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 01/30/2026

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 000	Initial Comments The Adult Care Licensure Section completed a follow up survey and complaint investigation from January 29, 2026 through January 30, 2026.	D 000	**Incomplete Medication Orders on FL-2** **Provider's Plan of Correction**	
D 237	10A NCAC 13F .0703 (e) Tuberculosis Test, Medical Exam & Immunization 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (e) The result of the medical examination required in Paragraph (b) of this Rule shall be documented on the North Carolina Medicaid Adult Care Home FL-2 form which is available at no cost on the Department's Medicaid website at https://medicaid.ncdhhs.gov/media/6549/open. The Adult Care Home FL-2 shall be signed and dated by the physician or physician extender completing the medical examination. The medical examination shall include the following: (1) resident's identification information, including the resident's name, date of birth, sex, admission date, county and Medicaid number, current facility and address, physician's name and address, a relative's name and address, current level of care, and recommended level of care; (2) resident's admitting diagnoses, including primary and secondary diagnoses and dates of onset; (3) resident's current medical information, including orientation, behaviors, personal care assistance needs, frequency of physician visits, ambulatory status, functional limitations, information related to activities and social needs, neurological status, bowel and bladder functioning status, manner of communication of needs, skin condition, respiratory status, and nutritional status including orders for therapeutic diets;	D 237	**Corrective Action for Affected Resident:** Resident #3's FL-2 was immediately corrected. The practitioner was contacted to obtain complete medication orders including dosage, frequency, and route. Updated FL-2 placed in chart. **2. Identification of Other Residents:** All residents' FL-2 forms were audited for complete medication orders. **3. Systemic Changes:** A new FL-2 verification checklist was implemented requiring RCC review before filing. **4. Monitoring:** RCC will audit all new/updated FL-2s weekly × 8 weeks, then monthly × 3 months. Results reviewed in QA. **5. Responsible Person:** RCC	**03/01/2026**

LABORATORY DIRECTOR'S — TITLE — (X6) DATE

Racheal Hilton — Feb/27/2026

Reviewed and Acknowledged CR 2/27/26

OR
PROVIDER/S
UPPLIER
REPRESENT
ATIVE'S
SIGNATURE

STATE
FORM 6899 TP5311 If continuation sheet 1 of 26
Division of Health Service Regulation

STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING: _____	COMPLETED
	HAL002009	B. WING _____	R-C **01/30/2026**

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 237	Continued From page 1 (4) special care factors, including physician orders for blood pressure, diabetic urine testing, physical therapy, range of motion exercises, a bowel and bladder program, a restorative feeding program, speech therapy, and restraints; (5) resident's medications, including the name, strength, dosage, frequency and route of administration of each medication; (6) results of x-rays or laboratory tests determined by the physician or physician extender to be necessary information related to the resident's care needs; and (7) additional information as determined by the physician or physician extender to be necessary for the care of the resident. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 3 sampled residents (#3) medications included the dosage, frequency and route of administration of each medication were included when the results of the resident's medical examination was documented on the resident's current FL2. The findings are: Review of Resident #3's current FL2 dated 01/12/26 revealed: -Diagnoses included cerebral vascular accident (stroke), hypertension, post-traumatic stress disorder, chronic obstructive pulmonary disease, deep vein thrombosis (blood clot), shortness of breath and depression. -There was an order for divalproex delayed	D 237		

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 01/30/2026

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 237	Continued From page 2 release (DR) (a medication to treat seizures or mental health disorders) 250mg tablet. -The divalproex DR 250mg order did not indicate a dosage, frequency and route of administration. -There was an order for donepezil (a medication to treat memory loss) 5mg tablet. -The donepezil 5mg order did not indicate a dosage, frequency and route of administration. -There was an order for duloxetine DR (a medication to treat depression) 20mg capsule. -The duloxetine DR 20mg order did not indicate a dosage, frequency and route of administration. -There was an order for farxiga (a medication to lower blood sugar levels) 10mg tablet. -The farxiga 10mg order did not indicate a dosage, frequency and route of administration. -There was an order for lisinopril (a medication to treat high blood pressure) 10mg tablet. -The lisinopril 10mg order did not indicate a dosage, frequency and route of administration. -There was an order for memantine (a medication to treat memory loss) 10mg tablet. -The memantine 10mg order did not indicate a dosage, frequency and route of administration. -There was an order for quetiapine (a medication to treat mental health disorders) 300mg tablet. -The quetiapine 300mg order did not indicate a dosage, frequency and route of administration. -There was an order for solifenacin (a medication to treat overactive bladder) 10mg tablet. -The solifenacin 10mg order did not indicate a dosage, frequency and route of administration. -There was an order for tamsulosin (a medication to treat symptoms of enlarge prostate) 0.4mg tablet. -The tamsulosin 0.4mg order did not indicate a dosage, frequency and route of administration. Review of Resident #3's Resident Register revealed he was admitted to the facility on	D 237		

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 01/30/2026

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 237	Continued From page 3 09/05/23. Interview with a representative with the facility's contracted pharmacy on 01/30/26 at 9:18am revealed: -The pharmacy did not receive Resident #3's FL2 dated 01/12/26. -If the facility had sent Resident #3's FL2 dated 01/12/26 to the pharmacy, the pharmacy would have reached out to the facility to clarify the medication orders. Telephone interview with Resident #3's Nurse Practitioner (NP) on 01/30/26 at 9:53am revealed: -Resident #3's previous NP had signed Resident #3's FL2 dated 01/12/26. -The medication orders on Resident #3's FL2 were not complete orders because they did not indicate a dosage, frequency and route of administration. Interview with the Administrator on 01/29/26 at 12:35pm revealed: -The Manager at that time audited all resident charts for completed and timely FL2s the week of 01/19/26. -The Manager at that time must have missed Resident #3's FL2 dated 01/12/26 did not have complete medication orders.	D 237		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff.	D 309		

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 01/30/2026

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 309	Continued From page 4	D 309		

This Rule is not met as evidenced by:
Based on record reviews and interviews the facility failed to maintain a current listing of residents with physician-ordered therapeutic diets for guidance of food service staff for 2 of 3 sampled residents (#4 & #5) who diets were changed to regular diets from a no added salt with chopped meats (#4) and a no concentrated sweets diet (#5).

The findings are:

Observation of the kitchen on 01/29/26 at 10:59am revealed:
-There was a list of residents on therapeutic diets hanging inside the cabinet.
-The list was titled "specialized diet list" and was undated.
-The specialized diet list included 5 residents on reduced concentrated sweets and one resident on no salt added with chopped meats.

Review of the regular weekly menu for Thursday 01/29/26 revealed the lunch menu was listed as baked ham, au gratin potatoes, baked acorn squash, baked roll and apple crisp.

1. Review of Resident #4's current FL2 dated 01/16/26 revealed:
-Diagnoses included Gerd, kidney disease and schizoaffective disorder.
-There was an order for a regular diet.

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 01/30/2026

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 309	Continued From page 5 Review of the undated specialized diet list hanging in the kitchen on 01/29/26 revealed Resident #4 was on a no added salt and chopped meats diet. Observation during the lunch meal service on 01/29/26 from 1:15pm to 1:45pm revealed Resident #4 as not in the facility. Interview with Resident #4's Nurse Practitioner (NP) on 01/30/26 at 9:51am revealed the current diet order dated 01/16/26 of a regular diet on the FL2 was accurate and Resident #4 should be served a regular diet. Refer to interview with the cook on 01/29/26 at 11:00am. Refer to interview with the Dietary Manager (DM) on 01/29/26 at 2:00pm. Refer to interview with the acting Manager on 01/30/26 at 11:20am. Refer to telephone interview with the Administrator on 01/30/26 at 10:59am. 2. Review of Resident #5's current FL2 dated 01/12/26 revealed: -Diagnoses included major depressive disorder, antisocial personality disorder, and schizoaffective disorder. -There was an order for a regular diet. Review of the undated "specialized" diet list hanging in the kitchen on 01/29/26 revealed Resident #5 was on a reduced concentrated sweets diet. Observation of the lunch meal service on	D 309	**Failure to Maintain Current** **Therapeutic Diet List** **Provider's Plan of Correction** **1. Corrective Action for Affected Residents:** Diet list updated immediately to reflect current physician-ordered diets for Residents #4 and #5. **2. Identification of Other Residents:** All residents' diet orders reviewed for accuracy. **3. Systemic Changes:** RCC will send diet order changes to dietary staff same day. Dietary Manager will maintain a dated, current diet list in the kitchen. **4. Monitoring:** Dietary Manager will verify diet list daily × 2 weeks, then weekly × 2 months. RCC will cross-check during monthly chart audits. **5. Responsible Person:** Dietary Manager & RCC	**03/01/26**

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 01/30/2026

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 309	Continued From page 6 01/29/26 at 1:33pm to 1: 40pm revealed: -Resident #5 was served the regular menu but was served a banana for dessert instead of the apple crisp. -Resident #5 requested to the DM who was in the dining room that he wanted the apple crisp for dessert. -The DM told him he was on a special diet and needed to talk to his doctor to get it changed. Interview with Resident #5 on 01/29/26 at 3:00pm revealed: -He was not a diabetic, was not taking insulin or metformin, nor did he require finger sticks to measure his blood sugar. -He was not happy about being served a banana when he was not diabetic. Interview with Resident #5's NP on 01/30/26 at 9:51am revealed the current diet order dated 01/12/26 of a regular diet on the FL2 was accurate and the facility should be following that diet order for Resident #5. Refer to interview with the cook on 01/29/26 at 11:00am. Refer to interview with the DM on 01/29/26 at 2:00pm. Refer to interview with the acting Manager on 01/30/26 at 11:20am. Refer to telephone interview with the Administrator on 01/30/26 at 10:59am. Interview with the cook on 01/29/26 at 11:00am revealed: -He had worked at the facility for approximately two weeks and was becoming more familiar with	D 309		

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 01/30/2026

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 309	Continued From page 7 the resident diet orders. -He had a diet list which was hanging in the kitchen for guidance, but it was not dated. -He thought the acting Manager was working on getting him an updated list. Interview with the DM on 01/29/26 at 2:00pm revealed: -She started her role as DM in December 2025. -She was responsible for ensuring the kitchen was clean, reviewing the weekly menus and ordering the food and monitoring inventory. -She thought the Manager at the time was responsible for making sure the physician ordered diets were available to kitchen staff for guidance. -Any changes in diet orders were to be given to her, and if she was not there it would be given to the cook. Interview with the acting Manager on 01/30/26 at 11:20am revealed: -Three weeks ago she began managing the facility when the facility Manager at the time went on leave. -The Manager was responsible for reviewing the FL2 for the most current diet order. -The Manager was responsible for ensuring the diet list was current and up to date in the kitchen. Telephone interview with the Administer on 01/30/26 at 10:59am revealed: -The RCC or the Manager was responsible for monitoring diet orders and diet order changes. -When a resident returns from an inpatient stay at the hospital staff should review the discharge paperwork and review any new diet orders and communicate them to the dietary staff as necessary. -The RCC or the Manager were responsible for	D 309		

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 01/30/2026

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 309	Continued From page 8 ensuring the diet list in the kitchen was the most current for each physician ordered diet and communicating any changes, so the dietary staff was aware.	D 309		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure physician orders were clarified for 2 of 3 sampled residents (#4, #5) who had orders for a regular diet. The findings are: Observation of the kitchen on 01/29/26 at 10:59am revealed: -There was a list of residents on therapeutic diets hanging inside the cabinet. -The list was titled "specialized diet list" and was undated. -The specialized diet list included 5 residents on reduced concentrated sweets and 1 resident on	D 344		

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 01/30/2026

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 344	Continued From page 9 no salt added with chopped meats. 1. Review of Resident #4's current FL2 dated 01/16/26 revealed: -Diagnoses included Gerd, kidney disease and schizoaffective disorder. -There was an order for a regular diet. Review of Resident #4's physician orders dated 12/02/25 revealed there was an order for regular diet with chopped meats. Review of the undated specialized diet list hanging in the kitchen on 01/29/26 revealed Resident #4 was on a no added salt and chopped meats diet. Interview with Resident #4's Nurse Practitioner (NP) on 01/30/26 at 9:51am revealed the current diet order dated 01/16/26 of a regular diet on the FL2 was accurate Resident #4 should be served a regular diet not a no added salt with chopped meat diet. Refer to telephone interview with the Administrator on 01/30/26 at 10:59am. 2. Review of Resident #5's current FL2 dated 01/12/26 revealed: -Diagnoses included major depressive disorder, antisocial personality disorder, and schizoaffective disorder.	D 344	**Failure to Clarify Conflicting Diet Orders** **Provider's Plan of Correction** **1. Corrective Action for Affected Residents:** Diet orders for Residents #4 and #5 were clarified with the NP. Updated orders communicated to dietary staff. **2. Identification of Other Residents:** Facility-wide audit completed to identify conflicting diet orders. **3. Systemic Changes:** New protocol implemented requiring immediate clarification of conflicting diet orders between FL-2, physician orders, or kitchen list. **4. Monitoring:** RCC will review all new diet orders weekly × 8 weeks, then monthly × 3 months. **5. Responsible Person:** RCC	**03/01/2026**

	-There was an order for a regular diet. Review of Resident #5's physician orders dated 10/30/25 revealed there was a diet order for reduced concentrated sweets. Review of the undated "specialized" diet list hanging in the kitchen on 01/29/26 revealed			

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 01/30/2026

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 344	Continued From page 10 Resident #5 was on a reduced concentrated sweets diet. Interview with Resident #5's Nurse Practitioner (NP) on 01/30/26 at 9:51am revealed the current diet order dated 01/12/26 of a regular diet on the FL2 was accurate and the facility should be following that diet order for Resident #5. Refer to telephone interview with the Administrator on 01/30/26 at 10:59am. Telephone interview with the Administer on 01/30/26 at 10:59am revealed: -The RCC or the Manager was responsible for monitoring diet orders and diet order changes. -If a Resident comes back from an inpatient stay at the hospital the RCC or the Manager should review the discharge paperwork and review any new diet orders and communicate that to staff as necessary. -The RCC was responsible for filling out the FL2 and having the doctor sign. -The diet orders for Resident #4 and #5 should have been clarified. -The RCC or the Manager was responsible for ensuring the diet list in the kitchen was the most current for each physician ordered diet and communicating any changes, so the dietary staff was aware.	D 344		

D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with:	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 01/30/2026

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 11 (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: The facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to medications for elevated blood sugar levels and sleep. The findings are: Review of Resident #3's current FL2 dated 01/12/26 revealed diagnoses included cerebral vascular accident (stroke), post-traumatic stress disorder and depression. Review of Resident #3's Resident Register revealed he was admitted to the facility on 09/05/23. a. Review of Resident #3's current FL2 dated 01/12/26 revealed there was no order for metformin (a medication to lower blood sugar levels). Review of Resident #3's Nurse Practitioner's (NP) progress note dated 08/19/25 revealed an order for metformin 500mg, one and one-half tablets twice daily. Review of Resident #3's December 2025 and January 2026 electronic medication administration records (eMAR) revealed there was no entry for metformin 500mg, one and one-half tablets twice daily. Observation of medications on hand for Resident #3 on 01/29/26 at 1:52pm revealed:	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 01/30/2026

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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

	REGULATORY OR LSC IDENTIFYING INFORMATION)			
D 358	Continued From page 12 -There were two bubble packs containing metformin 500mg, one and one-half tablets for Resident #3, with directions to administer one and one-half tablets twice daily. -The label on each bubble pack revealed metformin 500mg, 93 tablets were dispensed for Resident #3 on 12/29/25. -The bubble pack labeled "1 of 2" had 7 of 31 doses of metformin 500mg, one and one-half tablets remaining. -The bubble pack labeled "2 of 2" had 31 of 31 doses of metformin 500mg, one and one-half tablets remaining. Interview with Resident #3 on 01/30/26 at 9:52am revealed: -He did not know the names of the medications he took on a daily basis. -He knew the shapes and colors of the medication he was administered daily. -He counted the number of medications every morning and if there was one or more than usual he would ask what that	D 358	**Failure to Administer Medications as Ordered** **Provider's Plan of Correction** **1. Corrective Action for Affected Resident:** Metformin and melatonin orders reinstated and added to eMAR. Medication aides re-educated on administering only medications listed on eMAR and reporting discrepancies immediately. **2. Identification of Other Residents:** Full eMAR audit completed for all residents to identify missing or discontinued orders. **D358** **3. Systemic Changes:** Policy implemented prohibiting MAs from discontinuing medications in eMAR. Only pharmacy or RCC may make changes. **4. Monitoring:** RCC will conduct weekly eMAR and medication cart audits × 8 weeks, then monthly × 3 months. **5. Responsible Person:** RCC	**03/01/2026**

	medication or medications were. Telephone interview with a representative with the facility's contracted pharmacy on 01/30/26 at 9:18am and 10:13am revealed: -The pharmacy usually entered and discontinued resident orders in the eMAR system, but facility staff could also enter and discontinue medication orders. -The pharmacy did not receive Resident #3's FL2 dated 01/12/26. -Resident #3 had an active order dated 08/19/25 for metformin 500mg, one and one-half tablet twice daily. -Metformin 500mg, 78 tablets (26-day supply) was dispensed for Resident #3 on 08/19/25. -Metformin 500mg, 93 tablets (31-day supply)			

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 01/30/2026

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 13 was dispensed for Resident #3 on 09/02/25. -Metformin 500mg, 90 tablets (30-day supply) was dispensed for Resident #3 on 09/29/25. -Metformin 500mg, 90 tablets (30-day supply) was dispensed for Resident #3 on 10/29/25. -Metformin 500mg, 93 tablets (31-day supply) was dispensed for Resident #3 on 12/10/25. -Metformin 500mg, 93 tablets (31-day supply) was dispensed for Resident #3 on 12/29/25. -The facility returned metformin 500mg, 21 tablets (7-day supply) to the pharmacy on 09/17/25 from the metformin 500mg dispensed on 08/19/25. -The facility returned metformin 500mg, 45 tablets (15-day supply) to the pharmacy on 12/30/25 from the metformin 500mg dispensed on 10/29/25. -She was able to view Resident #3's December 2025 and January 2026 eMARs and there was no entry for metformin 500mg, one and one-half tablets twice daily. -The pharmacy did not receive a discontinue order for Resident #3's metformin 500mg, one and one-half tablets twice daily. -A medication aide (MA) at the facility discontinued Resident #3's metformin 500mg, one and one-half tablets twice daily on 10/13/25. -She did not know why the MA discontinued Resident #3's metformin 500mg, one and one-half tablets twice daily. Telephone interview with Resident #3's Nurse Practitioner (NP) on 01/30/26 at 9:53am revealed: -Resident #3 had a current order for metformin 500mg, one and one-half tablet twice daily. -If Resident #3 did not receive metformin 500mg, one and one-half tablet twice daily as ordered his blood sugar levels could be elevated. Telephone interview with a MA on 01/30/26 at	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 01/30/2026

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 14 10:40am revealed: -The pharmacy usually puts new orders and discontinued orders in the eMAR system and facility staff needed to approve the orders. -Resident #3's had metformin 500mg, one and one-half tablets twice daily available to administer on the medication cart. -She did not administer metformin 500mg, one and one-half tablets to Resident #3 because it was not indicated as a medication to administer during her medication pass. -She could not remember when, but she mentioned to the third shift MA metformin 500mg was in the medication cart for Resident #3 but not on his eMAR. -She mentioned it to the third shift MA because she was more knowledgeable as she had worked at the facility longer. -She spoke with the Manager on 01/09/26 about Resident #3's metformin 500mg one and one-half tablets twice daily not showing up on his eMAR and leave of absence forms. -On 01/09/26 the Manager stated she would call the pharmacy and investigate. -She did not know if the Manager called the pharmacy on 01/09/26. -She had not thought to call the pharmacy and check into why Resident #3 had metformin 500mg, one and one-half tablets twice daily on the medication cart but not on his eMAR. Refer to the telephone interview with the Administrator on 01/30/26 at 11:42am. b. Review of Resident #3's current FL2 dated 01/12/26 revealed there was no order for melatonin (a medication to treat insomnia). Review of Resident #3's Physician's Orders dated 10/30/25 revealed an order for melatonin 3mg,	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 01/30/2026

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 15 one tablet at bedtime. Review of Resident #3's December 2025 and January 2026 electronic medication administration records (eMAR) revealed there was no entry for melatonin 3mg, one tablet at bedtime. Observation of medications on hand for Resident #3 on 01/29/26 at 1:52pm revealed: -There was a bubble pack containing melatonin 3mg, one tablet for Resident #3, with directions to administer one tablet at bedtime. -The label on the bubble pack revealed melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/29/25. -The bubble pack had 17 of 31 doses of melatonin 3mg, one tablet remaining. Interview with Resident #3 on 01/30/26 at 9:52am revealed: -He did not know the names of the medications he took on a daily basis. -He knew the shapes and colors of the medication he was administered daily. -He counted the number of medications every morning and if there was one or more than usual he would ask what that medication or medications were. Telephone interview with a representative with the facility's contracted pharmacy on 01/30/26 at 9:18am and 10:13am revealed: -The pharmacy usually entered and discontinued resident orders in the eMAR system, but facility staff could also enter and discontinue medication orders. -The pharmacy did not receive Resident #3's FL2 dated 01/12/26. -Resident #3 had an active order dated 10/30/25	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 01/30/2026

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 16	D 358		

for melatonin 3mg, one tablet at bedtime.
-Melatonin 3mg, 31 tablets was dispensed for Resident #3 on 08/21/25.
-Melatonin 3mg, 30 tablets was dispensed for Resident #3 on 08/29/25.
-Melatonin 3mg, 30 tablets was dispensed for Resident #3 on 10/29/25.
-Melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/10/25.
-Melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/29/25.
-The facility returned melatonin 3mg, 26 tablets on 12/04/25 from the melatonin 3mg dispensed on 10/29/25.
-She was able to view Resident #3's December 2025 and January 2026 eMARs and there was no entry for melatonin 3mg, one tablet at bedtime.
-The pharmacy did not receive a discontinue order for Resident #3's melatonin 3mg, one tablet at bedtime.
-A medication aide (MA) at the facility discontinued Resident #3's melatonin 3mg, one tablet at bedtime on 10/13/25.
-She did not know why the MA discontinued Resident #3's melatonin 3mg, one tablet at bedtime.

Telephone interview with Resident #3's Nurse Practitioner (NP) on 01/30/26 at 9:53am revealed:
-Resident #3 had a current order for melatonin 3mg, one tablet at bedtime.
-Melatonin 3mg, one tablet at bedtime was stopped on Resident #3's eMAR but there was no order to discontinue the melatonin.
-If Resident #3 did not receive melatonin 3mg, one tablet at bedtime as ordered he could have difficulty falling asleep and may not sleep well.

Telephone interview with a MA on 01/30/26 at 10:40am revealed:

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 01/30/2026

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 17 -The pharmacy usually puts new orders and discontinued orders in the eMAR system and facility staff needed to approve the orders. -Resident #3's had melatonin 3mg, one tablet at bedtime available to administer on the medication cart. -She did not administer melatonin 3mg one tablet at bedtime to Resident #3 because it was not indicated as a medication to administer during her medication pass. -She could not remember when, but she mentioned to the third shift MA melatonin 3mg was in the medication cart for Resident #3 but not on his eMAR. -She mentioned it to the third shift MA because she was more knowledgeable as she had worked at the facility longer. -She spoke with the Manager on 01/09/26 about Resident #3's melatonin, 3mg at bedtime not showing up on his eMAR and leave of absence forms. -On 01/09/26 the Manager stated she would call the pharmacy and investigate. -She did not know if the Manager called the pharmacy on 01/09/26. -She had not thought to call the pharmacy and check into why Resident #3 melatonin 3mg, one tablet at bedtime was on the medication cart but not on his eMAR. Refer to the telephone interview with the Administrator on 01/30/26 at 11:42am. _____ Telephone interview with the Administrator on 01/30/26 at 11:42am revealed: -The MAs were responsible to administer resident medications according to the eMAR. -The MAs were to reach out to the Resident Care Coordinator (RCC) or the Manager if there were	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 01/30/2026

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 18 resident medications on the medication cart that were not on the resident's eMAR. -MAs could contact the pharmacy with questions but should also notify the RCC and/or Manager. -The pharmacy was responsible to discontinue resident medications in the eMAR system. -MAs were not to discontinue orders on the eMAR. -The facility did not complete audits of resident medications unless it was a controlled substance.	D 358		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order;(3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	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 01/30/2026

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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

	REGULATORY OR LSC IDENTIFYING INFORMATION)			
D 367	Continued From page 19 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure the electronic medication administration records (eMARs) were accurate for 1 of 3 residents (#3) related to inaccurate documentation of a medication used to treat high blood sugar levels and sleeplessness. The findings are: Review of Resident #3's current FL2 dated 01/12/26 revealed diagnoses included cerebral vascular accident (stroke), post-traumatic stress disorder and depression. a. Review of Resident #3's current FL2 dated 01/12/26 revealed there was no order for metformin (a medication to lower blood sugar levels). Review of Resident #3's Nurse Practitioner's (NP) progress note dated 08/19/25	D 367	**Inaccurate eMAR Documentation** **Provider's Plan of Correction** **1. Corrective Action for Affected Resident:** Resident #3's eMAR corrected to include all active medication orders. Pharmacy and RCC reviewed eMAR for accuracy. **2. Identification of Other Residents:** All residents' eMARs audited for accuracy. **D367** **3. Systemic Changes:** New eMAR accuracy verification process implemented requiring weekly checks by RCC. **4. Monitoring:** RCC will audit eMARs weekly × 8 weeks, then monthly × 3 months. Results reviewed in QA. **5. Responsible Person:** RCC	**03/01/2026**

	revealed an order for metformin 500mg, one and one-half tablets twice daily. Review of Resident #3's December 2025 and January 2026 electronic medication administration records (eMAR) revealed there was no entry for metformin 500mg, one and one-half tablets twice daily. Observation of medications on hand for Resident #3 on 01/29/26 at 1:52pm revealed: -There were two bubble packs containing metformin 500mg, one and one-half tablets for Resident #3, with directions to administer one and one-half tablets twice daily. -The label on each bubble pack revealed metformin 500mg, 93 tablets were dispensed for			

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 01/30/2026

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 367	Continued From page 20 Resident #3 on 12/29/25. -The bubble pack labeled "1 of 2" had 7 of 31 doses of metformin 500mg, one and one-half tablets remaining. -The bubble pack labeled "2 of 2" had 31 of 31 doses of metformin 500mg, one and one-half tablets remaining. Telephone interview with a representative with the facility's contracted pharmacy on 01/30/26 at 9:18am and 10:13am revealed: -The pharmacy usually entered and discontinued resident orders in the eMAR system, but facility staff could also enter and discontinue medication orders. -Resident #3 had an active order dated 08/19/25 for metformin 500mg, one and one-half tablet twice daily. -Metformin 500mg, 90 tablets (30-day supply) was dispensed for Resident #3 on 10/29/25. -Metformin 500mg, 93 tablets (31-day supply) was dispensed for Resident #3 on 12/10/25. -Metformin 500mg, 93 tablets (31-day supply) was dispensed for Resident #3 on 12/29/25. -She was able to view Resident #3's December 2025 and January 2026 eMARs and there was no entry for metformin 500mg, one and one-half tablets twice daily. -The pharmacy did not receive a discontinue order for Resident #3's metformin 500mg, one and one-half tablets twice daily. -A medication aide (MA) at the facility discontinued Resident #3's metformin 500mg, one and one-half tablets twice daily on 10/13/25 on the eMAR. -She did not know why the MA discontinued Resident #3's metformin 500mg, one and one-half tablets twice daily on the eMAR because there was no discontinue order.	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 01/30/2026

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 367	Continued From page 21 Telephone interview with a MA on 01/30/26 at 10:40am revealed: -Resident #3's had metformin 500mg, one and one-half tablets twice daily available to administer on the medication cart. -She did not administer metformin 500mg, one and one-half tablets to Resident #3 because it was not indicated as a medication to administer during her medication pass. -She did not know why MAs administered metformin 500mg, one and one-half tablets to Resident #3 since it did not appear on his December 2025 and January 2026 eMARs. Refer to the telephone interview with the Administrator on 01/30/26 at 11:42am. b. Review of Resident #3's current FL2 dated 01/12/26 revealed there was no order for melatonin (a medication to treat insomnia). Review of Resident #3's Physician's Orders dated 10/30/25 revealed an order for melatonin 3mg, one tablet at bedtime. Review of Resident #3's December 2025 and January 2026 electronic medication administration records (eMAR) revealed there was no entry for melatonin 3mg, one tablet at bedtime. Observation of medications on hand for Resident #3 on 01/29/26 at 1:52pm revealed: -There was a bubble pack containing melatonin 3mg, one tablet for Resident #3, with directions to administer one tablet at bedtime. -The label on the bubble pack revealed melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/29/25. -The bubble pack had 17 of 31 doses of	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 01/30/2026

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 367	Continued From page 22 melatonin 3mg, one tablet remaining. Telephone interview with a representative with the facility's contracted pharmacy on 01/30/26 at 9:18am and 10:13am revealed: -The pharmacy usually entered and discontinued resident orders in the eMAR system, but facility staff could also enter and discontinue medication orders. -Resident #3 had an active order dated 10/30/25 for melatonin 3mg, one tablet at bedtime. -Melatonin 3mg, 30 tablets was dispensed for Resident #3 on 10/29/25. -Melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/10/25. -Melatonin 3mg, 31 tablets was dispensed for Resident #3 on 12/29/25. -She was able to view Resident #3's December 2025 and January 2026 eMARs and there was no entry for melatonin 3mg, one tablet at bedtime. -The pharmacy did not receive a discontinue order for Resident #3's melatonin 3mg, one tablet at bedtime. -A medication aide (MA) at the facility discontinued Resident #3's melatonin 3mg, one tablet at bedtime on 10/13/25 on the eMAR. -She did not know why the MA discontinued Resident #3's melatonin 3mg, one tablet at bedtime on the eMAR because there was no discontinue order. Telephone interview with a MA on 01/30/26 at 10:40am revealed: -Resident #3's had melatonin 3mg, one tablet at bedtime available to administer on the medication cart. -She did not administer melatonin 3mg one tablet at bedtime to Resident #3 because it was not indicated as a medication to administer during her medication pass.	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 01/30/2026

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 367	Continued From page 23 -She did not know why MAs administered melatonin 3mg, one tablet to Resident #3 since it did not appear on his December 2025 and January 2026 eMARs. Refer to the telephone interview with the Administrator on 01/30/26 at 11:42am. _____ Telephone interview with the Administrator on 01/30/26 at 11:42am revealed: -She was not aware Resident #3 was administered medications that were not on his eMAR. -The MAs were to administer resident medications according to the eMAR. -If a medication was on the medication cart but not on the resident's eMAR, the MA should not be administering the medication. -The MAs were to notify the Manager, Resident Care Coordinator (RCC) or pharmacy if a medication was on the medication cart and not on the resident's eMAR. -The MAs were responsible to document accurately on the resident's eMAR. -The facility did not complete audits of resident eMARs and medications except for controlled substances.	D 367		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical	D 451		

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 01/30/2026

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	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE

	REGULATORY OR LSC IDENTIFYING INFORMATION)			
D 451	Continued From page 24 evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to notify the local county Department of Social Services (DSS) of an incident for 1 of 3 sampled residents who had an x-ray of his right arm and hand the facility after a fall (#2). The findings are: Resident #2's current FL2 dated 01/12/26 revealed diagnoses including dementia, behavioral disturbances and chronic obstructive pulmonary disease. Review of Resident #2's Resident Register revealed Resident #2 was admitted to the facility on 05/11/16. Review of Resident #2's record revealed:	D 451	**Failure to Report Incident to DSS** **Provider's Plan of Correction** **1. Corrective Action for Affected Resident:** Incident involving Resident #2 was reported to DSS immediately upon discovery. Staff re-educated on mandatory reporting requirements. For this particular instance we have sent timely email to DSS, but it seems the email was never delivered. Moving forward we will send the Incident reports with both email and fax to avoid this concern. **2. Identification of Other Residents:** **D451** Review of all incident reports from past 90 days completed to ensure all reportable incidents were submitted to DSS. **3. Systemic Changes:** New incident-reporting checklist implemented requiring Administrator review before filing. **4. Monitoring:** Administrator will review all incident reports weekly × 2 months, then monthly. **5. Responsible Person:** Administrator	**03/01/2026**

	-There was no Accident and Incident report dated 01/22/26. -There was no documentation the local county DSS had been notified of Resident #2's injury on 01/22/26. Interview with a medication aide (MA) on 01/29/26 at 3:55pm revealed: -On 01/22/26, she noticed Resident #2's right arm and wrist were swollen. -She contacted the primary care providers office and completed a virtual triage with Resident #2 and a physician. -The physician ordered a "STAT" x-ray of			

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 01/30/2026

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 451	Continued From page 25 Resident #2's right arm and wrist. -She asked Resident #2 if he fell and Resident #2 "nodded" his head no, but the roommate stated that Resident #2 did fall on 01/21/26. -She was responsible for completing the Accident and Incident report and sending the report to the local DSS but did not do so because Resident #2 was not sent out of the facility. Interview with the facility's Manager on 01/29/26 at 1:45pm revealed: -She was responsible for sending Accidents and Incident reports to the local county DSS and placing a copy in the residents' records. -She did not review an Accidents and Incident report dated 01/22/26 because Resident #2 was not sent out for evaluation. -On 01/22/26, Resident #2's PCP completed a "teletriage" with Resident #2 and ordered right arm and hand x-rays due to "swelling" and Resident #2 complained of "pain". Interview with the Administrator on 01/29/26 at 3:27pm revealed: -The facility Manager was responsible for sending Accidents and Incident reports to the local county DSS and placed a copy in the facility chart. -She did not know Resident #2's Accident & Incident report related to his right arm and hand injury requiring x-rays was not sent to DSS. -She expected all reportable Accident and Incident reports to be sent to DSS in a timely manner.	D 451		