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
	HAL070006	A. BUILDING: _____ B. WING _____	C 01/14/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE OF ELIZABETH CITY	100 TIMMERMAN DRIVE ELIZABETH CITY, NC 27909

(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 conducted a complaint investigation from 01/13/26 to 01/14/26. The complaint was initiated by Pasquotank County Department of Social Services on 09/24/25.	D 000	The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents by using the following guidelines Ensuring that every time a resident leaves the building for a medical visit, they carry a consultation form for the doctor to fill out. Upon the resident's return, a supervisor will review the discharge summary for new orders, medication changes, referrals or required treatments. If a referral was recommended but not completed (the resident refused or the family wanted a second opinion), the Primary Care will be notified and this will be documented in the progress notes to show the facility attempted the follow-up. Residents will be made aware that state regulations require them to inform facility of all referrals and follow up or facility shall contact physician to obtain information.	01/15/26
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: Based on observations, interviews, and record reviews, the facility failed to ensure referral and follow up to meet the health care needs for 1 of 6 sampled residents including failing to schedule a diabetic eye exam and coordinate physical therapy appointments (#6). The findings are: Review of a Resident Contract and Facility Disclosure packet signed by Resident #6 on 05/29/25 revealed: -The facility's services and accommodations included a comprehensive program of total care. -The facility would make appropriate arrangements for health care as needed. -Assistance would be given to residents on an individual basis with their eating, walking, dressing, bathing, personal grooming, ambulating, correspondence, scheduling of appointments and shopping when necessary. Review of Resident #6's current FL-2 dated 09/30/25 revealed:	D 273		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Janice C. Mills — TITLE: Administrator — (X6) DATE: 2-26-26

Reviewed and Acknowledged SJS 2/27/26

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D 273	Continued From page 1 -Diagnoses included diabetes, hypertension, major depressive disorder, and anxiety disorder. -The resident was semi ambulatory; there was no information provided related to the resident's orientation. -The resident's level of care was assisted living (AL). Review of the Resident Register revealed the resident was admitted to the facility on 05/29/25. Review of Resident #6's current care plan dated 06/06/25 revealed the resident was independent with eating, toileting, ambulation, bathing, dressing, grooming and transfers. a. Review of Resident #6's primary care provider (PCP) visit note dated 06/06/25 revealed she completed an order for Resident #6 to have a diabetic eye exam. Review of Resident #6's facility progress note dated 07/23/25 at 3:00pm revealed: -Resident #6's mental health case manager requested the resident be referred for an eye doctor appointment. -There was a note that the resident would be seen by her PCP on 08/12/25 and staff would request a referral order from the PCP. Review of Resident #6's signed physicians order dated 08/14/25 revealed an order for a referral to ophthalmology for a routine eye exam and diabetic eye exam. There was a handwritten note on the signed physician order dated 08/20/25 at 12:45pm that the eye doctor's office was closed due to inclement weather on 08/20/25.	D 273		

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D 273	Continued From page 2 Review of Resident #6's facility progress note dated 08/20/25 at 1:00pm revealed a call was placed to a local eye doctor and the office was closed due to inclement weather due to an approaching hurricane. Telephone interview with Resident #6 on 01/13/26 at 3:23pm revealed: -She no longer lived at the facility and was discharged to the community so she could live independently. -She was not seen by an eye doctor when she lived at the facility. -She knew that her primary care provider (PCP) wanted her to have an eye exam due to her diabetes. -Her mental health case management team had scheduled an appointment with an eye doctor on 01/27/26. Telephone interview with a representative at the eye doctor's office on 01/14/26 at 9:20am revealed: -Resident #6 was last seen at their office in 2021. -Their office was closed on 08/20/25 due to inclement weather. -There was no documentation in the system that an appointment had been scheduled for Resident #6 while she resided at the facility. -The resident had an upcoming eye doctor appointment scheduled for 01/27/26. interview with the Director of Health Services (DHS) on 01/14/26 at 1:02pm revealed: -She attempted to schedule Resident #6's eye doctor appointment on 08/20/25 but their office was closed due to inclement weather. -She or a medication aide (MA) scheduled appointments for residents. -When an appointment was made, the	D 273		

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D 273	Continued From page 3 appointment was documented in the appointment/transportation book, and the facility provided transportation for the resident to their appointment. -She was "almost sure" she made the resident an appointment with an eye doctor, however she and the MAs evidently overlooked it. -She should have called the eye doctor's office back to schedule the resident's eye exam as ordered by her PCP. Interview with the Administrator on 01/14/26 at 1:41pm revealed: -The transportation coordinator took Resident #6 to an eye appointment on 08/20/25, however the office was closed due to inclement weather. -Staff did not reschedule her appointment with the eye doctor because the resident did not have any type of insurance or resources to pay for the visit. -She notified the resident's PCP by telephone that the resident had no resources to pay for an eye doctor appointment. -The DHS or MA should have requested a discontinue order for the eye doctor referral from the PCP. Attempted telephone interview with Resident #6's PCP on 01/14/26 at 1:28pm was unsuccessful. b. Review of Resident #6's signed physicians order dated 08/20/25 revealed: -There was an order for a referral for physical therapy (PT) due to the residents unsteady gait and falls. -There was a handwritten note on the order by facility staff dated 08/29/25 that the order was faxed to a local PT office. Review of a communication note from the Director of Health Services (DHS) to Resident	D 273		

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D 273	Continued From page 4 #6's primary care provider (PCP) dated 08/29/25 revealed: -Multiple attempts had been made to coordinate a PT evaluation with a local provider. -Resident #6 had a PT evaluation scheduled for 10/02/25 at 10:15am. -The local provider needed an updated physician's order for Resident #6's PT and OT evaluation. Review of Resident #6's facility progress note dated 08/29/25 at 2:19pm revealed: -The resident was scheduled for an evaluation with physical therapy (PT) on 10/02/25. -The resident would need an updated referral for PT. -Staff at the facility faxed a new request for an order for a PT evaluation for Resident #6. Review of Resident #6's facility progress note dated 10/28/25 at 2:45pm revealed: -The facility received a telephone call from Resident #6's PT office staff. -The PT office staff reported that Resident #6 had missed appointments on 10/17/25, 10/22/25, 10/24/25, and 10/28/25. -Facility staff informed the PT office staff that Resident #6 had not informed them that she had appointments on these dates and that the resident was currently out of the facility and staff would have the resident call the PT office when she returned to the facility. -If the resident returned to the facility after hours, they would have the resident call the PT office the next day. Review of Resident #6's facility progress note dated 10/29/25 at 8:25am revealed: -Facility staff called Resident #6's PT office and informed staff again that they were not aware of	D 273		

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D 273	Continued From page 5 Resident #6's PT appointments because the resident had not informed staff about her appointment dates and times. -Facility staff provided Resident #6 with the telephone so she could speak to the PT office staff. -Resident #6's next PT appointment was scheduled for Thursday (10/30/25). Review of Resident #6's facility progress note dated 10/30/25 at 11:00am revealed: -Facility staff received a telephone call from a representative at the PT office to report that Resident #6 had called earlier in the morning to cancel her PT appointment because she did not have transportation. -The representative from the PT office reported that when the resident arrived at the PT office later in the day on 10/30/25 PT staff informed her that another person had already been scheduled in her place after she cancelled her appointment. Telephone interview with a representative from the local PT provider on 01/14/26 at 9:33am revealed: -Resident #6 was seen for her PT evaluation on 10/02/25. -Resident #6 was a no show for appointments scheduled for PT on 10/17/25, 10/22/25, 10/24/25, and 10/28/25. -When Resident #6 had her PT evaluation, she was provided with a schedule of upcoming PT visits. -She had called the facility on 10/28/25 to inquire about the residents' no shows for appointments and found out from facility staff that they were not aware of the scheduled appointments. -She informed facility staff that Resident #6 had an appointment scheduled for 10/30/25. -Resident #6 called on 10/30/25 to cancel her PT	D 273		

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D 273	Continued From page 6 appointment on 10/30/25. Telephone interview with Resident #6 on 01/13/26 at 3:23pm revealed: -She was transported by the facility to her PT evaluation. -She was not aware of any future PT appointments until a few weeks later she walked by the nursing station at the facility and facility staff told her the PT office was on the phone and needed to speak with her. -Staff from the PT office informed her that she had missed several appointments, she apologized and informed them that she was not aware she had appointments. -She had an upcoming appointment with PT on 01/27/26. Review of Resident #6's facility progress note dated 10/30/25 at 11:15am revealed the resident was discharged from the facility into the care of her case management mental health team. Interview with the DHS on 01/14/26 at 1:02pm revealed: -She or a medication aide (MA) reviewed primary care provider (PCP) visit notes and orders; if there were any referrals they coordinated the referral. -After a referral was made, they documented the appointment in the appointment/transportation book. -The facility provided transportation for residents to their appointments. -When the resident returned from her first PT evaluation, she asked the resident if she had any future PT appointments or an appointment card and the resident shook her head "no." -She assumed that when the resident shook her head "no" that the resident did not have any	D 273		

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D 273	Continued From page 7 additional appointments, because the resident was her own responsible party. -She did not call the PT office to ask if the resident had any additional PT appointments and was not aware of any MAs calling to inquire if the resident had additional PT appointments. Interview with the Administrator on 01/14/26 at 1:41pm revealed: -When residents had an appointment and returned to the facility the DHS or MA asked the resident if they had any future appointments so the appointments could be documented in the appointment/transportation book. -To her knowledge Resident #6 did not inform facility staff that she had any future PT appointments. -When staff asked a resident if they had future appointments, it was the resident's right whether or not they wanted to inform them of any appointments when they were alert and oriented and their own responsible party. Attempted telephone interview with Resident #6's PCP on 01/14/26 at 1:28pm was unsuccessful.	D 273		