STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FCL078122	A. BUILDING: _____ B. WING _____	01/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERITAGE CARE HOMES OF DIALS #3	70 CARE DRIVE PEMBROKE, NC 28372

(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
C 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on January 15, 2026. The complaint investigation was initiated by the Robeson County Department of Social Services on December 29, 2025.	C 000		3/31/26
C 342	10A NCAC 13G .1004(j) Medication Administration 10A NCAC 13G .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents (#1) including documentation for a medication used to treat	C 342	10A NCAC 13G.1004(j) Medication Administration The MT is responsible to keep accurate record of all narcotics. They are to click them off as soon as they give them and document it in the control log so the amount of meds match up with the control sheets. The Administrator will make daily rounds to ensure the count of all narcotics are correct for one monthly then monthly	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Rosi Worcester TITLE: Administrator (X6) DATE: 3/3/26 3/20/26

Reviewed and acknowledged on 03/23/26 by Joyce Johnston

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C 342	Continued From page 1 anxiety and agitation. The findings are: Review of the undated controlled substances policy revealed: -Every administration of a controlled substance must be recorded in both the electronic medication administration record (eMAR) and the controlled substance count sheet, to include resident's name, medication name, strength, dosage, quantity, date, time of administration, name/initials of person administering (with a signature equivalent, reason for PRN (to be taken as needed), and documentation of any omissions or refusals. -The eMAR and controlled substance count sheets must match exactly. -Discrepancies must be investigated and resolved immediately. -Managers/Administrators should conduct weekly audits comparing eMAR entries with the controlled substance count sheet. -If count does not match immediately notify manager/administrator, review eMARs, count sheet, inventory logs, document investigation and corrective action. Review of Resident #1's current FL-2 dated 01/13/2026 revealed: -Diagnoses included depression, bipolar, cerebral infarction, dementia with behavior disturbance, diabetes, hypertension, hyperlipidemia, and hypothyroidism. -She was semi-ambulatory. Review of Resident #1's Resident Register revealed an admission date of 01/15/2023. Review of the physician order sheet dated	C 342		

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C 342	Continued From page 2 10/14/25 revealed Resident #2 had an order for Lorazepam 1mg every 6 hours as needed for anxiety or agitation. Review of Resident #1's July 2025 electronic medication administration record (eMAR) on revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety. -There was documentation that Lorazepam 1 mg was administered once on 07/03/25, 07/05/25, 07/07/25, 07/13/26, 07/14/26, and 07/25/26. -There was not a time or reason for Lorazepam 1 mg was administered in the exceptions on any of the documented dates of administration. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was documentation that Lorazepam 1 mg was administered once on 08/02/25, 08/03/25, 08/05/25, 08/15/25, 08/18/25, 08/26/25. -There was not a time or reason for Lorazepam 1 mg was administered in the exceptions on any of the documented dates of administration. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was documentation that Lorazepam 1 mg was administered once on 09/13/25 and 09/14/25. -There was not a time or reason for Lorazepam 1 mg was administered in the exceptions on any of the documented dates of administration. Review of Resident #1's October 2025 eMAR revealed:	C 342		

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C 342	Continued From page 3 -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was not any documentation that Lorazepam 1 mg was administered from 10/01/25 to 10/31/25. Review of Resident #1's November 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was documentation that Lorazepam 1 mg was administered once on 11/07/25. -There was not a time or reason for Lorazepam 1 mg was administered in the exceptions on 11/07/25. Review of Resident #1's December 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was not any documentation that Lorazepam 1 mg was administered from 12/01/25 to 12/31/25. Review of Resident #1's January 2026 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety/agitation. -There was not any documentation that Lorazepam 1 mg was administered from 01/01/26 to 01/14/26. Telephone interview with the facility's contracted pharmacist on 01/15/26 at 11:47am revealed: -There was an order for Lorazepam 1mg every 6 hours as needed for Resident #1. -Lorazepam 1mg every 6 hours as needed was dispensed on 06/23/25 for 60 tablets (4 medication cards that contained 15 tablets each) for Resident #1.	C 342		

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C 342	Continued From page 4 -A delivery service delivered Resident #1's Lorazepam 1mg to the facility on 06/24/26. -A separate controlled substance sheet was sent with each narcotic card and the facility could also print the control substance sheet. -The pharmacy did not get a copy of the completed controlled substance sheet. Review of Resident #1's controlled substance logs revealed: -There were 2 controlled drug sheets provided for Lorazepam 1mg every 6 hours as needed that contained Resident #1's name, prescription number (8292400), date dispensed, quantity (60). -There was not any documentation on the controlled sheets that Lorazepam 1mg had been administered. -Review of one controlled substance sheet was for 15 tablets. -The Administrator's signature was documented by received for Lorazepam 1mg as needed and the amount was 15 and there was handwritten documentation on the controlled sheet; new staff on 09/08/25 1 pill missing. -There was not any documentation on the controlled substance logs that Lorazepam 1mg had been administered. Observation of medications on hand on 01/15/26 at 10:58am revealed: -There was a medication card dated 06/23/25 for Lorazepam 1mg labeled PRN (PRN is an abbreviation meaning as needed) 3 of 4 that contained 6 tablets. -There was a medication card dated 06/23/25 for Lorazepam 1mg labeled PRN 4 of 4 that contained 15 tablets. Interview with the Administrator on 01/15/26 at	C 342		

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C 342	Continued From page 5 12:47pm revealed: -She was also working as a medication aide (MA) at the facility. -She was hired on 07/22/24 and her last day of employment was 09/15/25. -She was rehired at the facility on 11/05/25. -She was the only MA since 12/15/25. -She knew that the time and reason for administering as needed medications should have been documented in the eMARs. -She was not sure why she had not documented Resident #1's Lorazepam 1mg on the controlled substance logs. -She was not sure why the MAs had not documented the Lorazepam 1mg on the controlled substance sheet. -She was not sure why the MAs had not documented the time and reason for administering the as needed Lorazepam 1mg in the eMARs. -She was aware that she was responsible for ensuring documentation was complete. Attempted telephone interview with facility's contracted primary care provider (PCP) on 01/15/26 at 12:15pm was unsuccessful.	C 342	10A NCAC 13G .1008(a) Controlled Substance The administrator will ensure that all control sheets are correct with all narcotics count. The administrator will do daily checks on all narcotic count sheets. for one month Then the administrator will do a narcotic check on control substance weekly.	
C 367	10A NCAC 13G .1008(a) Controlled Substances 10A NCAC 13G .1008 Controlled Substances (a) A family care home shall assure a readily retrievable record of controlled substances by documenting the receipt, administration and disposition of controlled substances. These records shall be maintained with the resident's record and in such an order that there can be accurate reconciliation. This Rule is not met as evidenced by:	C 367		

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C 367	Continued From page 6 Based on observations, interviews, and record reviews, the facility failed to ensure readily retrievable records that accurately reconciled the receipt and administration of controlled substances for 1 of 2 sampled residents (#1) with orders for a controlled substance used to treat anxiety or agitation. The findings are: Review of the undated controlled substances policy revealed: -Every administration of a controlled substance must be recorded in both the electronic medication administration record (eMAR) and the controlled substance count sheet, to include resident's name, medication name, strength, dosage, quantity, date, time of administration, name/initials of person administering (with a signature equivalent, reason for PRN (to be taken as needed), and documentation of any omissions or refusals. -The eMAR and controlled substance count sheets must match exactly. -Discrepancies must be investigated and resolved immediately. -Upon receipt verify the medication against the delivery record. -Record the medication in the controlled substance log including received and staff signature. -At the beginning and end of each shift two staff members should count all controlled substances together. -Managers/Administrators should conduct weekly audits comparing eMAR entries with the controlled substance count sheet. -If count does not match immediately notify manager/administrator, review eMARs, count sheet, inventory logs, document investigation and	C 367		

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C 367	Continued From page 7 corrective action. Review of Resident #1's current FL-2 dated 01/13/2026 revealed: -Diagnoses included depression, bipolar, cerebral infarction, dementia with behavior disturbance, diabetes, hypertension, hyperlipidemia, and hypothyroidism. -She was semi-ambulatory. Review of Resident #1's Resident Register revealed an admission date of 01/15/2023. Review of the physician order sheet dated 10/14/25 revealed Resident #2 had an order for Lorazepam 1mg every 6 hours as needed for anxiety or agitation (Lorazepam is used to treat anxiety and agitation). Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was documentation that Lorazepam 1 mg was administered once on 07/03/25, 07/05/25, 07/07/25, 07/13/26, 07/14/26, and 07/25/26. Review of Resident #1's August 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was documentation that Lorazepam 1 mg was administered once on 08/02/25, 08/03/25, 08/05/25, 08/15/25, 08/18/25, 08/26/25. Review of Resident #1's September 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation.	C 367		

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C 367	Continued From page 8 -There was documentation that Lorazepam 1 mg was administered once on 09/13/25 and 09/14/25. Review of Resident #1's October 2025 eMAR on 01/15/26 revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was not any documentation that Lorazepam 1 mg was administered from 10/01/25 to 10/31/25. Review of Resident #1's November 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was documentation that Lorazepam 1 mg was administered once on 11/07/25. Review of Resident #1's December 2025 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was not any documentation that Lorazepam 1 mg was administered from 12/01/25 to 12/31/25. Review of Resident #1's January 2026 eMAR revealed: -There was an entry for Lorazepam 1 mg every 6 hours as needed for anxiety or agitation. -There was not any documentation that Lorazepam 1 mg was administered from 01/01/26 to 01/14/26. Observation of Resident #1's medications on hand on 01/15/26 at 10:58am revealed: -There was a medication card dated 06/23/25 for Lorazepam 1mg labeled PRN (PRN is a medical abbreviation meaning as needed) 3 of 4 that	C 367		

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C 367	Continued From page 9 contained 6 tablets. -There was a medication card dated 06/23/25 for Lorazepam 1mg labeled PRN 4 of 4 that contained 15 tablets. Review of Resident #1's controlled substance logs revealed: -There were 2 controlled substance logs provided for Lorazepam 1mg every 6 hours as needed that contained Resident #1's name, prescription number, date dispensed, quantity (60). -There was not any documentation on the controlled substance logs that Lorazepam 1mg had been administered. -There was 1 controlled substance logs provided for Lorazepam 1mg every 6 hours as needed that contained Resident #1's name, prescription number, date dispensed, quantity (60). -The Administrator's signature was documented by received and by amount 15. -There was handwritten documentation on a controlled substance log, new staff on 09/08/25 1 pill missing. -There was not any documentation on the controlled substance logs that Resident #1's Lorazepam 1mg had been administered. Telephone interview with the facility's contracted pharmacist on 01/15/26 at 11:47am revealed: -There was an order for Lorazepam 1mg every 6 hours as needed for Resident #1. -Lorazepam 1mg every 6 hours as needed was dispensed on 06/23/25 for 60 tablets (4 medication cards that contained 15 tablets each) for Resident #1. -A delivery service delivered Resident #1's Lorazepam 1mg to the facility on 06/24/26. -A separate controlled substance logs were sent with each narcotic card and the facility could also print the control sheet.	C 367		

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C 367	Continued From page 10 -The pharmacy did not get a copy of the completed controlled substance logs. Interview with the Administrator on 01/15/26 at 12:47pm revealed: -She was also working as the facility's medication aide (MA). -She was hired on 07/22/24 and her last day of employment was 09/15/25. -She was rehired at the facility on 11/05/25. -The facility did not utilize a form to document the controlled substance count at shift change. -She did not perform a narcotic count of the medication cart when she was rehired or when the previous MA left employment on 12/15/25. -She was the only MA working at the facility since 12/15/25. -She had assumed a medication cart from another staff without counting the narcotics. -She did not know there was an issue with the controlled substance logs until today (01/15/26). -She tried to perform medication cart audits weekly but could not remember the last time she had performed a medication cart audit on this cart. -She could not remember why she did not sign out on the controlled substance log or place a time and reason on the eMAR for Resident #1's administered Lorazepam 1mg on 11/07/25. -She knew that the controlled substance log should be completed. -She did not know why Resident #1's controlled substance log was not completed. -She was aware that she was responsible for ensuring the documentation was complete. Attempted telephone interview with facility's contracted primary care provider (PCP) on 01/15/26 at 12:15pm was unsuccessful.	C 367		