because Staff A and Staff B told her that Staff L was who should be reported on the 24 hour and 5-day investigation report for drug diversion.</p> <p>Staff A and B remained working in the facility on 06/12/2025.</p> <p>Interview with the Administrator on 06/12/25 at 5:48pm revealed that she would be the person to submit the 24-Hour Initial Allegation and 5-Day Investigative Report and ensure reports were done in a timely manner and done properly.</p> <p>[Refer to tag 0330, 10A NCAC 13G .1008(a) Controlled Substances (Type B Violation)].</p> <p>_____</p> <p>The facility failed to ensure Staff A and B were reported to the HCPR for alleged drug diversion in relation to two resident's controlled substances. These controlled substances were allegedly thrown away. In addition, there were no controlled substance records, as required by law, to ensure controlled substances were accurately accounted for. A second 24-Hour Initial Allegation Report and 5-Day Investigation Report was submitted to HCPR on 06/05/25 and Staff A and B were not</p>	D 438		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 438	Continued From page 135 reported to HCPR. This 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 accordance with G.S. 131D-34 on 06/12/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED 07/27/25.	D 438		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to notify the local County Department of Social Services (DSS) of accident/incident that required emergency medical evaluation for 1 of 6 sampled residents (#5) who sustained a cut to the wrist and required transport to the local hospital by emergency medical services (EMS). The findings are:	D 451	10A NCAC 13F .1212 Reporting of Accidents and Incidents met as evidenced by, facility staff in-serviced on rule and responsibility for completing and turning in the Accident/Incident Report to DSS. Administrator contacted DSS county monitor for best contact fax number and email address to ensure timely delivery of the reports. Med techs will ensure daily, RCC will ensure weekly, Admin will oversee monthly and as needed.	7/24/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 451	<p>Continued From page 136</p> <p>Review of the facility's undated Accident and Incident Policy revealed: -The Supervisor in Charge/designee shall ensure that proper documentation and notification is completed. -Incidents that required more than first aide treatment shall be faxed to the local County Department of Social Services within 48 hours of incidents.</p> <p>Review of Resident #5's current FL2 dated 03/12/25 revealed diagnoses included schizophrenia, schizoaffective disorder bipolar type, chronic obstructive pulmonary disease, hypertension, hyperlipidemia and asthma.</p> <p>Review of Resident #5's hospital discharge report revealed he was admitted to the hospital on 02/28/25 through 03/13/25.</p> <p>Review of charting notes dated 02/28/25 at 5:00pm for Resident #5 revealed: -Resident #5 came to the medication room and was bleeding from the back of his right arm and said that he cut himself; Resident #5's wound was cleaned. -Emergency Medical Services (EMS), Resident #5's responsible person and the Administrator were notified.</p> <p>Interview with the Manager on 06/04/25 at 9:30am revealed there were no accident/incident reports for Resident #5.</p> <p>Interview with the Adult Home Specialist on 06/06/25 at 9:31am revealed there was no incident/accident report for Resident #5 for the incident on 02/28/25. sent to DSS.</p>	D 451		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL002009	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 06/12/2025
--	--	---	---

NAME OF PROVIDER OR SUPPLIER HERITAGE CARE HOME OF TAYLORSVILLE	STREET ADDRESS, CITY, STATE, ZIP CODE 360 WOOD ROAD TAYLORSVILLE, NC 28681
---	--

(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 451	<p>Continued From page 137</p> <p>Interview with the local Emergency Services Dispatch unit on 06/06/25 at 9:45am revealed: -A call was received from the facility on 02/28/25 at 3:54pm and arrived at the facility at 4:03pm. -Resident #5 was transported to the hospital and arrived at 4:38pm.</p> <p>Interview with the Manager on 06/11/25 at 4:00pm revealed the medication aide (MA) should have sent an incident report to DSS by the end of the day if he was sent to the hospital.</p> <p>Interview with the Administrator on 06/11/25 at 5:49pm revealed if a resident was sent to the hospital, an incident report would need to be completed and sent to DSS and the guardian and Primary Care Provider should be notified.</p>	D 451		