Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 000	Initial Comments The Adult Care Licensure Section and the Alexander County Department of Social Services completed a follow up survey and complaint investigation from September 4, 2025 through September 9, 2025.	D 000		
D 131	10A NCAC 13F .0406(a) Test For Tuberculosis 10A NCAC 13F .0406 Test For Tuberculosis (a) Upon employment or moving into an adult care home, the administrator, all other staff, and any persons living in the adult care home shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205, which is hereby incorporated by reference, including subsequent amendments. Amended Eff. July 1, 2021 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled staff (Staff B) was tested for tuberculosis (TB) disease upon employment, in compliance with control measures adopted by the Commission for Public Health. The findings are: Review of Staff B's personnel record revealed: -Staff B was hired as a personal care aide (PCA) on 07/10/25. -There was documentation her first TB test was completed 08/07/25 and was read as negative on 08/09/25. -There was documentation a second TB test was completed 08/20/25 and read as negative on 08/22/25.	D 131	UPON THE START DATE OF ALL POTENTIAL STAFF MEMBERS A TB TEST WILL BE ALREADY ADMINISTERED. ALL TEST WILL BE READ BY AN RN BETWEEN 48-72 HOURS AFTERWARDS.	10/1/25

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE — (X6) DATE

Reviewed and Acknowledged by SSD on 11/10/25
Sharon Dunton RN

Liz Turner 11/3/2025
ASSISTANT ADMINISTRATOR

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 R-C 09/09/2025

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D 131	Continued From page 1 -There was no documentation a TB test was completed upon employment. Interview with the Administrator on 09/05/25 at 3:35pm and 09/09/25 at 3:20pm revealed: -She started work as Assistant Administrator on 08/18/25 and as Administrator on 09/03/25. -The Licensed Health Professional Support (LHPS) nurse completed TB tests for new hires when she visited the facility monthly. -She recently became aware that Staff B did not have a TB tests done upon employment. -She or the Resident Care Coordinator (RCC) were responsible to make sure new hires' TB tests were completed upon hire. -Her expectation was that new hires would have a negative TB test result prior to starting work. -If a new hire did not have documentation of a recent negative TB test, they would not be allowed to start work until it was completed.	D 131	A TRACKING SYSTEM WILL BE PUT INTO PLACE WHICH WILL INCLUDE THE FIRST DATE OF THE TB AND DATE OF READING ALONG WITH THE RESULTS. MUST BE WITHIN 48-72 HOURS AFTER ADMINISTERED. DONE BY THE ASSISTANT ADMINISTRATOR WEEKLY.	10/1/25
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. (B) 20 hours of aide duty for facilities with a	D 194	FACILITY WILL STAFF THE FOLLOWING FOR 7A-11P: 1 MED TECH 2 PCA'S ALONG WITH A COOK, HOUSEKEEPER, ADMIN OR ASSISTANT ADMIN. MT MANAGER/RCC WILL	10/1/25

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D 194	Continued From page 4 shifts and 1 of 15 second shifts sampled from 08/19/25 through 09/02/25. The findings are: 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. Observation during a tour 09/05/25 revealed the facility was not sprinklered for fire suppression. Review of the facility's census for 08/19/25 to 09/02/25 revealed there were between 21 and 40 residents which required 16 aide duty hours on first shift and second shift. Review of the facility's residents receiving Personal Care Services (PCS) revealed: -A total of 22 residents received PCS. -There were 3 of 3 sampled residents who received PCS. -There was 1 of 3 sampled residents who required extensive assistance with toileting, bathing, ambulation and transfers. -There were 2 of 3 sampled residents who required extensive assistance with grooming. 1. Review of the facility's census from 08/19/25 to 09/02/25 revealed there were 21-40 residents which required 16 aide duty hours on first shift. Review of the employee time punch detail report dated 08/22/25 revealed there was a total of 15 aide duty hours provided on first shift with a shortage of 1.0 aide duty hours. Review of the employee time punch detail report dated 08/29/25 revealed there was a total of	D 194	ALTERNATE WEEKENDS WITH ASSISTANT ADMIN. FACILITY WILL STAFF THE FOLLOWING FOR 11P-7A: 1 MEDTECH 1 PCA THIS WILL BE MONITORED BY THE ADMINISTRATOR ON A WEEKLY BASIS.	10/1/25

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D 194	Continued From page 5	D 194		

Continued From page 5

13.25 aide duty hours provided on first shift with a shortage of 2.75 aide duty hours.

Refer to interview with a personal care aide (PCA) on 09/09/25 at 2:25pm.

Refer to interview with a medication aide (MA) on 09/09/25 at 2:27pm.

Attempted telephone interview with the RCC on 09/09/25 at 3:30pm was unsuccessful.

Refer to interview with the Administrator on 09/05/25 at 8:50am and 09/09/25 at 3:25pm.

2. Review of the facility's census for 08/19/25 to 09/02/25 revealed there were 21-40 residents which required 16 aide duty hours on second shift.

Review of the employee time punch detail report dated 08/22/25 revealed there was a total of 15.25 aide duty hours on second shift with a shortage of 0.75 aide duty hours.

Refer to interview with a personal care aide (PCA) on 09/09/25 at 2:25pm.

Refer to interview with a medication aide (MA) on 09/09/25 at 2:27pm.

Attempted telephone interview with the RCC on 09/09/25 at 3:30pm was unsuccessful.

Refer to interview with the Administrator on 09/05/25 at 8:50am and 09/09/25 at 3:25pm.

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Interview with a personal care aide (PCA) on 09/09/25 at 2:25pm revealed:
-There was never less than two staff on duty in

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D 194	Continued From page 6	D 194		

the facility that she was aware of, since mid-August 2025.
-She usually started work at 6:00am and made rounds "first thing" to see each resident and assist them as needed.
-She made rounds on residents every two hours during her workday.

Interview with a medication aide (MA) on 09/09/25 at 2:27pm revealed:
-She had never worked when there were less than two staff working, and "there is usually more staff here."
-She did rounds on the residents when she started work at 6am and provided care as needed at that time.
-She made rounds on residents every two hours during her workday.

Interview with the Administrator on 09/05/25 at 8:50am and 09/09/25 at 3:25pm revealed:
-She was hired as Assistant Administrator on 08/18/25 and became Administrator 09/03/25.
-She believed the census was 26 when she became Administrator.
-Her expectations for staffing from 6:00am to 6:00pm were two PCAs and one MA.
-Her expectations for staffing from 6:00pm to 6:00am were two PCAs and one MA.
-The facility owner was doing the staffing after the previous Administrator left on 09/02/25 but it was now the responsibility of one MA, with the Resident Care Coordinator (RCC) as backup scheduler.

[Refer to tag 0273, 10A NCAC 13F .0902(b) Healthcare (Type B Violation)].

______

The facility failed to ensure qualified staff were present to meet the needs of all of the residents

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D 194	Continued From page 7 which placed the residents at risk that their personal and healthcare care needs could not be met. This failure is detrimental to the residents' health, safety and welfare and constitutes a Type B violation. ______ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/30/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2025.	D 194		
D 273	10A NCAC 13F .0902(b) Health Care 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. This Rule is not met as evidenced by: The Type A2 Violation is abated. Non-compliance continues. TYPE B VIOLATION Based on interviews and record reviews, the facility failed to ensure referral and follow-up for 3 of 3 sampled residents (#1, #2 and #3) related to a medication to decrease delusions and auditory hallucinations (Resident #1), for a discharge plan to a skilled nursing facility and laboratory bloodwork (Resident #2), and for a follow-up appointment to treat a right inguinal hernia (Resident #3). The findings are:	D 273	ALL APPOINTMENTS ARE SCHEDULED BY THE ASSISTANT ADMIN & MT MANAGER/RCC. ALL HOSPITAL DISCHARGED PAPERWORK IS REVIEWED AND INITIALED BY THE "VIEWER," WHICH IS THE ASSISTANT ADMIN OR RCC. ALL APPOINTMENTS ARE WRITTEN DOWN IN A PLANNER WHICH IS KEPT IN THE ADMIN	10/1/25

Division of Health Service Regulation

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D 273	Continued From page 8 1. Review of Resident #3's FL2 dated 05/12/25 revealed: -Diagnoses included schizophrenia and tobacco use. -Resident #3 was alert and oriented. -Resident #3 was ambulatory. Review of Resident #3's Resident Register dated 11/01/24 revealed an admission date of 11/01/24. Review of Resident #3's discharge instructions from the emergency department (ED) on 07/22/25 revealed: -Resident #3 had diagnoses of abdominal pain and right inguinal hernia. -Resident #3 had a follow-up appointment within one week to a general surgeon. -Resident #3 had a follow-up with his Primary Care Physician (PCP) in two-three days. Review of Resident #3's record revealed there was no documentation of a visit with the surgeon after the ED discharge on 07/22/25. Review of Resident #3's discharge instructions from the ED on 08/31/25 revealed: -A follow-up appointment was scheduled with a general surgeon the next day on 09/01/25. -Resident #3 complained of periodic pain on the right side of his abdomen. -Resident #3 was given a prescription for hydrocodone-acetaminophen 5-325mg one tablet by mouth every 8 hours as needed for pain. -Resident #3 was to keep his appointment with the general surgeon on 09/01/25. Review of Resident 3's discharge instructions on 09/01/25 with the general surgeon revealed resident #3 had a surgery date of 09/05/25.	D 273	OFFICE AND THEN ALL ALL APPOINTMENTS ARE TRANSCRIBED TO THE GOOGLE DOC TOOL WHICH IS AVAILABLE & VIEWABLE BY MANAGEMENT AND OWNERS. THE CALENDAR IS PRINTED OUT & POSTED IN MED ROOM, PCA ROOM, BREAKROOM AND ADMIN OFFICE & RCC OFFICE. APPOINTMENT LOG & CALENDER IS REVIEWED DAILY. THIS WILL BE MONITORED BY THE ASSISTANT ADMINISTRATOR ON A DAILY BASIS.	10/1/25

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D 273	Continued From page 9	D 273		

Continued From page 9

Review of Resident #3's discharge documentation from 09/05/25 revealed:
-Diagnoses included unilateral inguinal hernia, without obstruction or gangrene.
-Resident #3 had a follow up appointment with the general surgeon on 09/17/25 at 1:30pm.

Interview with Resident #3 on 09/04/25 at 10:40am revealed:
-He was having surgery tomorrow on his hernia 09/05/25.
-He could not remember how long he had the hernia.

Telephone interview with Resident #3's guardian on 09/04/25 at 12:10pm revealed:
-The facility failed to take Resident #3 to the follow up appointment until sometime in September 2025.
-Resident #3 got agitated with the guardian if she asked too many questions so she did not see him as often as she would like and the facility made her aware of any issues going on with him.

Telephone interview with Resident #3's PCP on 09/09/25 at 9:37am revealed:
-She took over the care of Resident #3 on 06/01/25.
-Resident #3 refused many of his medications and she received a copy of the Medication Administration Record (MAR) at the end of each month so she was able to see what he took or refused.
-She was not aware of the missed appointment with the surgeon.
-Resident #3 would not say too much to her except what medications he took and he could not sleep.
-She was not aware Resident #3 did not attend

Division of Health Service Regulation

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D 273	Continued From page 10	D 273		

his follow up appointment with the general surgeon.

Telephone interview with Resident #3's general surgeon on 09/09/25 at 8:47am revealed:
-He was the general surgeon who performed a unilateral inguinal hernia on Resident #3 on 09/05/25.
-The surgery would have been emergent if Resident #3 was impacted or if the hernia had become strangulated, but it did not.
-He would have preferred for Resident #3 to follow his orders for an appointment one week after he was seen in the ED on 07/22/25.
-Resident #3 had a follow up appointment with him on 09/17/25.

Interview with the Administrator on 09/04/25 at 1:10pm revealed:
-She started at the facility on 08/18/25 as the Assistant Administrator and became the Administrator on 09/03/25.
-Resident #3 came to see her on her second week at the facility and showed her his hernia.
-She called Resident #3's PCP to discuss what Resident #3 showed her, but the PCP would not talk with her because the Former Administrator wanted everything to go through her.
-She reviewed Resident #3's chart and found a copy of the 07/22/25 ED discharge notes and made the appointment for Resident #3 for 09/03/25.

Interview with the Administrator on 09/09/25 at 3:20pm revealed:
-She started at the facility on 08/18/25 as the Assistant Administrator and became the Administrator on 09/03/25.
-The RCC was responsible for the discharge paperwork being completed since 09/03/25 and

D 273 | Continued From page 11 | D 273

the Administrator would be a second set of eyes.
-Chart audits are being completed weekly on 3-4 random charts with all charts completed monthly.
-She was aware of the missed appointments when she was the Assistant Administrator and was auditing the charts and made the Former Administrator aware.
-The Former Administrator stated she would handle it.

2. Review of Resident #1's current FL2 dated 08/20/25 revealed diagnoses included major depression, impulsive control disorder and schizoaffective disorder.

Review of Resident #1 Primary Care Provider's (PCP) orders dated 06/09/25 and 09/02/25 revealed there was an order of Perseris ER (extended release) 120mg, inject 120mg under the skin monthly (a medication to treat schizophrenia).

Review of Resident #1's September 2025 electronic Medication Administration Record (eMAR) revealed no documentation Perseris ER 120mg was administered to Resident #1.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Perseris ER 120mg was last dispensed for Resident #1 on 01/06/25.
-The pharmacy was waiting on a prior authorization from Resident #1's PCP since February 2025.
-If Resident #1 did not receive the Perseris ER 120mg injection monthly he was at risk for increased psychotic episodes.

Telephone interview with Resident #1's PCP on

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D 273	Continued From page 12	D 273		

09/09/25 at 9:37am revealed:
-She was notified today (09/09/25) Resident #1 needed a prior authorization for Perseris ER 120mg for the insurance company to pay for the medication.
-She was not aware Perseris ER 120mg was not administered to Resident #1 since February 2025.
-Resident #1's Mental Health Provider (MHP) ordered Perseris ER 120mg monthly for Resident #1 and may have been notified the medication was not administered to the resident since around February 2025.

Telephone interview with Resident #1's MHP on 09/09/25 at 10:09am revealed:
-She was notified about a month ago Resident #1 required a prior authorization for the insurance company to pay for the Perseris ER 120mg monthly.
-She had been working on the prior authorization since being made aware Resident #1 was not receiving the medication since around February 2025.
-Resident #1 could experience increased delusions and auditory hallucinations if Perseris ER 120mg was not administered as ordered.

Interview with a medication aide (MA) on 09/09/25 at 11:14am revealed:
-She accidentally documented she administered Perseris ER 120mg to Resident #1 on 08/01/25 but did not because it was not available to administer.
-She was unsure when Perseris ER 120mg was last available to administer to Resident #1 but it had not been available "for a long time".
-MAs were to notify the Resident Care Coordinator (RCC) or the Administrator if a medication was not available for administration.

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D 273	Continued From page 13 Interview with the Administrator on 09/09/25 at 3:20pm revealed: -She began working at the facility as the Assistant Administrator around 08/18/25 and became the Administrator on 09/03/25. -She was not aware Perseris ER 120mg monthly was not being administered monthly to Resident #1. -She contacted the pharmacy yesterday (09/08/25) and was informed Perseris ER 120mg was last dispensed for Resident #1 in January 2025 because the resident's insurance would not pay for it. -The MAs were to notify the RCC if a medication was not available for administration. 3. Review of Resident #2's current FL2 dated 08/26/25 revealed diagnoses included hemiplegia (weakness or paralysis on one side of the body) following cerebrovascular disease (conditions that affect blood flow to the brain) and cerebral amyloid angiopathy (protein buildup in the arteries of the brain). a. Review of Resident #2's current FL2 dated 08/26/25 revealed the discharge plan was for skilled nursing facility (SNF). Review of Resident #2's Primary Care Provider's (PCP) order dated 07/22/25 revealed there was an order for SNF placement. Review of Resident #2's significant change care plan dated 06/03/25 revealed: -Resident #2 was verbally and physically abusive. -Resident #2 resisted care and had disruptive behaviors. -Resident #2 had no mobility in his legs, was dependent with transfers and utilized a motorized	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 273	Continued From page 14	D 273		

wheelchair for mobility.
-Resident #2 was dependent with toileting, bathing, grooming.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 needed to be in a SNF because he had increased care needs, especially with transfers and mobility.
-She placed all new orders in the electronic chart system and also verbally informed the RCC in the facility of any new orders.
-There may have been miscommunication between the previous Resident Care Coordinator (RCC) and the current RCC with Resident #2's placement to a SNF.

Interview with the RCC on 09/08/25 at 4:04pm revealed:
-Resident #2 was a 2-3 person assist with activities of daily living (ADL) and needed to be transferred to a SNF.
-She had Resident #2's PCP complete a new FL2 indicating the discharge plan for Resident #2 was a SNF.
-She was working on placement for Resident #2 to a SNF but she had not yet found placement.

Interview with the Administrator on 09/05/25 at 11:06am revealed:
-She was notified by the previous RCC on 08/26/25 that Resident #2 was to be placed in a SNF.
-The previous RCC said there was a updated FL2 for Resident #2 for SNF placement but the Administrator was not able to locate it.
-The RCC was responsible for getting an updated FL2 and finding placement for a SNF for Resident #2.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

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

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D 273	Continued From page 15	D 273		

b. Review of Resident #2's record revealed:
-There was an order dated 07/30/25 for the resident to have laboratory (lab) blood tests completed including a complete blood count (CBC), comprehensive metabolic panel (CMP), fasting lipid panel, thyroid stimulating hormone (TSH) with free T4, Hemoglobin A1C and valproic acid level.
-There were no results for the lab tests dated 07/30/25.

Interview with the Administrator on 09/05/25 at 3:30pm revealed:
-She called the lab today (09/05/25) and was informed they had not received Resident #2's lab orders dated 07/30/25.
-The Primary Care Provider (PCP) and the Mental Health Provider (MHP) were to send all lab orders directly to the lab.
-The facility should have followed up on all resident lab orders to ensure the order was completed and the facility received the lab results.

The facility failed to ensure 3 residents had referrals made when they did not schedule a follow up appointment with the surgeon for repair of a right inguinal hernia (Resident #3), notify the provider of missed doses of a medication to decrease delusions and auditory hallucinations (Resident #1) and placement was not followed up for a resident who required a SNF (Resident #2). 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 09/09/25 for this violation.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 273	Continued From page 16 THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED OCTOBER 24, 2025.	D 273		
D 317	10A NCAC 13F .0905 (d) Activities Program 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. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to provide at least 14 hours per week of planned group activities for residents residing at the facility. The findings are: Review of the facility's census on 09/05/25 revealed there were 27 residents. Observations during a facility tour 09/05/25 at 9:30am,10:30am and 2:00pm revealed: -There was an activities calendar posted across from the day room that did not include the current month, year or specific times of listed activities. -No activities were observed being conducted in the day room, halls or outside the facility. Observation of the facility on 09/08/25 at 10:25am revealed: -There was a new activities calendar posted across from the day room dated September 2025, that included 4 to 6 activities per day.	D 317	THE FACILITY HAS HIRED AN ACTIVITY DIRECTOR. WE HAVE IMPLENTED AN ACTIVITY BINDER WHICH CONSISTS OF THE NAME OF THE ACTIVITY AND RESIDENT WHO PARTICIPATED. THERE'S ALSO A NEW CALENDAR POSTED ON THE WALL ACROSS FROM THE DAYROOM. IF AN ACTIVITY IS SUBSTITUTED ON IT IS DOCUMENTED ON THE CALENDAR AND LOG BOOK.	10/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 317	Continued From page 17 -One resident was watching television in the day room. -The "Roll and Stroll" activity was scheduled for 10:00am and several residents were observed walking around the outside of the building with the new Activities Director. Observation of the facility on 09/08/25 at 3:35pm revealed no activities were occurring. Observation of the facility on 09/09/25 at 10:30am revealed four residents participating in a corn hole game outside with the Activities Director. Observation of the facility on 09/09/25 at 3:30pm revealed no activities were occurring. Interview with a resident on 09/05/25 at 2:10pm revealed: -There had not been many activities offered at the facility but a new Activity Director had been hired. -She enjoyed doing activities and would participate in them. -She was sometimes notified by staff when activities were scheduled. Interview with a second resident on 09/09/25 at 2:25pm revealed: -He did not recall many activities being provided at the facility. -He did not like to participate in activities when offered. -Staff sometimes notified the residents when activities were to occur. -He believed the facility had hired a new Activity Director and "activities stuff is going on" at the facility now. Interview with a personal care aide (PCA) on 09/08/25 at 11:00am revealed:	D 317	ALL RESIDENTS ARE BEING ASKED TO PARTICIPATE WITH ACTIVITIES. THE HAVE ALSO BEEN ASKED ABOUT THEIR LIKES AND DISLIKES.	10/1/25

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	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 317	Continued From page 18 -The PCAs and housekeeping staff provided activities for the residents before the Activity Director was hired. -Activities included movies, devotions, singing and corn hole but they were not done every day. Interview with the new Activity Director on 09/08/25 at 10:10am and 12:50pm revealed: -Her first day at the facility was 09/06/25 (two days ago). -She has spent time getting to know the residents and asking their activity preferences. -She did outside walks and some small activities including easy crafts with the residents. -She was hired to work four hours/day, five days a week but believed her work hours would be increasing. Interview with the Administrator on 09/05/25 at 10:35am revealed: -She was aware the current activities calendar was not updated or accurate. -Staff or the Resident Care Coordinator (RCC) would organize activities as their schedules permitted but they did not occur throughout each day. -A new Activity Director had been hired and would start tomorrow (09/06/25). -Her expectation was that at least 14 hours of activities would be scheduled a week and residents would be aware of what was scheduled.	D 317		
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	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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D 358	Continued From page 19 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: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 3 of 3 sampled residents (#1, #2 and #3) related to medications for anxiety, depression, high blood pressure, swelling, involuntary movements, underactive thyroid gland, mood disorder (#1), dry skin, elevated cholesterol levels, clot prevention, mood disorder, fluid retention, high blood pressure, elevated blood sugar levels, urinary retention (#2), pain and agitation (#3). The findings are: 1. Review of Resident #1's current FL2 dated 08/20/25 revealed diagnoses included hypertension, hypothyroidism, major depression, impulsive control disorder and schizoaffective disorder. a. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for buspirone (a medication to treat anxiety) 10mg one tablet twice daily. Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for buspirone 10mg one tablet twice daily scheduled at 6:00am and 6:00pm. -There was no documentation buspirone 10mg one tablet was administered at 6:00am on	D 358	MT MANAGER/RCC, ASST ADMINISTRATOR AND ADMINISTRATOR WILL CONDUCT WEEKLY CART AND MAR AUDITS. MT MANAGER/ RCC WILL REVIEW THE MAR'S DAILY. IF 3 CONSECUTIVE REFUSALS ~~AND~~ THE PROVIDER WILL BE NOTIFIED.	10/1/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

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

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D 358	Continued From page 20 08/25/25 and 08/28/25, and at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 through 08/31/25 with no explanation. -There was documentation on 08/11/25 at 6:00am buspirone 10mg one tablet was not administered to Resident #1 due to the medication being on order. -There was documentation on 08/01/25 at 6:00pm and 08/27/25 at 6:00am buspirone 10mg one tablet was not administered to Resident #1 due to the resident refusing the medication. -There were 10 of 62 opportunities buspirone 10mg was not documented as administered to Resident #1. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for buspirone 10mg one tablet twice daily scheduled at 6:00am and 6:00pm. -There was no documentation buspirone 10mg one tablet was administered at 6:00am and 6:00pm on 09/01/25 with no explanation. -There were 2 of 7 opportunities buspirone 10mg was not documented as administered to Resident #1. Review of Resident #1's medication release form dated 09/04/25 revealed buspirone 10mg eighteen tablets were released with Resident #1's medications upon his discharge. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed: -Resident #1 had an order for buspirone 10mg, one tablet twice daily. -Buspirone 10mg one tablet twice daily was given to Resident #1 for anxiety. -The Pharmacy had issues with the facility's	D 358	MED TECHS WILL BE REQUIRED TO FILL OUT A REFUSAL FORM EACH TIME A MEDICATION IS REFUSED BY A RESIDENT. THIS WILL BE MONITORED BY THE RCC DAILY.	10/1/25

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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D 358	Continued From page 21 computers and new software had to be applied on another computer for the facility around the end of August 2025. -The Pharmacy dispensed 60 tablets of buspirone 10mg on 07/08/25 and 08/11/25. -If buspirone 10mg, one tablet twice daily was not administered to Resident #1 as prescribed he could experience increased anxiety. Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could be more anxious if he did not receive buspirone 10mg as ordered. Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm. Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm. Refer to the interview with the Administrator on 09/09/25 at 3:20pm. b. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for escitalopram (a medication to treat depression) 10mg one tablet once daily. Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed: -There was an entry for escitalopram 10mg one tablet once daily scheduled at 6:00am. -There was no documentation escitalopram 10mg one tablet was administered at 6:00am on 08/25/25 and 08/28/25 with no explanation.	D 358		

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	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 358	Continued From page 22 -There was documentation on 08/10/25 and 08/11/25 at 6:00am escitalopram 10mg one tablet was not administered to Resident #1 due to the medication being on order. -There was documentation on 08/27/25 at 6:00am escitalopram 10mg one tablet was not administered to Resident #1 due to the resident refusing the medication. -There were 2 of 31 opportunities escitalopram 10mg was not documented as administered to Resident #1. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for escitalopram 10mg one tablet once daily scheduled at 6:00am. -There was no documentation escitalopram 10mg one tablet was administered at 6:00am 09/01/25 with no explanation. -There was 1 of 4 opportunities escitalopram 10mg was not documented administered to Resident #1. Review of Resident #1's medication release form dated 09/04/25 revealed escitalopram 10mg, eight tablets were released with Resident #1's medications upon his discharge. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed: -Resident #1 had an order for escitalopram 10mg one tablet daily. -Escitalopram 10mg one tablet daily was given to Resident #1 for depression. -The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025. -The Pharmacy dispensed 30 tablets of	D 358	ADMINISTRATOR WILL CONDUCT A FULL AUDIT ON BOTH CARTS EACH TUESDAY. THE AUDITS WILL INCLUDE THE FOLLOWING: 1. RESIDENT'S NAME 2. A LIST OF CURRENT MEDICATION 3. CHECK LABELS ON MEDICATIONS INCLUDING EYE DROPS, PATCHES, INHALERS, CREAMS, OINTMENTS, EAR DROPS AND MEDICATION CARDS. 4. DATES 5. QUANTITY 6. CLEANLINESS & ORGANIZATION OF MED CARTS INSIDE & OUT. 7. ALL ANTIBIOCTICS WILL BE CHECKED TO ENSURE THEY ARE BEING GIVEN AS PRESCRIBED AND TO ENSURE NO DOSES ARE MISSED. THIS WILL BE DONE DAILY. (ALL ANTIBIOTICS) ACC WILL CONDUCT IN THE ABSENCE OF ADMINISTRATOR	10/28/25

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 358	Continued From page 23	D 358	ALL NEW ORDERS WILL BE REVIEWED BY RCC & ASSISTANT ADMIN ONCE RECIEVED. AFTER THE ORDER NEEDS & INSTRUCTIONS HAVE BEEN MET, RCC & ASSIST. ADMIN WILL INITIAL & DATE. THIS WILL PREVENT ERRORS.	10/20/25

escitalopram 10mg on 07/08/25 and 08/11/25.
-If escitalopram 10mg, one tablet daily was not administered to Resident #1 as prescribed he could experience increased depression.

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could experience increased depression if he did not receive escitalopram 10mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

c. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for hydrochlorothiazide (HCTZ) (a medication to treat hypertension and swelling from excess fluid) 12.5mg one tablet once daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for HCTZ 12.5mg one tablet once daily scheduled at 6:00am.
-There was no documentation HCTZ 12.5mg one tablet was administered at 6:00am on 08/25/25 and 08/28/25 with no explanation.
-There was documentation on 08/10/25 and 08/11/25 at 6:00am HCTZ 12.5mg one tablet was not administered to Resident #1 due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

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

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D 358	Continued From page 24	D 358		

medication being on order.
-There was documentation on 08/27/25 at 6:00am HCTZ 12.5mg one tablet was not administered to Resident #1 due to the resident refusing the medication.
-There were 2 of 31 opportunities HCTZ 12.5mg was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for HCTZ 12.5mg one tablet once daily scheduled at 6:00am.
-There was no documentation HCTZ 12.5mg one tablet was administered at 6:00am 09/01/25 with no explanation.
-There was 1 of 4 opportunities HCTZ 12.5mg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed HCTZ 12.5mg nine tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for HCTZ 12.5mg one tablet daily.
-HCTZ 12.5mg one tablet daily was given to Resident #1 to decrease fluid buildup and swelling.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 30 tablets of HCTZ 12.5mg on 07/08/25 and 08/11/25.
-If HCTZ 12.5mg, one tablet daily was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 25	D 358		

administered to Resident #1 as prescribed he could experience increased swelling from fluid buildup.

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could have increased blood pressure if he did not receive HCTZ 12.5mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

d. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for Ingrezza (a medication to treat involuntary movements) 40mg one tablet once daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for Ingrezza 40mg one capsule once daily scheduled at 6:00pm.
-There was no documentation Ingrezza 40mg one capsule was administered at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 to 08/31/25 with no explanation.
-There was documentation on 08/22/25 and 08/23/25 at 6:00pm Ingrezza 40mg one capsule was not administered to Resident #1 due to the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 26	D 358		

medication being on order.
-There was documentation on 08/01/25 at 6:00pm Ingrezza 40mg one capsule was not administered to Resident #1 due to the resident refusing the medication.
-There were 8 of 31 opportunities Ingrezza 40mg was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for Ingrezza 40mg one capsule once daily scheduled at 6:00pm.
-There was no documentation Ingrezza 40mg one capsule was administered at 6:00pm 09/01/25 with no explanation.
-There was 1 of 4 opportunities Ingrezza 40mg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed Ingrezza 40mg twenty-four tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for Ingrezza 40mg one capsule at bedtime.
-Ingrezza 40mg one capsule daily was given to Resident #1 to decrease involuntary lip and hand movements
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 30 capsules of Ingrezza 40mg on 07/14/25 and 08/25/25.
-If Ingrezza 40mg, one capsule daily was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 27	D 358		

administered to Resident #1 as prescribed he could experience increased involuntary lip and hand movements.

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could have increased shaking, fatigue or dry mouth if he did not receive Ingrezza 40mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

e. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for levothyroxine (a medication to treat an underactive thyroid gland) 50mcg one tablet once daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for levothyroxine 125mcg once tablet daily scheduled at 6:00am.
-There was no documentation levothyroxine 125mcg once tablet was administered at 6:00am on 08/25/25 and 08/28/25 with no explanation.
-There was documentation on 08/10/25 and 08/11/25 at 6:00am levothyroxine 125mcg once tablet was not administered to Resident #1 due to the medication being on order.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 28	D 358		

-There was documentation on 08/27/25 at 6:00am levothyroxine 125mcg once tablet was not administered to Resident #1 due to the resident refusing the medication.
-There were 2 of 31 opportunities levothyroxine 125mcg once tablet was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for levothyroxine 125mcg once tablet once daily scheduled at 6:00am.
-There was no documentation levothyroxine 125mcg once tablet was administered at 6:00am 09/01/25 with no explanation.
-There was 1 of 4 opportunities levothyroxine 125mcg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed levothyroxine 50mcg eight tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for levothyroxine 50mcg one tablet daily.
-Levothyroxine 50mcg one tablet daily was given to Resident #1 for low thyroid hormone levels.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 30 tablets of levothyroxine 50mcg on 07/08/25 and 08/11/25.
-If levothyroxine 50mcg, one tablet daily was not administered to Resident #1 as prescribed he could experience weight gain or swelling.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 29	D 358		

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could experience tiredness or have weight gain if he did not receive levothyroxine 125mcg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

f. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for lorazepam (a medication to treat anxiety) 0.5mg one tablet twice daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for lorazepam 0.5mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation lorazepam 0.5mg one tablet was administered at 6:00am on 08/25/25 and 08/28/25, and at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 through 08/31/25 with no explanation.
-There was documentation on 08/01/25 at 6:00pm and 08/27/25 at 6:00am lorazepam 0.5mg one tablet was not administered to Resident #1 due to the resident refusing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 30	D 358		

-There were 10 of 62 opportunities lorazepam 0.5mg was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for lorazepam 0.5mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation lorazepam 0.5mg one tablet was administered at 6:00am and 6:00pm on 09/01/25 with no explanation.
-There were 2 of 7 opportunities lorazepam 0.5mg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed lorazepam 0.5mg four tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for lorazepam 0.5mg one tablet twice daily.
-Lorazepam 0.5mg one tablet twice daily was given to Resident #1 to decrease anxiety.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 60 tablets of lorazepam 0.5mg on 06/25/25 and 07/30/25.
-If lorazepam 0.5mg one tablet twice daily was not administered to Resident #1 as prescribed he could experience increased anxiety.

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 31	D 358		

have increased anxiety if he he did not receive lorazepam 0.5mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

g. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for metoprolol (a medication to treat high blood pressure) 50mg one tablet twice daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for metoprolol 50mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation metoprolol 50mg one tablet was administered at 6:00am on 08/25/25 and 08/28/25, and at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 through 08/31/25 with no explanation.
-There was documentation on 08/11/25 at 6:00am metoprolol 50mg once tablet was not administered to Resident #1 due to the medication being on order.
-There was documentation on 08/01/25 at 6:00pm and 08/27/25 at 6:00am metoprolol 50mg one tablet was not administered to Resident #1 due to the resident refusing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 32 D 358

-There were 10 of 62 opportunities metoprolol 50mg was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for metoprolol 50mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation metoprolol 50mg one tablet was administered at 6:00am and 6:00pm on 09/01/25 with no explanation.
-There were 2 of 7 opportunities metoprolol 50mg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed metoprolol 50mg eighteen tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for metoprolol 50mg one tablet twice daily.
-Metoprolol 50mg one tablet twice daily was given to Resident #1 to decrease his blood pressure.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 60 tablets of metoprolol 50mg on 07/08/25 and 08/11/25.
-If metoprolol 50mg, one tablet twice daily was not administered to Resident #1 as prescribed he could experience elevated blood pressure.

Telephone interview with Resident #1's PCP on 09/09/25 at 9:37am revealed Resident #1 could

D 358 Continued From page 33 D 358

have elevated blood pressure if he did not receive metoprolol 50mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

h. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for risperidone (a medication to treat mood) 2mg one tablet twice daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for risperidone 2mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation risperidone 2mg one tablet was administered at 6:00am on 08/25/25 and 08/28/25, and at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 through 08/31/25 with no explanation.
-There was documentation on 08/11/25 at 6:00am risperidone 2mg once tablet was not administered to Resident #1 due to the medication being on order.
-There was documentation on 08/01/25 at 6:00pm and 08/27/25 at 6:00am risperidone 2mg one tablet was not administered to Resident #1 due to the resident refusing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 34	D 358		

-There were 10 of 62 opportunities risperidone 2mg was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for risperidone 2mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation risperidone 2mg one tablet was administered at 6:00am and 6:00pm on 09/01/25 with no explanation.
-There were 2 of 7 opportunities risperidone 2mg was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed risperidone 2mg eighteen tablets were released with Resident #1's medications upon his discharge.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for risperidone 2mg one tablet twice daily.
-Risperidone 2mg one tablet twice daily was given to Resident #1 to decrease psychotic outbursts.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 60 tablets of risperidone 2mg on 07/08/25 and 08/11/25.
-If risperidone 2mg, one tablet twice daily was not administered to Resident #1 as prescribed he could experience increased psychotic outbursts.

Telephone interview with Resident #1's Mental

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 35	D 358		

Health Provider (MHP) 09/09/25 at 10:09am revealed Resident #1 could have psychotic episodes if he did not receive risperidone 2mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

i. Review of Resident #1's physician's orders dated 06/09/25 and 09/02/25 revealed there was an order for valproic acid (a medication to treat mood) 250mg/5ml solution 10ml twice daily.

Review of Resident #1's August 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for valproic acid 250mg/5ml solution 10ml twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation valproic acid 250mg/5ml solution 10ml was administered at 6:00am on 08/25/25 and 08/28/25 and at 6:00pm on 08/16/25, 08/20/25, 08/25/25, 08/26/25 and from 08/28/25 through 08/31/25 with no explanation.
-There was documentation on 08/01/25 at 6:00pm and 08/27/25 at 6:00am valproic acid 250mg/5ml solution 10ml was not administered to Resident #1 due to the resident refusing the medication.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 36	D 358		

-There were 10 of 62 opportunities valproic acid 250mg/5ml solution 10ml was not documented as administered to Resident #1.

Review of Resident #1's September 2025 eMAR revealed:
-There was an entry for valproic acid 250mg/5ml solution 10ml twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation valproic acid 250mg/5ml solution 10ml was administered at 6:00am and 6:00pm on 09/01/25 with no explanation.
-There was documentation on 09/02/25 at 6:00pm and on 09/03/25 at 6:00am valproic acid 250mg/5ml 10ml was not administered to Resident #1 due to the medication being on order.
-There were 2 of 7 opportunities valproic acid 250mg/5ml solution 10ml was not documented as administered to Resident #1.

Review of Resident #1's medication release form dated 09/04/25 revealed there was no documentation valproic acid 250mg/5ml solution was released with Resident #1's medications upon his discharge.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #1 revealed there was a full bottle of valproic acid 250mg/5ml 473ml dispensed on 09/03/25 available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #1 had an order for valproic acid 250mg/5ml, 10ml twice daily.
-Valproic acid 250mg/5ml, 10ml tablet twice daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 37	D 358		

was given to Resident #1 to treat mood issues.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed valproic acid 250mg/5ml 473ml (24-day supply) on 07/09/25 and 08/04/25 and 09/03/25.
-If valproic acid 250mg/5ml, 10ml twice daily was not administered to Resident #1 as prescribed he could experience mood issues.

Telephone interview with Resident #1's Mental Health Provider (MHP) 09/09/25 at 10:09am revealed Resident #1 could have increased mood swings if he did not receive valproic acid 250mg/5ml 10ml as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

2. Review of Resident #2's current FL2 dated 08/20/25 revealed diagnoses included hyperlipidemia, diabetes mellitus type 2, benign prostatic hyperplasia and hemiplegia following cerebrovascular accident (stroke).

a. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for ammonium lactate 12% cream (a medication to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 38	D 358		

treat dry skin) apply to both lower legs, ankles and feet daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for ammonium lactate 12% cream apply to both lower legs, ankles and feet daily scheduled at 6:00pm.
-There was no documentation ammonium lactate 12% cream was applied on 09/01/25 with no explanation.
-There was 1 of 3 opportunities ammonium lactate 12% cream was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was no ammonia lactate 12% available for administration on the medication cart.

Interview with a medication aide (MA) on 09/05/25 at 11:02am revealed:
-Ammonia lactate 12% was not available for administration for Resident #2 but had already been ordered.
-Resident #2 frequently refused medications and his PCP was aware of his refusals.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for ammonium lactate 12% cream, apply to both legs daily.
-Ammonia lactate 12% cream was prescribed for Resident #2 to treat dry skin.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 39	D 358		

-The Pharmacy dispensed ammonia lactate 12% cream 385gm for Resident #2 on 10/11/24 and that day (09/05/25) to treat dry skin.
-Ammonia lactate 12% 385gm should last about 30 days if applied daily.
-If ammonia lactate 12% cream was not applied to both legs as prescribed, Resident #2 could experience dry skin.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a MA on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

b. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for atorvastatin (a medication to treat high cholesterol levels) 80mg one tablet daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for atorvastatin 80mg one tablet daily scheduled at 6:00pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 40	D 358		

-There was no documentation atorvastatin 80mg one tablet was administered on 09/01/25 with no explanation.
-There was 1 of 3 opportunities atorvastatin 80mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was atorvastatin 80mg, 21 tablets available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for atorvastatin 80mg one tablet daily.
-Atorvastatin 80mg one tablet daily was given to Resident #2 to treat high cholesterol levels.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed atorvastatin 80mg 31 tablets for Resident #2 on 08/11/25 and 09/05/25.
-If atorvastatin 80mg one tablet daily was not administered to Resident #2 as prescribed he could have increased cholesterol levels.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 41	D 358		

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

c. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for clopidogrel (a medication to prevent blood clots) 75mg one tablet daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for clopidogrel 75mg one tablet daily scheduled at 6:00am.
-There was no documentation clopidogrel 75mg one tablet was administered on 09/01/25 with no explanation.
-There was 1 of 3 opportunities clopidogrel 75mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was clopidogrel 75mg, 3 tablets available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for clopidogrel 75mg one tablet daily.
-Clopidogrel 75mg one tablet daily was given to Resident #2 to treat decrease the risk of a blood clot.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 42	D 358		

-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed clopidogrel 75mg 31 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If clopidogrel 75mg one tablet daily was not administered to Resident #2 as prescribed he could have increased risk of a blood clot.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

d. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for divalproex (a medication to treat mood) 250mg one tablet twice daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:

(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 43 -There was an entry for divalproex 250mg one tablet twice daily scheduled at 6:00am and 6:00pm. -There was no documentation divalproex 250mg one tablet was administered on 09/01/25 at 6:00am and 6:00pm with no explanation. -There were 2 of 7 opportunities divalproex 250mg one tablet was not documented as administered to Resident #2. Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was divalproex 250mg, 25 tablets available for administration on the medication cart. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed: -Resident #2 had an order for divalproex 250mg one tablet twice daily. -Divalproex 250mg one tablet twice daily was given to Resident #2 to treat mood. -The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025. -The Pharmacy dispensed divalproex 250mg 62 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25. -If divalproex 250mg one tablet twice daily was not administered to Resident #2 as prescribed he could have increased risk of mood issues. Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed: -Resident #2 frequently refused his medications. -It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 44 Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm. Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm. Refer to the interview with the Administrator on 09/09/25 at 3:20pm. e. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for hydrochlorothiazide (HCTZ) (a medication to treat fluid retention) 12.5mg one tablet daily. Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed: -There was an entry for HCTZ 12.5mg one tablet daily scheduled at 6:00am. -There was no documentation HCTZ 12.5mg one tablet was administered on 09/01/25 at 6:00am with no explanation. -There was 1 of 4 opportunities HCTZ 12.5mg one tablet was not documented as administered to Resident #2. Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was HCTZ 12.5mg, 3 tablets available for administration on the medication cart. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed: -Resident #2 had an order for HCTZ 12.5mg one	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 45	D 358		

tablet daily.
-HCTZ 12.5mg one tablet daily was given to Resident #2 to treat swelling.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed HCTZ 12.5mg 31 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If HCTZ 12.5mg one tablet daily was not administered to Resident #2 as prescribed he could have increased swelling.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

f. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for lisinopril (a medication to treat high blood pressure) 40mg one tablet daily.

(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 46	D 358		

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for lisinopril 40mg one tablet daily scheduled at 6:00am.
-There was no documentation lisinopril 40mg one tablet was administered on 09/01/25 at 6:00am with no explanation.
-There was 1 of 4 opportunities lisinopril 40mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was lisinopril 40mg, 3 tablets available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for lisinopril 40mg one tablet daily.
-Lisinopril 40mg one tablet daily was given to Resident #2 to lower his blood pressure.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed lisinopril 40mg 31 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If lisinopril 40mg one tablet daily was not administered to Resident #2 as prescribed he could have increased blood pressure.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 47	D 358		

because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

g. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for metformin (a medication to lower blood sugar levels) 1000mg one tablet twice daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for metformin 1000mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation metformin 1000mg one tablet was administered on 09/01/25 at 6:00am and 6:00pm with no explanation.
-There were 2 of 7 opportunities metformin 1000mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was metformin 1000mg, 85 tablets available for administration on the medication cart.

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ____ B. WING ____	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 48	D 358		

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for metformin 1000mg one tablet twice daily.
-Metformin 1000mg one tablet twice daily was given to Resident #2 to lower his blood sugar levels.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed metformin 1000mg 62 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If metformin 1000mg one tablet twice daily was not administered to Resident #2 as prescribed he could have increased blood sugar levels.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 49	D 358		

h. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for paroxetine (a medication to treat mood) 20mg one tablet daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for paroxetine 20mg one tablet daily scheduled at 6:00am.
-There was no documentation paroxetine 20mg one tablet was administered on 09/01/25 at 6:00am with no explanation.
-There was 1 of 4 opportunities paroxetine 20mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was paroxetine 20mg, 33 tablets available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for paroxetine 20mg one tablet daily.
-Paroxetine 20mg one tablet daily was given to Resident #2 to lower anxiety.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed paroxetine 20mg 31 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If paroxetine 20mg one tablet daily was not administered to Resident #2 as prescribed he could have increased anxiety.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 50	D 358		

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.
Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

i. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for risperidone (a medication to treat mood) 1mg one tablet twice daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for risperidone 1mg one tablet twice daily scheduled at 6:00am and 6:00pm.
-There was no documentation risperidone 1mg one tablet was administered on 09/01/25 at 6:00am and 6:00pm with no explanation.
-There were 2 of 7 opportunities risperidone 1mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 51	D 358		

there was risperidone 1mg, 85 tablets available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for risperidone 1mg one tablet twice daily.
-Risperidone 1mg one tablet twice daily was given to Resident #2 to decrease risk of delusions.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed risperidone 1mg 62 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If risperidone 1mg one tablet twice daily was not administered to Resident #2 as prescribed he could have increased risk of delusions.

Telephone interview with Resident #1's Mental Health Provider (MHP) 09/09/25 at 10:09am revealed Resident #2 could have increased risk of psychotic episodes if he did not receive risperidone 1mg as ordered.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 52	D 358		

j. Review of Resident #2's physician's orders dated 06/09/25 revealed there was an order for tamsulosin (a medication to treat benign prostatic hyperplasia) 0.4mg one tablet daily.

Review of Resident #2's September 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for tamsulosin 0.4mg one tablet daily scheduled at 6:00am.
-There was no documentation tamsulosin 0.4mg one tablet was administered on 09/01/25 at 6:00am with no explanation.
-There was 1 of 4 opportunities tamsulosin 0.4mg one tablet was not documented as administered to Resident #2.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #2 revealed there was tamsulosin 0.4mg, 34 capsules available for administration on the medication cart.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Resident #2 had an order for tamsulosin 0.4mg one capsule daily.
-Tamsulosin 0.4mg one capsule daily was given to Resident #2 to decrease urinary retention.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed tamsulosin 0.4mg 31 tablets for Resident #2 on 07/05/25, 08/01/25 and 09/02/25.
-If tamsulosin 0.4mg one capsule daily was not administered to Resident #2 as prescribed he

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 53	D 358		

could have increased urinary retention.

Telephone interview with Resident #2's PCP on 09/09/25 at 9:37am revealed:
-Resident #2 frequently refused his medications.
-It was difficult to determine any outcomes of missing medication doses for Resident #2 because he did not take his medications consistently.

Refer to the interview with a medication aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

3. Review of Resident #3's FL2 dated 05/12/25 revealed diagnoses included schizophrenia and tobacco use.

a. Review of Resident #3's Resident Register dated 11/01/24 revealed an admission date of 11/01/25.

Review of Resident #3's physician's orders dated 06/16/25 revealed there was an order for Melatonin (a medication to treat sleep disorders) 3mg one tablet twice daily scheduled at 6am and 6pm.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Melatonin 3mg one tablet

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 54	D 358		

Continued From page 54

twice daily at 6:00am and 6:00pm.
-There was no documentation on 08/20/25 at 6:00pm Melatonin 3mg one tablet was administered to Resident #3.
-There was no documentation on 08/29/25 at 6:00pm Melatonin 3mg one tablet was administered to Resident #3.
-There was no documentation on 08/31/25 at 6:00am Melatonin 3mg one tablet was administered to Resident #3.
-There were 3 of 62 opportunities Melatonin 3mg was not documented as administered to Resident #3.

Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 4:30pm revealed:
-The order for Resident #3 was Melatonin 3mg one tablet twice daily.
-Melatonin 3mg was given to Resident #3 for agitation.
-The Pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025.
-The Pharmacy dispensed 62 tablets of Melatonin 3mg tablets on 07/08/25, 62 tablets on 08/11/25 and 62 tablets on 09/05/25.
-If Resident #3 did not get Melatonin 3mg, it could have caused the resident to be more agitated.

Telephone interview with Resident #3's PCP on 09/09/25 at 9:37am revealed:
-She was aware Resident #3 did not always receive his medications because of his mental status and agitation.
-She received a copy of Resident #3's eMAR at month's end so she could evaluate what medications he took and did not take.
-She worked with Resident #3's mental health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOME OF TAYLORSVILLE	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 55	D 358		

provider on his medications.
-She was aware Melatonin was usually used for sleep but in Resident #3's case, he felt it helped calm him down and not feel so agitated, so the PCP and mental health provider were fine with that.
-If Resident #3 did not get Melatonin twice a day he could become more agitated.

Refer to the interview with a Medication Aide (MA) on 09/09/25 at 11:14am.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

b. Review of Resident #3's physician's orders dated 05/12/25 revealed there was an order for Gabapentin (a medication to treat nerve pain) 800mg one tablet three times daily scheduled at 6:00am, 12:00pm and 6:00pm.

Review of Resident #3's August 2025 eMAR revealed:
-There was an entry for Gabapentin 800mg one tablet three times a day at 6:00am, 12:00pm and 6:00pm.
-There was no documentation on 08/20/25 at 6:00pm Gabapentin 800mg one tablet was administered to Resident #3.
-There was no documentation on 08/29/25 at 6:00pm that Gabapentin 800mg one tablet was administered to Resident #3.
-There was no documentation on 08/31/25 at

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 358	Continued From page 56 6:00am that Gabapentin 800mg one tablet was administered to Resident #3. -There was no documentation on 08/31/25 at 12:00pm that Gabapentin 800mg one tablet was administered to Resident #3. -There were 4 of 62 opportunities gabapentin 800mg was not documented as administered to Resident #3. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 09/08/25 at 4:30pm revealed: -The order for Resident #3 was Gabapentin 800mg one tablet three times a day. -The pharmacy had issues with the facility's computers and new software had to be applied on another computer for the facility around the end of August 2025. -The pharmacy dispensed 93 tablets on 07/08/25, 93 tablets on 08/11/25 and 93 tablets on 09/05/25. -If Resident #3 did not get Gabapentin 800mg, it could have caused the resident to have pain. Telephone interview with Resident #3's PCP on 09/09/25 at 9:37am revealed: -She was aware Resident #3 refused his medications because of his mental status and agitation. -She received a copy of Resident #3's eMAR at month's end so she could evaluate what medications he took and did not take. -She worked with Resident #3's mental health provider on his medications. Refer to the interview with a Medication Aide (MA) on 09/09/25 at 11:14am. Refer to the interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 358	Continued From page 57	D 358		

Refer to the telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm.

Refer to the interview with the Administrator on 09/09/25 at 3:20pm.

____

Interview with a medication aide (MA) on 09/09/25 at 11:14am revealed:
-She would always sign out medications given to the residents.
-The facility was having issues with signing off medications on the eMAR the end of August 2025 and she made the Former Administrator and Resident Care Coordinator (RCC) aware but the issues were not taken care of.
-She and other MA's would put the issue on the 24 hour report so the Former Administrator was aware they could not click off on the medications when given.
-The MAs suggested to the Former Administrator to have a paper eMAR until the issue could be fixed but she would not allow it.

Interview with the Resident Care Coordinator (RCC) on 09/05/25 at 4:01pm revealed:
-She started working at the facility on 08/15/25.
-The medication aides (MA) informed her they were unable to document medication administration because of computer/internet issues.
-She was unsure when the MAs informed her of the computer/internet issues.
-Pharmacy provided the computers used during the medication passes and she contacted the pharmacy on 09/01/25.
-The pharmacy provided two computers on 09/03/25 and there were no additional issues with documenting on the residents' electronic

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ___ B. WING ___	R-C 09/09/2025

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

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D 358	Continued From page 58 medication administration records. Telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed: -Pharmacy staff were at the facility the previous Wednesday (09/03/25) because the computers used during the medication pass were not functioning properly. -When the computers were not working properly, the medication aides (MAs) were not able to document medication administration in the eMAR system. Interview with the Administrator on 09/09/25 at 3:20pm revealed: -She became the Administrator of the facility on 09/03/25. -She was aware of the computer issues and eMAR issues but was not aware of the empty spaces left on the eMARs. -Staff made her aware of the computer issues when she first started with the facility and discussed with the previous Administrator if staff could use paper eMARs until the computer issues were fixed but she would not allow it. -She and the RCC worked with Pharmacy and now the staff can sign out the medications when given to the residents. -A paper eMAR is readily available when needed. -Missed medication reports were not being done but the Administrator will begin doing them. -The RCC was responsible for doing random chart audits weekly on 3-4 residents.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 367	Continued From page 59	D 367		

(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:
Based on observations, interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 3 residents (#1) related to inaccurate documentation of a medication used to treat mental health disorders.

The findings are:

Review of Resident #1's current FL2 dated 08/20/25 revealed diagnoses included major depression, impulsive control disorder and schizoaffective disorder.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 367	Continued From page 60	D 367		

Review of Resident #1 Primary Care Provider's (PCP) orders dated 06/09/25 and 09/02/25 revealed there was an order of Perseris ER (extended release) 120mg, inject 120mg under the skin monthly (a medication to treat schizophrenia).

Review of Resident #1's July 2025 electronic Medication Administration Record (eMAR) revealed there was documentation Perseris ER 120mg was administered to Resident #1 on 07/01/25 at 6:00am.

Review of Resident #1's August 2025 eMAR revealed there was documentation Perseris ER 120mg was administered to Resident #1 on 08/01/25 at 6:00am.

Review of Resident #1's medication release form dated 09/04/25 revealed there was no Perseris ER 120mg released with Resident #1's medications upon his discharge.

Observations on 09/05/25 at 11:02am of medications on hand for Resident #1 revealed there was no Perseris ER 120mg available for administration on the medication cart.

Telephone interview with a Pharmacist with the facility's contracted pharmacy on 09/08/25 at 12:46pm revealed:
-Perseris ER 120mg was last dispensed for Resident #1 on 01/06/25.
-The pharmacy was waiting on a prior authorization from Resident #1's PCP since February 2025.

Interview with a medication aide (MA) on 09/09/25 at 11:14am revealed:
-Resident #1 Perseris ER 120mg injection

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 367	Continued From page 61 medication had not been in the facility for a "long time". -She was unsure when she last saw the Perseris ER 120mg medication in the medication cart for Resident #1. -She accidentally documented she administered Perseris ER 120mg to Resident #1 on 08/01/25 at 6:00am. -She thought she probably rushed through the med pass and accidentally clicked of the Perseris ER 120mg for Resident #1. Interview with the Administrator on 09/09/25 at 3:20pm revealed: -Perseris ER 120mg was last dispensed for Resident #1 in January 2025. -The MAs were responsible to administer and document the administration of resident medications. -The MAs were not to sign off on the eMAR if a medication was not administered. -She thought some of the MAs were administering resident medications based on memory and not what was in the eMAR system.	D 367	RESIDENTS WHO RECEIVE MONTHLY INJECTIONS WILL BE CLOSELY MONITORED. A LOG WILL BE CREATED WHICH WILL INCLUDE THEIR NAME, INJECTION INFORMATION, DATE AND LOCATION/SITE. THIS WILL BE MONITORED BY THE RCC ON A WEEKLY BASIS.	10/27/25
D 392	10A NCAC 13F .1008 (a) Controlled Substances 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. This Rule is not met as evidenced by: Based on interviews, observations, and record reviews, the facility failed to ensure a readily	D 392		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL002009	A. BUILDING: ______ B. WING ______	R-C 09/09/2025

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

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D 392	Continued From page 62 retrievable record that accurately reconciled the administration of controlled substances for 1 of 3 sampled residents who received an anxiety medication (Resident #1). Findings include: Review of the facility's undated Controlled Substances policy revealed: -Documentation of controlled substances will be maintained by the facility and will be available for review. -The medication aide (MA) reporting to duty would review both the count sheet and the medications and the MA going off duty would do the same and both MAs would sign and verify the count was correct. -The front and back of the card had to be looked at. -If the count was incorrect, the MA reporting to duty would not take the keys and the Administrator/designee would be notified. -Both MAs would remain on duty unless directed otherwise. Review of Resident #1's FL2 dated 08/20/25 revealed diagnoses included impulsive control disorder, mental retardation, schizoaffective disorder, Type 2 diabetes mellitus, and seizure disorder. Review of Resident #1's physician orders dated 06/09/25 revealed there was an order for Lorazepam (a medication used to treat anxiety) 1mg take one tablet by mouth every 24 hours as needed for agitation or hallucinations. Review of Resident #1's Control Substance Count Sheet (CSCS) for Lorazepam 1 mg by mouth every 24 hours as needed for agitation or	D 392	FACILITY HAS A NARCOTIC BINDER FOR EACH CART. THE SIGN ON/OFF SHEET IS SIGNED BY ON-COMING + OFF-GOING MED TECH.	10/1/25

(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	Continued From page 63 hallucinations revealed: -Lorazepam 1 mg as needed, 23 tablets were dispensed from the pharmacy on 07/28/25. -There were 22 tablets out of 23 tablets remaining on the CSCS card on 09/04/25. Observation of Resident #1's medications on hand on 09/04/25 at 09:50am revealed there were 22 tablets of Lorazepam remaining for Resident #1. Interview with the MA on 09/04/25 at 10:02am revealed: -She did not know why the count was off. -She counted with the oncoming and off going MAs daily and did not know what happened. -She stated the card was hard to see the tablet punched out, but the count should have been correct. -She found documentation on 08/13/25 at 12:13pm where the tablet had been given to Resident #1 for agitation and not subtracted from the medications on hand. Interview with another MA on 09/08/25 at 11:50pm revealed: -She always did a narcotic count with the oncoming and outgoing MA. -She did not ever remember making an error of not signing out the Lorazepam 1mg given on the CSCS sheet on 08/13/25 even though she was the MA on duty during that time. Telephone interview with a pharmacist at the facility's contracted pharmacy on 09/08/25 at 4:40pm revealed: -Lorazepam 1 mg was dispensed 07/28/25 for 23 tablets. -Lorazepam 0.5mg was dispensed 07/29/25 for 61 tablets.	D 392	NARCOTIC BINDERS WILL BE REVIEWED DAILY. NARCOTICS WILL BE COUNTED BY RCC OR ASSIST ADMIN DAILY & DOCUMENTED.	10/1/25

(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	Continued From page 64 -Resident #1 could have an increase in agitation if he was not getting this medication. Interview with the Administrator on 09/09/25 at 3:20pm revealed: -She was not aware of the discrepancy on the CSCS for Resident #1. -She expected the MAs to sign the CSCS when the medication was administered. -She expected the MAs to follow the policy that was written after the last survey in June 2025. -The Resident Care Coordinator (RCC) had started doing cart audits last week on the two carts but apparently started on the other cart first.	D 392		