Adult Care Home Corrective Action Report (CAR)

I. Facility Name: Heritage Care Home of Taylorsville
Address: 668 Wood Rd Taylorsville, NC 28681
II. Date(s) of Visit(s): 8/1/25, 8/4/25, 8/12/25, 8/13/25, 8/18/25, 8/19/25, 8/25/25, 8/31/25

County: Alexander
License Number: HAL 002-009
Purpose of Visit(s): Complaint Investigation

Exit/Report Date: ______

Instructions to the Provider ***(please read carefully)***:

In column **III (b)** please provide a plan of correction to address *each of the rules* which were violated and cited in column **III (a)**. The plan must describe the steps the facility will take to achieve and maintain compliance. In column **III (c)**, indicate a specific completion date for the plan of correction.

*If this CAR includes a **Type B violation**, failure to meet compliance after the date of correction provided by the facility could result in a civil penalty in an amount up to $400.00 for each day that the facility remains out of compliance.

*If this CAR includes a **Type A1 or an Unabated B violation**, this agency *will* plan to submit an Administrative Penalty Recommendation for the violation(s). If this CAR includes a **Type A2 violation**, this agency *may* submit an Administrative Penalty Recommendation for the violation(s). The facility has an opportunity to schedule an Informal Dispute Resolution (IDR) meeting within **15 working days** from the mailing or delivery of this CAR. If on follow-up survey the **Type A1 or Type A2** violations are not corrected, a civil penalty of up to $1000.00 for each day that the facility remains out of compliance may be assessed. If on follow-up survey the **Unabated B** violations are not corrected, a civil penalty of up to $400.00 for each day that the facility remains out of compliance may also be assessed.

III (a). Non-Compliance Identified *For each citation/violation cited, document the following four components:* • *Rule/Statute violated (rule/statute number cited)* • *Rule/Statutory Reference (text of the rule/statute cited)* • *Level of Non-compliance (Type A1, Type A2, Type B, Citation, Unabated Type A1, Unabated Type A2, Unabated Type B)* • *Findings of non-compliance*	**III (b). Facility plans to correct/prevent:** *(Each Corrective Action should be cross-referenced to the appropriate citation/violation)*	**III (c). Date plan to be completed**
Rule/Statute Number: 10A NCAC 13F .0902(b)		___
Rule/Statutory Reference: Health Care		
Level of Non-Compliance: Type A2 Violation		
Findings: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow-up to meet the acute health care needs for 4 of 4 sampled residents (#1, #2, #3, and #4) related to a resident who missed appointments with an infectious disease specialist and was not scheduled an eye exam (#1), a resident who was not scheduled an appointment with a gastroenterologist (#2), a resident who missed an appointment with a dermatologist (#3), missed two weeks of dialysis treatments (#4). The findings are: 1. Review of Resident #1's current FL2 dated 6/9/25 revealed: -Diagnoses included/ type 2 diabetes, anemia, colon, and communicable disease. -His level of care was assisted living.		

-The resident was semi-ambulatory, used a wheelchair, and was intermittently disoriented. -The resident was incontinent of bowel and bladder. Observations of the appointment board outside of the facility's nurses station on 8/12/25 at 12:23 pm revealed Resident #1 had an appointment scheduled with his Infectious Disease Provider (IDP) on 8/27/25 at 9:00 a.m. Telephone interview with Resident #1's guardian on 8/6/25 at 3:19 pm revealed: -The facility's previous Administrator told him that she would take Resident #1 to his appointments in June 2025. -Resident #1 was last seen by his IDP on 12/19/24. -Resident #1 was supposed to be seen by his IDP every 6 months. -Resident #1 missed appointments with his IDP on 6/2/25 and 6/30/25. -In September 2024, he requested Resident #1 be sent for an eye exam. -He has no knowledge if Resident #1 was scheduled for an eye exam. Interview with nurse at Resident #1's IDP office on 8/27/25 at 7:30 am revealed: -Resident #1 is scheduled every 6 months for routine labs to ensure medication is continuing to fight the virus and not damaging other organs. -Without lab monitoring the viral load can increase causing other opportunistic infections. Interview with previous Administrator on 9/23/25 at 3:03 p.m. -She mentioned there was no process of scheduling labs when she was first employed at the facility. -Previous administrator mentioned MD would send over the labs to the laboratory and at times she realized the MD was not submitting these lab referrals. -The previous administrator did submit the labs over to laboratory and received a fax confirmation. -All communication within the staff at the facility was all verbal and there was no written communication. -Previous administrator did have a conversation with the owner of the facility and indicated he was uncertain what needs to take place. Telephone interview with a representative at Resident #1's IDP office on 8/6/25 at 8:50 a.m. revealed:		

Facility Name:

-The IDP Resident #1 to be scheduled for an appointment every 6 months.
-Resident #1's last appointment was on 12/19/24.
-Resident #1 missed 4 appointments since his last visit on 5/2/25, 5/19/25, 6/2/25, and 6/30/25.
-There were no notes as to why Resident #1 was not brought to his appointments
-Resident #1's next scheduled appointment was on 8/27/25 at 9:00 a.m.

Interview with the previous Administrator on 9/23/25 at 3:03 p.m. revealed:
-She was not employed by the facility during the times of Resident #1's missed appointment.
- She only worked at the facility for a short time.
-She revealed that there was no process prior to be employed at the facility of scheduling appointments.
-She and RCC worked to schedule appointments and note when the upcoming appointments were for the residents.
-She revealed that the facility van was out of compliance from 9/11/25-9/16/25 and was supposed to return on this date. The vehicle never did return.
-She addressed concerns with owner that staff were transporting residents to their own appointments and uncertain if the employee had valid insurance or license to transport the resident to their appointment.

Based on observations and record reviews it was determined Resident #1 was not interviewable.

2. Review of Resident #2's FL2 dated 3/12/25 revealed:
-Diagnoses included paranoid schizophrenia, hypertension (HTN), gastroesophageal reflux disease (GERD), Vitamin D deficiency, abdominal pain and dyslipidemia.
-The level of care was assisted living.
-The resident was ambulatory with no assistive device and was intermittently disoriented.
-The resident was continent of bowel and bladder.

Review of Resident #2's Primary Care Provider's (PCP) progress notes dated 4/17/25 revealed an order for a referral to a gastrologist for irritable bowel syndrome (IBS) with diarrhea.

Review of Resident #2's PCP progress notes dated 6/10/25 revealed:

Facility Name:

-Schedule an appointment with Resident #1's gastrologist. -Resident #2's guardian provide transportation -Resident #2 did not need a referral since she has seen them in the past. Interview with a representative at Resident #2's gastrologist office on 8/21/25 at 3:02 pm revealed: -Resident #2's appointment was cancelled because the resident was in the hospital. -Resident #2's appointment was cancelled because the resident was in the hospital. -Resident #2's appointment was cancelled because the provider was out of the office. -Resident #2's appointment on 7/21/25 at 9:00 am was cancelled through the automatic call system and rescheduled for 1:00 pm the same day. -Resident #2's appointment on 7/21/25 at 1:00 pm was cancelled by the facility Administrator. Interview with a nurse case manager at Resident #2's gastrologist's office on 9/2/25 at 9:50 am revealed: -Resident # 2 has a diagnosis of irritable bowel syndrome. -She missed an appointment on 7/21/25. -Missing appointments could result in worsening symptoms such as flare ups and dehydration causing a hospitalization. Interview with a MA on 8/4/25 at 1:37 pm revealed: -Resident #2 had an appointment with a gastrologist in July 2025 but it was cancelled -The facility did not cancel the appointment. -MA does not know who cancelled the appointment. Telephone interview with Resident #2's guardian on 8/21/25 at 2:24 pm revealed: -Resident #2 was scheduled for an appointment with a gastrologist on 7/21/25. -Resident #2's guardian called the gastrologist after arriving at the facility and found the appointment to have been cancelled. -The gastrologist office explained that an automated confirmation had been sent to the facility but no one confirmed the appointment. -The guardian rescheduled the appointment for a later appointment on the same day (7/21/25) at 1:00 pm. -The Administrator (previous Administrator) at the facility during that time told the guardian that she would transport Resident #2 to her appointment.		

Facility Name:

-The Administrator failed to take Resident #2 to her appointment due to a conflict with transporting another resident to a separate appointment. Telephone interview with current Administrator on 8/25/25 at 3:05 pm revealed: -Resident #2's guardian came to the facility on 7/21/25, to transport resident to gastrologist appointment. -Resident #2's guardian called the gastrologist after arriving at the facility and found the appointment to have been cancelled by the gastrologist's office automatic system. -Resident #2's guardian scheduled an appointment for 7/21/25 at 1:40 pm. -The Administrator told the guardian that appointments needed to be scheduled for 3 days out. -Resident #2's guardian could not take her to her 1:00 pm appointment. -Resident #2's family member requested that she didn't want her mother using public transportation. Review of Resident #3's current FL2 dated 6/9/25 revealed: -Diagnoses included skin cancer, suicidal ideations, schizophrenia, hypertension, bipolar disorder, mixed hyperlipidemia, high cholesterol and seizures. -The level of care was assisted living. -The resident was ambulatory and constantly disoriented. -The resident was continent of bowel and bladder. Review of Resident #3's PCP progress notes dated 7/25/25 revealed: -Chief complaint/reason for visit: Facility notified PCP today that Resident #3 was not able to be seen by Ear Nose Throat (ENT) for his appointment on 7/24/25 due to office needing to reschedule. -Staff noted that the swollen area on Resident #3's cheek was starting to slightly drain. -Possible abscess could have formed. -Area will need to be covered until he is seen by the Dermatologist on 7/29/25 and ENT on 8/4/25. Review of Resident #3's Medicaid Transportation Trip at DSS Request Log revealed: -Resident #3 was scheduled for transportation to dermatologist on 7/29/25 at 2:00 pm. -Resident #3 was scheduled for transportation to ENT on 8/4/25 at 10:00 am.		

Facility Name:

Review of the facility's appointment calendar for August 2025 revealed: -Resident #3 had an appointment at ENT scheduled on 8/4/25 at 9:00 am. -Resident #3 had an appointment at ENT for pre-op, that was scheduled for 8/12/25 at 2:00 pm. -Resident #3 had an appointment for surgery scheduled on 8/20/25 (hospital will call with the time). Interview with Resident #3's Medicaid transportation provider on 8/14/25 at 3:10 pm revealed: -There was no transportation appointment scheduled for Resident #3 on 8/12/25. Interview with MA on 8/13/25 revealed: -The RCC faxed a transportation request on 8/5/25 for Resident #3 to be transported to ENT for surgery. -Medicaid transportation did not show up on 8/12/25 to transport Resident #3 for surgery. -The RCC called Medicaid transportation to reschedule pre-op appointment for 8/6/25 at 4:00 pm, which resident was transported to appointment. Telephone interview with dermatologist's medical assistant on 8/25/25 at 3:25 pm revealed: -Resident #3 had skin cancer on the right side of his face. -The dermatologist wanted the surgery scheduled as soon as possible. -Surgery was ordered for 8/6/25. -The dermatologist's office rescheduled the surgery from 8/6/25 to 8/12/25. -Resident #3 was a "no show" on 8/12/25. -Appointment was rescheduled for 9/17/25. -The risk for Resident #3 not having surgery as soon as possible was a metastasizing of the cancer. Review of Resident #4's FL2 dated 5/27/25 revealed: -Diagnoses included chronic kidney disease, hypertension, Type 2 diabetes, hypercholesterolemia, coronary artery disease, glaucoma and cognitive impairment. -The level of care was assisted living. -The resident was ambulatory and intermittently disoriented. -The resident was continent of bowel and incontinent of bladder. Review of the facility's appointment calendar for August 2025 revealed Resident #4 was scheduled for dialysis on 8/5/25, 8/7/25, 8/9/25, 8/12/25, 8/14/25, 8/17/25, 8/19/25, 8/21/25,		

8/23/25, 8/26/25, 8/28/25 and 8/3025 from 10:00 am to 3:00 pm. Review of Resident #4's incident report dated 8/16/25 revealed: -At 11:30 am there was documentation Resident #4 was scheduled for dialysis treatment this morning at 10:00 am. -Transportation was unavailable due to the company vehicle being in the shop. -Resident #4 missed his scheduled treatment. -An alternative transportation method was established but the dialysis center stated that it was too late to bring him. Review of clinical notes from dialysis center dated 8/16/25 at 12:44 pm revealed: -Resident #4 was a no show to unit today. -Resident #4's appointment was scheduled for 10:00 am. -The dialysis nurse called the facility multiple times on 8/16/25 between 10:00 am and 10:30 am but no one answered the phone. -The facility called the dialysis center on 8/16/25 at 12:30 pm (2 ½ hours after patient due at unit). -The facility explained that it was too late to start the procedure and would do Resident #4 more harm than good. -The dialysis nurse explained that it was the facility's responsibility to bring Resident #4 to dialysis treatments in a timely manner as missing appointments could result in adverse effects including patient death. -The dialysis nurse asked the facility to bring the resident for makeup treatments including regular treatment days during week of 8/18/25 -8/23/25. -The dialysis nurse told facility to take Resident #4 to hospital emergency room if patient has any symptoms of shortness of breath or physical complaints before next scheduled treatment. Telephone interview with the dialysis nurse on 8/18/25 at 7:55 am revealed: -Resident #4 was no show on 8/16/25 at 11:30 am. -No one answered the phone at the facility when the dialysis center called. -The facility called the dialysis center on 8/16/25 at 12:30 pm to set up to bring Resident #4 in for his appointment but it was too late to start procedure. Telephone interview with clinical administrator assessor at dialysis clinic on 9/23/25 at 3:34 p.m. -Revealed that Resident #4 has dialysis 3 days per each week.		

-She mentioned adult miss appointment on 8/18/25, which was rescheduled on 8/23/25. -8/23/2025 Resident # 4 was on the dialysis machine from 12:30 p.m. until 3:00 p.m. Resident normal schedule on the dialysis machine is from 10:20 a.m.-3:00 p.m. -9/18/25 Resident # 4 showed up late and got on the machine at 11:48 a.m.-3:00 p.m. -Assessor revealed all missed appointments have been made up by rescheduling the appointments. -Resident # 4 each week resident is late 2 out of three appointments. -Facility does not call the dialysis clinic to let them know they are late. The clinic will call the facility and revealed they have a hard time getting through the phone lines for a staff member to answer the phone. Telephone interview with MA on 8/18/25 at 8:03 am revealed: -Another MA was scheduled for first shift on 8/16/25. -The van was not in the shop being fixed. Interview with RCC on 8/19/25 at 2:15 pm revealed: -8/16/25 was her second day of working at the facility. -She was unaware that Resident #4 had a dialysis appointment of 8/16/25. -The MA that was scheduled to work first shift on 8/16/25 called out of work. Telephone interview with Administrator on 8/18/25 at 2:02 p.m. revealed: -The MA that was scheduled for 8/16/25 called out of work. -There was a new RCC that worked on 8/16/25. -The owner of the facility had the facility van taken into the shop without communicating it to everyone. ________________________________ The facility failed to ensure the residents were seen for referral or follow up appointments with medical specialists when Resident #4 was not seen for dialysis treatments that were scheduled three times a week from 08/05/23 to 08/18/25, and ________________________________ The facility provided an acceptable plan of protection in accordance with G.S. 131D-34 on 9/2/2025. THE CORRECTION DATE FOR VIOLATION WILL NOT EXCEED 10/2/2025.		

Facility Name:

Health Care 10A NCAC 13F.0902(b)
Dropped off CAR + POP - 9/26/25

IV. Delivered Via:	Julie Sebastian - DSS	Date:
DSS Signature:	[signature] 9/26/25	Return to DSS By:

V. CAR Received by:	Administrator/Designee (print name):	
	Signature:	Date:
	Title:	

VI. Plan of Correction Submitted by:	Administrator (print name):	
	Signature:	Date:

VII. Agency's Review of Facility's Plan of Correction (POC)		
☐ *POC Not Accepted*	By:	Date:
Comments:		
☐ *POC Accepted*	By:	Date:
Comments:		

VIII. Agency's Follow-Up	By:	Date:
	Facility in Compliance: ☐ Yes ☐ No	Date Sent to ACLS:
Comments:		

**For follow-up to CAR, attach Monitoring Report showing facility in compliance.*