STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 and Pender County Department of Social Services conducted an annual survey and complaint investigation from 07/29/25 to 07/31/25. The complaint investigation was initiated by the Department of Social Services on 07/08/25.	D 000		
D 225	10A NCAC 13F .0702 (c) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (c) The facility administrator or their designee shall assure the following requirements for written notice are met before discharging a resident: (1) The Adult Care Home Notice of Discharge with the Adult Care Home Hearing Request Form shall be completed and hand delivered, with receipt requested, to the resident on the same day the Adult Care Home Notice of Discharge is dated. These forms may be obtained at no cost from theDivision of Health Benefits, on the internet website https://policies.ncdhhs.gov/divisional/healthbenefits-nc-medicaid/forms. The Adult Care Home Notice of Discharge shall include the following: (A) the date of notice; (B) the date of transfer or discharge; (C) the reason for the notice; (D) the name of responsible person or contact person notified; (E) the planned discharge location; (F) the appeal rights; (G) the contact information for the long-term care ombudsman; and (H) the signature and date of the administrator. (2) A copy of the completed Adult Care Home Notice of Discharge and Adult Care Home Hearing Request Form shall be hand delivered,	D 225		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 225	Continued From page 1	D 225		

with receipt requested, or sent by certified mail to the resident's responsible person or legal representative and the individual identified upon admission to receive a discharge notice on behalf of the resident on the same day the Adult Care Home
Notice of Discharge is dated. For the purposes of this Rule "responsible person" means a person chosen by the resident to act on their behalf to support the resident in decision-making; access to medical, social, or other personal information of the resident; manage financial matters; or receive notifications. The Adult Care Home Hearing Request Form shall include the following:
(A) the name of the resident;
(B) the name of the facility;
(C) the date of transfer or discharge;
(D) the date of scheduled transfer or discharge;
(E) the selection of how the hearing is to be conducted;
(F) the name of the person requesting the hearing; and
(G) for the person requesting the hearing, their relationship to the resident, address, telephone number, their signature, and date of the request.
(3) Provide the following material in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to the resident and the resident's legal representative and the individual identified upon admission to receive a copy the discharge notice on behalf of the resident:
(A) a copy of the resident's most current FL-2 form required in Rule .0703 of this Subchapter;
(B) a copy of the resident's current physician's orders, including medication order;
(4) Failure to use and simultaneously provide the specific forms according to Subparagraphs (c)(1) and (c)(2) of this Rule shall invalidate the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 225	Continued From page 2	D 225		

discharge.
(5) A copy of the completed Adult Care Home Notice of Discharge, the Adult Care Home Hearing Request Form as completed by the facility administrator or their designee prior to giving to the resident and a copy of the receipt of hand delivery or the notification of certified mail delivery shall be maintained in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a written discharge notice was hand delivered or sent by certified mail to the responsible party or legal representative for 1 of 2 sampled resident, (#13) prior to discharging the resident.

The findings are:

Resident #13's current FL-2 dated 01/14/25 revealed diagnoses included Alzheimer's dementia and hypercholesterolemia.

Review of Resident #13's Notice of Transfer/Discharge form was not available for review.

Telephone interview with Resident #13's responsible party on 07/30/25 at 9:42am revealed:
-The resident was issued a 30-day discharge notice on 05/28/25 by the facility.
-He was notified via phone by the Executive

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 225	Continued From page 3 Director (ED) of the 30-day notice discharge. -He received a telephone call from the ED on 06/03/25 stating that Resident #13 was being immediately discharged from the facility due to an altercation with another resident. -He received an email regarding Resident #13's immediate discharge from the ED after he visited the resident on 06/03/25. Interview with Resident #13's primary care provider (PCP) on 07/31/25 at 9:54am revealed: -She was aware of Resident #13's aggressive behaviors which included several residents being assaulted. -She received a telephone call from the ED on 06/03/25 following a resident-to-resident altercation involving Resident #13. -She informed the ED to send Resident #13 to the hospital because his behaviors were not managed by his medications. Interview with the ED at 07/30/25 at 3:51pm revealed: -She was responsible for discharging residents from the facility. -She contacted Resident #13's family member on 05/28/25 via telephone to make them aware of the need to issue the resident a 30-day discharge notice. -She completed an immediate discharge notice and sent it with Resident #13 when Emergency Medical Services (EMS) transported him to the hospital. -She did not keep a copy of the discharge notice.	D 225		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 4 to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews the facility failed to ensure referral and follow-up to meet the acute health care needs of 1 of 5 sampled residents (#1) related to notifying a resident's primary care provider (PCP) of a skin irritation, causing a delay in treatment. The findings are: Review of Resident #1's current FL-2 dated 05/12/25 revealed: -Diagnoses included dementia, hypertension, hypercholesterolemia, urinary incontinence, and cerebrovascular disease. -The resident was ambulatory. Review of Resident #1's Resident Register revealed she was admitted to the facility on 06/11/25. Review of Resident #1's care plan dated 07/14/25 revealed: -She was independent with ambulation and transfer. -She required supervision with toileting, dressing, and grooming. -She required limited assistance with eating and bathing. Review of a physician's order dated 07/10/25 revealed there was an order to apply Nystatin Cream 100,000/gram under skin folds twice per day for 10 days. Review of Resident #1's July 2025 electronic	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 5	D 273		

medication administration record (eMAR) revealed:
-There was an entry for Nystatin cream 100,000 unit/gram, Apply topically to affected areas under the skin folds twice a day for 10 days, to be administered 8:00am and 8:00pm.
-Nystatin 100,000 unit/gram was documented as administered from 8:00pm on 07/11/25 through 8:00pm on 07/21/25.

Telephone interview with Resident #1's family member on 07/29/25 at 10:25am revealed:
-On 07/07/25, she helped Resident #1 to the bathroom.
-Resident #1 complained of burning and pain in her abdominal fold area.
-She observed redness and blisters in Resident #1's abdominal fold.
-Resident #1 had a history of redness and blistering in the abdominal fold in the past.
-On 07/07/25, she told the Executive Director (ED) and the medication aide (MA) about the redness and blistering in the abdominal fold of Resident #1 and requested that a fungal cream be applied.
-Staff was not aware of the redness and blistering in the abdominal fold prior to her telling them.
-On 07/09/25, she visited Resident #1, and the fungal cream had not arrived to the facility.
-On 07/10/25, she was told by the ED that the primary care provider (PCP) was on vacation, and she was unsure the medication had been ordered.
-She was informed by the ED that the anti-fungal cream was an over-the-counter medication.
-Family obtained the anti-fungal cream on 07/09/25.
-Resident #1 had a sitter on Tuesdays and Thursdays.
-The sitter started applying the anti-fungal cream

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 6	D 273		

to the abdominal fold 07/09/25.
-When she saw Resident #1 on 07/14/25, the irritation in the abdominal fold was clearing and there were no breaks, blisters or redness.

Telephone interview with Resident #1's private sitter on 07/30/25 at 11:16am revealed:
-She was Resident #1's sitter on Tuesdays and Thursdays.
-She provided assistance with activities of daily living (ADLs) such as showers, sitting with her at breakfast, activities, hair cuts, and toileting.
-She noticed the irritation in Resident #1's abdominal fold but did not recall the date.
-Resident #1's family member told her about the irritation in the abdominal fold on 07/07/25.
-On 07/07/25, Resident #1's family member told her that the MA was going to order an antifungal cream.
-On 07/08/25, she took an anti-fungal cream with her to the facility to apply to the abdominal fold of Resident #1; and applied the cream every visit.
-She was unsure if the facility obtained anti-fungal cream.

Telephone interview with a personal care aide (PCA)/MA on 07/30/25 at 4:28pm revealed:
-First shift PCAs provided personal care to Resident #1.
-Resident #1's sitter gave her baths on the days she came in.
-None of the PCAs noticed irritation in Resident #1's abdominal fold.
-When Resident #1's family member complained about a fungus in the abdominal fold, staff looked in the area and there was no irritation observed.
-Staff applied Nystatin to the abdominal fold even though no irritation was observed.
-She did not remember the dates she became aware of the redness in Resident #1's abdominal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 7 fold or when the cream was started. Telephone interview with the facility's contracted pharmacy on 07/30/25 at 10:07am revealed a verbal order from the PCP for Nystatin cream for Resident #1's skin fold was sent by the facility on 07/10/25 and delivered to the facility on 07/11/25. Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 10:21am revealed: -She was told by Resident #1's family member the resident had a rash and needed a fungal cream. -She wrote the verbal order and asked a MA to call Resident #1's provider and get the order and fax it afterwards. -When she returned to work a couple of days later, she asked the MA if the verbal order was done and found out it was not. -She asked the MA again to call and get the order. -She did not check with MA to see if the order was complete; she assumed it was. -She found out later that the fungal cream was never sent to the provider. Interview with the ED on 07/30/25 at 4:41pm revealed: -Resident #1's family member called on 07/10/25 and stated the resident was supposed to have Nystatin for the abdominal fold. -The facility's Regional Nurse checked the abdominal fold area and there was no irritation there; and the family member was informed. -Nystatin was ordered 07/10/25 by Resident #1's PCP. -Resident #1's family member brought Nystatin in on the same day that it was ordered (07/10/25). -She was unsure what day Nystatin arrived from the pharmacy.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 273	Continued From page 8 -She was not aware of the irritation Resident #1's abdominal fold prior to the family member calling on 07/10/25. Telephone interview with Resident #1's PCP on 07/30/25 at 3:55pm revealed: -She saw Resident #1 for the first time on 07/01/25. -On 07/01/25, she told the ED that she would not round the next week (07/07/25 through 07/11/25) because she would be on vacation, but would be available by phone. -The ED called her numerous times about other residents but did not call her to inform her that Resident #1 needed an anti-fungal cream for a fungus in the abdominal fold. -On 07/10/25, Resident #1's family member informed her that the resident needed an anti-fungal cream for a fungus under the abdominal fold and that she had been talking to the ED about it since the previous Friday (07/04/25). -She called the ED on 07/10/25 and gave a verbal order for Nystatin Cream 100,000 units/gram twice a day for 10 days for the abdominal fold. -She expected orders to be sent to the pharmacy right away. -She saw Resident #1 on 07/14/25 and the area looked good. Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable.	D 273		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 276	Continued From page 9 (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure implementation of orders for 1 of 5 sampled residents (#1) related to daily dressing changes. The findings are: Review of Resident #1's current FL-2 dated 05/12/25 revealed: -Diagnoses included dementia, hypertension, hypercholesterolemia, urinary incontinence, and cerebrovascular disease. -The resident was ambulatory. Review of Resident #1's July 2025 electronic medication administration record (eMAR) revealed there was no entry for daily dressing changes to the left forearm from 07/01/25 through 07/31/25. Review of the Medication/Treatment Notification Medication Error Report dated 07/10/25 on 07/29/25 revealed: -The date of discovery was 07/10/2025. -The dates of error were 07/01/25 through 07/10/25. -The number of errors was 10. -In the section labeled name of the medication, "change dressing to left forearm daily" was documented. -The reason for making the error was that the pharmacy stated they never received an order.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 276	Continued From page 10 -There was no effect on the resident. -The error was discovered when the "family was changing resident skin tear." -The RCC (Resident Care Coordinator) and ED (Executive Director) discovered the error. -The RCC and ED notified the physician. -The physician's order was to change the dressing to the left forearm daily. -The precautions that would be taken in the future to prevent similar errors was the RCC would fax all orders to the pharmacy as well as get confirmation of the fax. -The report was signed by the ED. Telephone interview with Resident #1's family member on 07/29/25 at 10:25am revealed: -Resident #1 had a skin tear on her left forearm on 07/01/25. -She informed the ED and the primary care provider (PCP) about the skin tear. -The PCP was present and advised she would write orders to have the skin tear taken care of in the facility. -She did not see Resident #1 between 07/01/25 and 07/07/25. -On 07/07/25, she noticed the skin tear was not wrapped. -On 07/09/25, the skin tear was wrapped. -On 07/10/25, she called the facility and spoke with the Regional Nurse who advised the facility was not allowed to apply wraps. On 07/10/25, she spoke with the ED and was informed that the PCP was on vacation, and she was unsure if any orders had been written regarding Resident #1's care. -She last saw Resident #1 on 07/25/25 and the skin tear had cleared up. Telephone interview with Resident #1's private sitter on 07/30/25 at 11:16am revealed:	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 276	Continued From page 11	D 276		

-She was Resident #1's sitter on Tuesdays and Thursdays.
-She helped with activities of daily living (ADLs) such as showers, sitting with her at breakfast, activities, haircuts, and toileting.
-She first noticed the skin tear approximately 3 weeks ago but did not remember the date.
-Resident #1's family member told her she could cover the skin tear.
-She did not need to cover the skin tear because it was already covered with a dressing.
-The following Thursday, she returned, and the skin tear was not covered.
-She washed the area and covered the skin tear with materials provided by facility staff.
-The following Tuesday, she washed the area and covered it with supplies that had been left by Resident #1's family member.
-A nurse or MA saw the covered forearm and told her she could not cover the area and removed the dressing.

Interview with a personal care aide (PCA)/MA on 07/30/25 at 4:28pm revealed:
-She did not know when Resident #1 obtained the skin tear.
-A caretaker came in one day and put tape on the skin tear.
-She was told to wrap the skin tear when the caretaker came to the desk one morning asking for supplies to wrap the skin tear.
-She gave the caretaker the proper supplies to wrap the skin tear.
-During that same week, the caretaker came and gave Resident #1 a shower and the dressing came off.
-The facility had been wrapping the skin tear ever since the dressing came off during the shower by the caretaker.
-There was no order to wrap the skin tear prior to

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 276	Continued From page 12	D 276		

the family member complaining.
-She did not recall the dates of anything regarding the skin tear for Resident #1.

Interview with the RCC on 07/30/25 at 11:38am revealed:
-She was unsure when the skin tear on Resident #1's left forearm occurred.
-The family was coming in and wrapping the forearm, so they were not wrapping Resident #1's forearm.

Interview with the ED on 07/30/25 at 4:41pm revealed:
-On 07/01/25, Resident #1's family member told her the resident had a skin tear.
-The PCP was on site and went to see Resident #1 with the family member.
-The PCP wrote an order to change the dressing and gave the order to either the MA or the RCC.
-The order was sent to the facility's contracted pharmacy but was never transcribed to the MAR.
-On 07/10/25, she found out the order was never transcribed to the MAR when the family called complaining about the dressing changes not occurring.
-When she arrived to the facility, she notified the PCP that the dressing changes were not done for 10 days.
-By the time she notified the PCP, the skin tear had healed.
-The family member and someone hired by the family had been changing the dressing daily but that was no excuse for the facility not to change the dressing.
-Staff stated the skin tear area was always cleaned and dressed when they saw it.
-The dressing changes were not documented on the MAR so there was no proof that staff changed the dressing.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 276	Continued From page 13 Interview with the PCP on 07/30/25 at 3:35pm revealed: -Her first visit with Resident #1 was on 07/01/25. -Resident #1's left forearm had been wrapped by a family member. -Resident #1's family member told her there was a dime size skin tear on the resident's left forearm. -She did not examine Resident #1's left forearm that day because the family member was there and had put a dressing on it. -On 07/01/25, she wrote an order for daily dressing changes and gave the order to the ED. -Dressing changes should have started the next day (07/02/25). -On 07/10/25, the ED told her Resident #1's visitor had been coming in and doing the dressing changes.	D 276		
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: (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: TYPE A1 VIOLATION Based on observation, interviews, and record reviews, the facility failed to ensure that a medication was administered as ordered for 1 of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

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D 358	Continued From page 14 5 sampled residents (#4) related to a medication used to treat moderate to severe pain. The findings are: Review of Resident #4's current FL-2 dated 07/23/25 revealed diagnoses included unspecified dementia, Parkinson's disease, chronic pain syndrome, and anxiety disorder unspecified. Review of Resident #4's current Care Plan dated 05/18/25 revealed: -Resident #4 was able to feed herself with set up and used her wheelchair independently for mobility. -Resident #4 required limited assistance with toileting, transferring, grooming, and hygiene. -Resident #4 required extensive assistance with bathing and dressing. Review of Resident #4's Physician Order Sheet from a pain management provider dated 04/30/25 revealed there was an order to continue to administer Morphine extended-release (ER) 15 mg every 12 hours scheduled (Morphine is an opioid narcotic medication used to treat moderate to severe levels of pain). Review of Neurology Provider Progress Notes dated 06/25/25 revealed: -Resident #4 was seen by pain management for back pain. -Resident #4's Morphine was "discontinued inadvertently by facility so patient has been struggling with pain issues". Review of Resident #3's Physician Order Sheet from a neurology provider dated 06/25/25 revealed an included note to the facility that	D 358		

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D 358	Continued From page 15 Resident #4 was suffering from worsening pain due to being off oral Morphine. Review of Resident #4's electronic medication administration record (eMAR) for June 2025 revealed: -There was an entry for Morphine ER 15 mg extended-release tablet give 1 tablet every 12 hours at 8:00am and 8:00pm. -There was no documentation that Morphine ER 15mg was administered from 06/11/25 at 8:00pm to 06/25/25 8:00pm for a total of 29 missed doses. Review of Resident #4's Controlled Substance Report for June 2025 revealed: -The eMAR documentation for Morphine ER 15mg administration matched the controlled substance count administration for Morphine ER 15mg. -Morphine ER 15 mg count reached zero once the 06/11/25 8:00am dose was administered and there was no further documentation until the Morphine ER 15 mg was refilled by the pharmacy in the quantity of 56 tablets on 06/25/25 and received by the facility on 06/26/25. Review of Resident #4's Progress Note dated 06/11/25 revealed a medication aide (MA) requested a Morphine refill from the primary care provider (PCP) and no outcome was documented. Review of Resident #4's Progress Note dated 06/12/25 revealed: -The Resident Care Coordinator (RCC) called the pain management provider and requested a Morphine refill and a hold order of the scheduled Morphine until the medication arrived to the facility.	D 358		

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D 358	Continued From page 16	D 358		

-There was no outcome of this call documented.
-There was no other documentation in June 2025 progress notes to reflect additional attempts to obtain Morphine for Resident #4.

Record Review of Resident #4's Physician Orders revealed there was no hold order for Morphine ER 15mg from 06/11/25 to 06/25/25.

Observation of Resident #4's medications on hand on 07/30/25 at 10:10am revealed Morphine ER 15 mg was dispensed on 07/17/25 with a quantity of 56 tablets with 43 tablets remaining.

Telephone interview with a representative from the facility-contracted pharmacy on 07/30/25 at 10:00am revealed:
-Morphine ER 15mg tablets were dispensed on 05/08/25 in the amount of 60 tablets for a 30-day supply and then not again until 06/25/25 in the amount of 56 tablets for a 28-day supply.
-Morphine ER 15mg was not dispensed earlier in June because the pharmacy required a prescription from a provider to dispense the medication.

Interview with Resident #4 on 07/31/25 at 9:35am revealed:
-Her pain was usually managed to her satisfaction by scheduled Morphine.
-She thought some facility staff did not believe her when she reported pain.
-She did not recall the exact dates she did not receive the scheduled Morphine, but she remembered hurting "so much, so so much" when she did not receive the medication.
-She had chronic pain in her neck, back, and legs for years.

Interview with Resident #4's family member on

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D 358	Continued From page 17 07/30/25 at 4:35pm revealed: -Resident #4 had a history of severe chronic neck and lower back pain from spinal stenosis and crushed vertebral discs since 2020. -Resident #4's Morphine was discontinued when she moved to the facility in March 2023 and the family member had to take her back to the pain management provider to get Morphine restarted in November or December of 2024. -Resident #4 had improvements in ability to move, a better mood, and lessened tremors once Morphine was reordered and administered in December 2024. -Resident #4 required steroid injections for pain in her neck and back in May 2025. -Facility staff did not report to her that Resident #4 was out of Morphine in June 2025. -She was notified by pain management that Resident #4's Morphine was not refilled and she also received complaints of increased pain from Resident #4. -Once she learned that Morphine was not refilled, she contacted or visited the facility 2 to 3 times a week to inquire about the refill. -After learning that the Morphine was still not refilled on 06/23/25, she contacted pain management on 06/24/25 and scheduled an appointment for Resident #4 with pain management for 06/25/25. -Pain management provided a prescription for a Morphine refill at the 06/25/25 appointment. Interview with a MA on 07/31/25 at 8:11am revealed: -Resident #4 frequently complained of pain, shakes, and reported her legs were hurting. -Resident #4's pain was eased by scheduled Morphine when it was administered. -She did not remember details about a delay in obtaining a refill for Morphine.	D 358		

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D 358	Continued From page 18 Interview with the RCC on 07/30/25 at 3:25pm revealed: -Resident #4 did not complain of pain any more than usual for the two weeks she did not receive the scheduled Morphine in June 2025. -The Morphine refill was delayed because of miscommunication between Resident #4's pain management provider and the facility contracted pharmacy. -She documented one attempt to obtain the Morphine refill. -The Morphine was refilled after the family member took Resident #4 to a pain management clinic appointment. -She did not believe Resident #4 required Morphine for pain because Resident #4 reported no increase in pain while the Morphine was not on hand at the facility. -Morphine was a medication ordered by a provider and scheduled twice a day for Resident #4 and facility staff should have ensured the medication supply was available and administered to Resident #4. -She should have called pain management and the pharmacy at least daily to ensure Morphine was refilled and given to Resident #4 as scheduled. -The facility process was for MA's to request refills for any medications patients needed before the medication ran out. -MAs should have reported any problem obtaining refills to her and she would then follow up to ensure the refill was obtained. -She called the pharmacy and pain management provider many times over the time period that the facility did not have the Morphine 15mg in stock for the resident but she did not document those attempts.	D 358		

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D 358	Continued From page 19 Interview with the Executive Director on 07/30/25 at 3:35pm revealed: -The PCP refused to refill Resident #4's Morphine because she did not believe Resident #4 needed the medication. -Resident #4 did not complain of pain any more than usual for the two weeks she did not receive the scheduled Morphine in June 2025. -She did not believe Resident #4 required Morphine for pain because she saw no difference in behavior, saw no increase in symptoms, and Resident #4 did not report increased pain when she did not receive Morphine. -Morphine was a medication ordered by a provider and scheduled twice a day for Resident #4 and facility staff should have ensured the medication supply was available and administered to Resident #4. -The facility process was for MAs to request refills for any medications patients needed before the medication ran out. -MAs should have reported any problem obtaining refills to the RCC who would then follow up to ensure the refill was obtained. Telephone interview with Resident #4's PCP on 07/31/25 at 8:30am revealed: -She was not comfortable refilling Morphine because she did not think Resident #4 needed it. -She weaned Resident #4 off of Morphine at admission to facility in March 2023 and believed Resident #4 was fine without the medication. -The pain management provider managed Morphine and since it was a scheduled medication, the facility staff should have ensured that Resident #4 did not run out of the medication. -Facility staff should have contacted pain management early enough to ensure the medication did not run out and scheduled an	D 358		

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D 358	Continued From page 20 appointment with pain management for Resident #4 if that was required to refill Morphine. -She did not believe a sudden omission instead of tapering of scheduled Morphine ER at Resident #4's dose of 15 mg twice daily would cause adverse effects to the resident. Telephone interview with Resident #4's pain management provider's medical assistant on 07/31/25 at 10:12am revealed: -The facility called their office one time to request a Morphine refill in June 2025. -Their office sent a prescription to the pharmacy for a refill of Morphine on 06/06/25 but the pharmacy later told her they did not receive the prescription. -The medical assistant called the facility once to inquire if the facility received the Morphine refill from the pharmacy and was told Resident #4 did not take any pain medication. -Their office did not receive any additional calls from the facility or the facility contracted pharmacy and did not know Resident #4 was still out of Morphine until the family member called to schedule an appointment on 06/24/25. -Both she and the pain management provider were very upset at Resident #4's status on 06/25/25 because the resident was in a lot of pain, had increased tremors, and had difficulty moving and communicating compared to her usual status when she received the Morphine as scheduled. -Resident #4 had chronic neck and back pain. -Resident #4 returned to the pain management office on 07/23/25 for an appointment and was much improved and back to baseline, reporting lower pain levels, was more communicative, and had less tremors since resuming her scheduled Morphine dose.	D 358		

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D 358	Continued From page 21 Review of the facility's Medication Policy revealed the policy did not address routine administration of scheduled medication or obtaining refills of medication. _____ The facility failed to ensure a resident's scheduled Morphine was on hand in the facility and available for administration twice a day for Resident #4 as ordered for chronic neck pain, chronic back pain, and chronic pain syndrome. The omission of 29 scheduled doses of Morphine Sulfate ER 15 mg over a 15 day period of time resulted in the resident experiencing severe pain, increased tremors, and difficulty moving. This failure resulted in serious neglect and constitutes a Type A1 violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 31, 2025 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 30, 2025.	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;	D 367		

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D 367	Continued From page 22 (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 medication administration records were accurate for 2 of 6 sampled residents (#1, #6) including documentation for a controlled substance for moderate to severe pain (#6), a controlled substance for anxiety and agitation (#6), and a vitamin supplement (#1). The findings are: 1. Review of Resident #6's current FL-2 dated 01/29/25 revealed diagnoses included dementia, cognitive communication deficit, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease, acute on chronic diastolic congestive heart failure, presence of cardiac pacemaker, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation. a. Review of Resident #6's hospice verbal orders dated 07/10/25 at 8:49pm revealed an order to start Morphine Concentrate 100mg/5ml take	D 367		

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D 367	Continued From page 23 0.25ml (5mg) every 4 hours scheduled. (Morphine Concentrate is a controlled substance used for moderate to severe pain.) Review of Resident #6's pharmacy packing slip for controlled substances dated 07/11/25 revealed there were 7.5mls (30 prefilled syringes) of Morphine Concentrate 100mg/5mL received by the facility on 07/11/25. Review of Resident #6's July 2025 facility progress notes revealed: -On 07/10/25 at 8:41pm: per hospice and family request, all the resident's medications would be discontinued except for Lorazepam (for anxiety) and an order for Morphine would be added to be administered every 4 hours. -On 07/11/25 at 7:12pm: the resident's Morphine Concentrate was received at 7:00pm and the Resident Care Coordinator (RCC) gave the first dose; the primary care provider (PCP) was made aware and the resident was in bed calm and resting. Interview with Resident #6's family member on 07/31/25 at 10:35am revealed: -He observed the RCC administer Morphine in an oral syringe to Resident #6 on the evening of 07/11/25. -He thought it was around 6:00pm or a little after 6:00pm, but he was not sure of the exact time. Review of Resident #6's July 2025 electronic medication administration record (eMAR) dated 07/01/25 - 07/29/25 revealed there was no entry for Morphine Concentrate 100mg/5ml on the July 2025 eMAR and none was documented as administered. Review of Resident #6's electronic controlled	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 367	Continued From page 24	D 367		

substance record (eCSR) for Morphine Concentrate 100mg/5ml revealed:
-A quantity of 30 Morphine Concentrate prefilled syringes were documented as received on 07/11/25 at 7:09pm.
-There was one dose of Morphine Concentrate documented as "wasted" on 07/11/25 at 7:11pm, leaving a balance of 29 prefilled syringes.
-The reason for wasting a dose was documented as "other" and there was no documentation in the comment section.

Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed:
-The pharmacy staff usually entered orders into the eMAR system.
-They received an electronic prescription for Resident #6's Morphine Concentrate on 07/10/25 at 9:15pm.
-There were 30 prefilled syringes (7.5ml) of Morphine Concentrate 100mg/5ml dispensed and delivered on 07/11/25.
-The facility had to verify medication orders before they became active in the eMAR system.

Interview with the RCC on 07/31/25 at 9:19am revealed:
-On the evening of 07/10/25, the hospice provider wrote an order for Morphine Concentrate as a comfort medication because Resident #6 was transitioning.
-The MA sent the order for Morphine Concentrate to the pharmacy when it was received on 07/10/25.
-The facility's contracted pharmacy usually entered orders into the eMAR system.
-She was responsible for verifying medication orders so the order would become active in the eMAR system.

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D 367	Continued From page 25	D 367		

-Resident #6's Morphine Concentrate was delivered around 7:01pm on 07/11/25.
-She counted the Morphine Concentrate prefilled syringes to make sure it matched the invoice and then immediately went to the resident's room and administered one prefilled syringe to the resident.
-Once she administered the Morphine Concentrate, she tried to verify and approve the order in the eMAR system but there was nowhere on the eMAR to document the administration of the Morphine.
-She had to put in the quantity received into the eCSR system but since she was not able to document the administration on the eMAR, the count did not decline on the eCSR.

Interview with the Executive Director (ED) on 07/31/25 at 3:25pm revealed:
-Her facility title was ED but she was also a licensed Administrator.
-She was not aware Resident #6's Morphine Concentrate was not on the July 2025 eMAR.
-The facility's contracted pharmacy usually entered orders into the eMAR system and the RCC usually approved the orders.
-The MAs and the RCC were responsible for checking the eMARs weekly to ensure accuracy.

b. Review of Resident #6's hospice verbal order dated 07/11/25 at 10:30am revealed a one-time order for Lorazepam 1mg once time for agitation and anxiety. (Lorazepam is a controlled substance used to treat anxiety and agitation.)

Review of Resident #6's hospice visit note dated 07/11/25 revealed:
-The resident was seen by a hospice registered nurse (RN) for a daily visit for actively transitioning.
-The resident was semi-comatose (altered state

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 367	Continued From page 26	D 367		

of consciousness with limited responsiveness and awareness) and hypotensive (low blood pressure).
-The resident's breathing was labored at 49 beats per minute.
-A one-time dose of Lorazepam 1mg was given per the resident's primary care provider (PCP) for anxiety/agitation.

Review of Resident #6's July 2025 electronic medication administration record (eMAR) dated 07/01/25 - 07/29/25 revealed there was no entry for Lorazepam 1mg to be given as a one-time dose on 07/11/25 and none was documented as administered.

Telephone interview with a medication aide (MA) on 07/31/25 at 8:45am revealed:
-There was an order for Resident #6 to receive a one-time dose of Lorazepam 1mg on 07/11/25.
-The hospice nurse told her how to administer the Lorazepam by dissolving the tablets in a little water and administering it using an oral syringe because the resident was transitioning and having problems swallowing.
-She could not recall what time she administered the one-time dose of Lorazepam but the hospice nurse assisted her on 07/11/25.
-She documented the administration of the one-time dose of Lorazepam 1mg in the progress notes.
-She did not recall documenting the one-time dose of Lorazepam on the eMAR because she documented it in the progress notes.

Telephone interview with Resident #6's hospice nurse on 07/31/25 at 12:07pm revealed:
-She helped a MA administer a one-time dose of Lorazepam 1mg to Resident #6 on the morning of 07/11/25.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 27 -They used two of Resident #6's Lorazepam 0.5mg tablets to equal 1mg. -She was not sure if the MA documented the administration of the one-time dose of Lorazepam 1mg on the eMAR. Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -The facility had to verify medication orders before they became active in the eMAR system. -The pharmacy never received the order dated 07/11/25 for a one-time dose of Lorazepam 1mg so it was never entered into the eMAR system. Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am revealed: -The facility's contracted pharmacy usually entered orders into the eMAR system. -She was responsible for verifying medication orders in the eMAR so the order would become active in the eMAR system. -She was not sure why Resident #6's order for Lorazepam 1mg was not entered into the eMAR system. Interview with the Executive Director (ED) on 07/31/25 at 3:25pm revealed: -Her facility title was ED but she was also a licensed Administrator. -She was not aware Resident #6's Lorazepam 1mg one-time dosage was not on the July 2025 eMAR. -The facility's contracted pharmacy usually entered orders into the eMAR system and the RCC usually approved the orders. -The MAs and the RCC were responsible for checking the eMARs weekly to ensure accuracy.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 367	Continued From page 28 2. Review of Resident #1's current FL-2 dated 05/12/25 revealed diagnoses included dementia, hypertension, hypercholesterolemia, urinary incontinence, and cerebrovascular disease. Review of Resident #1's Resident Register revealed she was admitted on 06/11/25. Review of a physician order for Resident #1 dated 07/01/25 revealed there was an order to start Vitamin D3 50,000IU 1 tablet every week. Observation of Resident #1's medications on hand on 07/29/25 revealed: -There was 1 pack of Vitamin D3 50,000IU dispensed on 07/01/25 with a quantity of 2 capsules. -There were 2 capsules remaining. Review of Resident #1's July 2025 electronic medication administration records (eMAR) revealed there was no entry for Vitamin D3 50,000IU 1 tablet every week. Interview with the Resident Care Coordinator (RCC) on 07/29/25 at 4:23pm revealed: -She also worked as a medication aide (MA). -Resident #1 was prescribed Vitamin D3 but she was unable to locate the medication on the MAR. -The facility's contracted pharmacy added orders to the eMAR. -Medication orders were usually sent directly to the pharmacy from the primary care provider (PCP). -The Vitamin D3 order was sent directly to the pharmacy from the PCP. -She did not know where the D3 had been documented as administered since it was not on the eMAR.	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 367	Continued From page 29 -Vitamin D3 was to be administered twice a week. -She had not administered Vitamin D3 to Resident #1. -If she had administered Vitamin D3 to Resident #1, she would have noticed that the medication was not on the eMAR and would have contacted the pharmacy. Second interview with the RCC/MA on 07/30/25 at 7:30am revealed: -MAs were notified of medication changes by the facility's contracted pharmacy. -A pop-up screen showed on the computer when medications were discontinued. -MAs were notified of a new medication when that medication appeared on the eMAR. -There was no pop-up screen to show when there was a new medication order; the medication just arrived with the batch medications. -When administering medications, she read each medication on the eMAR and compared the medication to the multidose packs. -Resident #1's Vitamin D3 was administered on Mondays. Telephone contact with a pharmacist at the facility's contracted pharmacy on 07/30/25 at 10:07am revealed: -Resident #1 had an order dated 07/01/25 for D3 50,000IU 1 capsule per week. -Vitamin D3 was prescribed to supplement Vitamin D levels. -Vitamin D3 50,000IU with a quantity of 2 capsules were dispensed in a non multi dose pack on 07/01/25 and shipped 07/02/25; the facility would have received the medication on 07/03/25. -The facility received cycle filled medications weekly and the cycle started every Monday. -Multidose packs were dispensed on 07/09/25	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 367	Continued From page 30	D 367		

with 1 Vitamin D3 capsule within that cycle.
-Multidose packs were dispensed on 07/16/25 with 1 Vitamin D3 capsule within that cycle.
-Multidose packs were dispensed on 07/23/25 with 1 Vitamin D3 capsule within that cycle.
-Discontinued medications and new medication orders were added to the eMAR by the pharmacy.
-Orders came from either the facility or the PCP.
-The Vitamin D3 order came from the facility as if it were a verbal order from the prescriber.
-She had a note stating to re-enter the Vitamin D3 to the eMAR because the facility could no longer see the order on the eMAR.
-She was unsure why the facility could not see the Vitamin D3 on the eMAR because it had always shown up on the pharmacy's view of the eMAR.
-The pharmacy had been dispensing Vitamin D3 since the beginning of July for Resident #1 but just heard about the medication not showing up on the eMAR.
-Sometimes the eMAR system went down but if the facility did not call to let the pharmacy know about the medication missing from the eMAR, the pharmacy would not know.

Interview with the PCP on 07/30/25 at 3:35pm revealed:
-She first saw Resident #1 on 07/01/25.
-She did not recall ordering Vitamin D3 for Resident #1, but it was possible that she did order D3 because she saw the resident on 07/01/25.
-Vitamin Vitamin D3 was prescribed for Vitamin D deficiency.
-She wrote the Vitamin D3 order on a prescription pad and gave it to the Executive Director (ED).
-The facility should have sent any orders received to the pharmacy right away.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 367	Continued From page 31 Interview with the Administrator on 07/30/25 at 4:41pm revealed: -She was not aware of Resident #1's Vitamin D3 order until 07/10/25. -She was unsure when Resident #1's Vitamin D3 was ordered. -The pharmacy did not put Vitamin D3 on Resident #1's eMAR. -The facility was responsible for checking the eMAR to ensure all orders were there. -When administering medication, the MA was supposed to check the MAR against the medications 3 times. -All the MAs were new to the facility but had been MAs at other facilities and were aware of the process for administering medication. -The MA should have noticed that Vitamin D3 was not on the eMAR because the medication was sent to the facility. -When the MA noticed that the medication had been sent but was not on the eMAR, they were supposed to call the pharmacy to notify them of the missing order on the eMAR.	D 367		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 371	Continued From page 32	D 371		

implemented during medication passes on 07/30/25 by the medication aide observed who failed to wash or sanitize their hands prior to preparing and after administering multiple oral medications to residents and an eye drop to a resident; and administered a medication that was dropped on top of the medication cart to a resident.

The findings are:

Observation of a medication aide (MA) administering medications during the 8:00am medication pass on 07/30/25 from 7:44am - 8:22am revealed:
-There was a bottle of hand sanitizer inside a drawer on both medication carts.
-At 7:44am, the MA was standing at the medication carts parked outside the dining room near the nurses' station.
-The MA opened the drawer to one of the medication carts to retrieve medications for a resident.
-The MA did not sanitize or wash her hands prior to preparing medications for the resident.
-The MA administered 5 different oral medications to the resident in the dining room at 7:46am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered 3 different oral medications to a second resident in the dining room at 8:09am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA wore gloves and administered eye drops

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 371	Continued From page 33	D 371		

to a third resident at 8:22am.
-The third resident's eyes were red and there was a thick, white discharge in the resident's right eye.
-The MA changed gloves and used a tissue to wipe the white discharge from the third resident's right eye.
-The MA returned to the medication cart, put the tissue and the gloves in the trash can.
-The MA used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.

Observation of the same MA administering medications during the 11:00am/12:00pm medication pass on 07/30/25 from 10:13am - 11:52am revealed:
-There was a bottle of hand sanitizer inside a drawer on both medication carts.
-At 10:13am, the MA opened the drawer to one of the medication carts to retrieve medications for a resident.
-The MA did not sanitize or wash her hands prior to preparing medications for a resident.
-The MA prepared a 2 ½ tablets of an oral medication for a resident.
-The MA dropped the ½ tablet on top of the medication cart.
-The MA picked up the ½ tablet using a tissue and put it back in the medication cup with the other two whole tablets.
-The MA administered the medication, including the ½ tablet that was dropped on the medication cart to the resident in a sitting area at 10:14am.
-The MA returned to the medication cart and used her hands to enter documentation into the computer system.
-The MA did not sanitize or wash her hands.
-The MA prepared and administered an oral medication with 2 ½ tablets for a second resident in the resident's room at 11:10am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 371	Continued From page 34 -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA prepared and administered an oral medication for a third resident in the dining room at 11:52am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. Interview with the MA on 07/30/25 at 10:14am revealed: -She did not have another ½ tablet to replace the ½ tablet that she dropped on top of the medication cart. -The medications were supplied in multi-dose packs (MDPs) so if she took a tablet from another MDP, then the dosage would not be correct when it was due to be administered again. Second interview with the MA on 07/30/25 at 12:23pm revealed: -There was a bottle of hand sanitizer kept inside each medication cart. -The MAs were supposed to sanitize their hands between each resident when they administered medications. -She usually used hand sanitizer between each resident when she administered medications. -She was nervous during the medication passes observed on 07/30/25 and she forgot to use the hand sanitizer. Interview with the Executive Director (ED) on 07/30/25 at 12:15pm revealed: -The MAs were trained to sanitize or wash their hands between each resident when administering medications.	D 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 371	Continued From page 35 -Hand sanitizer was available and stored inside of the medication carts. -The MA should have sanitized or washed her hands between each resident when she administered medications on 07/30/25. -If a tablet was dropped on top of the medication cart, the MA was supposed to discard the tablet in the Sharp's container and get another tablet or contact the pharmacy to get a replacement dose.	D 371		
D 389	10A NCAC 13F .1007 (d) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (d) All medications destroyed at the facility shall be destroyed by the administrator or the administrator's designee and witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the medication. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications destroyed at the facility for 1 of 1 sampled resident (#6) were witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner. The findings are: Review of the facility's Medication/Controlled Substance Destruction Record Policy dated September 2021 revealed: -The Medication Destruction Record was	D 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 389	Continued From page 36	D 389		

completed for any medication and/or controlled substance requiring facility destruction.
-This record would be scanned into the electronic health record and maintained in the resident record.
-There was no additional information about the destruction of medications listed in the facility's policy.

Review of Resident #6's current FL-2 dated 01/29/25 revealed diagnoses included dementia, cognitive communication deficit, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease, acute on chronic diastolic congestive heart failure, presence of cardiac pacemaker, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation.

Review of Resident #6's facility progress note dated 07/11/25 at 8:54pm revealed staff spoke with the on-call hospice nurse to inform them that the resident had passed.

Observations of medications on hand on 07/29/25 at 8:27am and 07/30/25 at 11:53am revealed there were no medications on hand for Resident #6.

Review of Resident #6's Medication Destruction Record dated 07/11/25 revealed:
-There were seven medications listed as being destroyed on 07/11/25.
-The medications included Pantoprazole (for acid reflux), Eliquis (blood thinner), Furosemide (diuretic for swelling), Potassium Chloride (potassium supplement), Vitamin B12 (for Vitamin B12 deficiency), Vitamin D3 (for Vitamin D deficiency), and Hydroxyzine (can be used for anxiety or to help with sleep).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 389	Continued From page 37	D 389		

-For quantity destroyed, staff documented "MDP" (multi-dose pack) for each medication.
-The Method of Destruction was documented as "Drug Buster".
-The column for Facility Administrator Designee was signed by the Executive Director (ED).
-The column for Medication Aide (MA)/Witness was signed by the Resident Care Coordinator (RCC).
-There was no documentation of the destruction witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner.

Interview with the ED on 07/30/25 at 9:00am.
-Her title was ED and she was also a licensed Administrator.
-The facility's contracted pharmacy would not accept any returned medications, including controlled substances.
-The facility used "Drug Buster" to destroy all medications onsite at the facility. (Drug Buster is a drug disposal system with a solution designed to neutralize and dissolve medications, making the safe for disposal.)

Interview with a MA on 07/30/25 at 4:59pm revealed:
-The MAs always had to have a witness when destroying medications whether the medication was a controlled substance or not.
-The witness could be another MA, a personal care aide (PCA), a supervisor, or the RCC.
-The MAs were responsible for completing the Medication Destruction Record form.

Telephone interview with a second MA on 07/31/25 at 8:45am revealed:
-The MAs were not supposed to administer medications that had been discontinued.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 389	Continued From page 38	D 389		

-The pharmacy staff had told her previously not to send any medications back to the pharmacy but to destroy them at the facility.
-The MAs destroyed all medications at the facility because the pharmacy would not take the medications back.

Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed:
-The pharmacy's policy was not to take any returned medications from assisted living facilities.
-The facility had its own policy for destruction of all medications.
-To his knowledge, no one from the facility had called the pharmacy to get approval or to ask for witnesses for the destruction of any medications.
-He was not aware of that being a requirement for the facility to destroy medications.

Interview with the RCC on 07/31/25 at 9:19am revealed:
-She started working at the facility as the RCC in June 2025.
-The facility's contracted pharmacy would not take any returned medications, so they destroyed all medications onsite at the facility.
-The RCC or the ED were supposed to destroy and/or witness controlled substances with a MA.
-The MAs usually destroyed any other medications that were not controlled substances.
-The destruction of medications was supposed to be documented on the Medication Destruction Record form.
-She and the ED destroyed Resident #6's medications (non-controlled substances) after the medications were discontinued on 07/11/25.
-They put the medications in the "Drug Buster" container and filled out the Medication

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 389	Continued From page 39 Destruction Record form. Second interview with the ED on 07/31/25 at 3:25pm revealed: -Her facility title was ED but she was also a licensed Administrator. -The facility did not have any other written policy for the destruction of medications except for the Medication Destruction Record form policy. -All medications had to be destroyed at the facility because the facility's contracted pharmacy would not accept any returned medications. -Either the MAs or the RCC would destroy medications by putting them in the "Drug Buster" container. -Whoever destroyed the medications was supposed to fill out the Medication Destruction Record form and the witness also had to sign the form. -The MAs or RCC were supposed to scan the Medication Destruction Record form into the electronic computer system and keep a hard copy. -No one contacted a licensed pharmacist or dispensing practitioner to have the destruction of the medications witnessed or to get a designee of the pharmacy or dispensing practitioner. -She was not aware of the rule requirement for a licensed pharmacist or dispensing practitioner or their designee to witness destruction of medications at the facility. Telephone interview with Resident #6's primary care provider (PCP) on 07/29/25 at 3:26pm revealed she did not designate anyone to destroy or witness the destruction of Resident #6's medications.	D 389		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 40	D 392		
D 392	10A NCAC 13F .1008 (a) Controlled Substances 10A NCAC 13F .1008 Controlled Substances (a) An adult care home shall assure a record of controlled substances by documenting the receipt, administration, and disposition of controlled substances. These records shall be maintained with the resident's record in the facility and in such an order that there can be accurate reconciliation of controlled substances. This Rule is not met as evidenced by: Based on 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 4 residents (#6) sampled with orders for a controlled substance used to treat moderate to severe pain and a controlled substance used to treat anxiety. The findings are: Review of Resident #6's current FL-2 dated 01/29/25 revealed diagnoses included dementia, cognitive communication deficit, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease, acute on chronic diastolic congestive heart failure, presence of cardiac pacemaker, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation. Review of Resident #6's facility progress note dated 07/11/25 at 8:54pm revealed staff spoke with the on-call hospice nurse to inform them that the resident had passed. Observations of medications on hand on 07/29/25 at 8:27am and 07/30/25 at 11:53am revealed	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 392	Continued From page 41 there were no medications on hand for Resident #6. a. Review of Resident #6's physician's order dated 01/29/25 revealed an order for Lorazepam 0.5mg 1 tablet 3 times a day. (Lorazepam is a controlled substance used to treat anxiety.) Review of Resident #6's hospice verbal orders dated 07/10/25 at 8:49pm revealed an order to change Lorazepam 0.5mg to 1 tablet every 4 hours scheduled. Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed: -There were 45 Lorazepam 0.5mg tablets dispensed on 04/30/25. -There were 45 Lorazepam 0.5mg tablets dispensed on 05/12/25. -There were 45 Lorazepam 0.5mg tablets dispensed on 05/27/25. -There were 45 Lorazepam 0.5mg tablets dispensed on 06/09/25. -There were 45 Lorazepam 0.5mg tablets dispensed on 06/27/25. -There were 45 Lorazepam 0.5mg tablets dispensed on 07/09/25. -There were 90 Lorazepam 0.5mg tablets dispensed on 07/11/25. Review of Resident #6's Medication Destruction Record dated 07/14/25 revealed: -There were 3 prescription numbers listed for 3 supplies of Lorazepam 0.5mg tablets. -The quantities listed for the 3 supplies of Lorazepam were 26 tablets, 45 tablets, and 90 tablets. -A total of 161 Lorazepam 0.5mg tablets were documented as being destroyed on 07/14/25.	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

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D 392	Continued From page 42 Review of Resident #6's May 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily for anxiety or agitation scheduled at 8:00am, 2:00pm, and 8:00pm. -Lorazepam 0.5mg was documented as administered 3 times a day from 05/01/25 - 05/31/25, for a total of 93 doses. Review of Resident #6's May 2025 electronic controlled substance record (eCSR) for Lorazepam 0.5mg tablets revealed: -The first dose documented as administered was on 05/01/25 at 8:23am, leaving a balance of 0. -The next entry was for 45 tablets received on 05/01/25 at 12:55pm, leaving a balance of 45 tablets. -There were 92 doses of Lorazepam 0.5mg tablets documented as administered from 05/01/25 - 05/31/25 but 93 doses were documented for the same time period on the May 2025 eMAR. -There was no 2:00pm dose documented as administered on the eCSR on 05/13/25 but it was documented as administered on the eMAR for that date and time. -The eCSR was not accurate and did not match the eMAR. -There was an entry on 05/13/25 at 5:59pm noting 1 tablet was "return" but declined the count from 54 to 53 tablets. -There was no comment documented to indicate what "return" meant. -The ending balance on 05/31/25 at 7:42pm was 43 tablets. Review of Resident #6's June 2025 eMAR revealed:	D 392		

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

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D 392	Continued From page 43 -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily for anxiety or agitation scheduled at 8:00am, 2:00pm, and 8:00pm. -Lorazepam 0.5mg was documented as administered on 83 occasions from 06/01/25 - 06/30/25. -Lorazepam 0.5mg was documented as administered on 5 occasions due to the resident being asleep and on 2 occasions with no reason documented. Review of Resident #6's June 2025 eCSR for Lorazepam 0.5mg tablets revealed: -There were 83 doses of Lorazepam 0.5mg tablets documented as administered from 06/01/25 - 06/30/25. -The first dose documented as administered was on 06/01/25 at 8:27am, leaving a balance of 42 tablets. -There was an entry on 06/10/25 at 11:13am for 45 tablets received, leaving a balance of 61 tablets. -There was an entry on 06/15/25 at 7:26pm with 1 tablet "received", increasing the balance from 46 to 47 tablets. -There was no comment documented to explain why 1 tablet was received and added back to the balance. -There was an entry on 06/21/25 at 7:06pm with 1 tablet "received", increasing the balance from 29 to 30 tablets. -There was no comment documented to explain why 1 tablet was received and added back to the balance. -There was an entry on 06/29/25 at 7:17pm for 45 tablets received, leaving a balance of 56 tablets. -The ending balance on 06/30/25 at 7:51pm was 52 tablets. Review of Resident #6's July 2025 eMAR	D 392		

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D 392	Continued From page 44 revealed: -There was an entry for Lorazepam 0.5mg 1 tablet 3 times daily for anxiety or agitation scheduled at 8:00am, 2:00pm, and 8:00pm. -Lorazepam 0.5mg was documented as administered on 24 occasions from 07/01/25 - 07/11/25 (8:00am). -The scheduled Lorazepam 0.5mg 3 times a day was documented as discontinued on 07/11/25. -There was a second entry for Lorazepam 0.5mg 1 tablet every 4 hours for anxiety scheduled at 4:00am, 8:00am, 4:00pm, 8:00pm, and 11:59pm. -Lorazepam 0.5mg every 4 hours was documented as administered on one occasion on 07/11/25 at 8:00pm. -The 11:59pm dosage on 07/11/25 and the 4:00am dosage on 07/12/25 were documented as not administered due to the resident being deceased. -There was a total of 25 Lorazepam 0.5mg tablets documented as administered from 07/01/25 - 07/11/25. Review of Resident #6's July 2025 eCSR for Lorazepam 0.5mg tablets revealed: -There were 25 doses of Lorazepam 0.5mg tablets documented as administered from 07/01/25 - 07/11/25. -The first dose documented as administered was on 07/01/25 at 7:01am, leaving a balance of 51 tablets. -There was an entry on 07/10/25 at 2:28pm for 45 tablets received, leaving a balance of 74 tablets. -The next entry on 07/10/25 at 2:33pm documented 39 tablets were "wasted" with no reason noted, leaving a balance of 35 tablets. -The next entry on 07/10/25 at 3:54pm documented 35 tablets were "received" leaving a balance of 70, not accounting for 4 tablets. -The next entry on 07/10/25 at 3:54pm (14	D 392		

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 392	Continued From page 45	D 392		

seconds later) documented 5 tablets were "received", increasing the balance to 75 tablets.
-There was an entry on 07/11/25 at 2:58pm documenting 1 tablet was "wasted" with no reason noted, leaving a balance of 73 tablets.
-There was an entry on 07/11/25 at 3:00pm documenting 73 tablets were "wasted" with no reason, leaving a balance of 0.
-The next entry on 07/11/25 at 2:58pm (out of sequence) documented 73 tablets were "received", leaving a balance of 73 tablets.
-The next entry on 07/11/25 at 3:02pm documented 1 tablet was "wasted" with no reason noted, leaving a balance of 72 tablets.
-There was an entry on 07/11/25 at 7:11pm for 90 tablets received, leaving a balance of 162 tablets.
-The last entry was on 07/11/25 at 8:20pm with 1 tablet administered, leaving a balance of 161 tablets.
-There was no entry on 07/14/25 noting 161 tablets of Lorazepam 0.5mg were destroyed by the facility staff.
-The eCSR did not accurately reflect the receipt and destruction of Lorazepam 0.5mg tablets.

Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am revealed:
-Some of the issues with Resident #6's eCSR for Lorazepam were due to glitches in the system or the medication aides (MAs) not clicking when a medication was administered.
-On 07/10/25, a MA input an incorrect number, and it showed 5 extra doses, but the doses were corrected to match the number on hand.
-It may have been caused by tablets being moved to a different prescription number for the same medication.
-This usually occurred when they received a new supply of medication and there was a different prescription number because the eMAR system

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 392	Continued From page 46	D 392		

closed out the old prescription number when a new one was received.
-On 07/11/25, a dose was documented as "wasted" because a MA failed to click the eMAR when she administered a dose so that caused the count to be too high so to get the count to match, a dose had to be "wasted" in the system.
-The dose was not wasted but was administered and the MA failed to be documented on the eCSR when it was actually administered.

Refer to interview with a medication aide (MA) on 07/30/25 at 4:59pm.

Refer to telephone interview with a second MA on 07/31/25 at 8:45am.

Refer to interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am.

Refer to interview with the Executive Director (ED) on 07/31/25 at 3:25pm.

b. Review of Resident #6's hospice verbal orders dated 07/10/25 at 8:49pm revealed an order to start Morphine Concentrate 100mg/5ml take 0.25ml (5mg) every 4 hours scheduled. (Morphine Concentrate is a controlled substance used for moderate to severe pain.)

Review of Resident #6's pharmacy packing slip for controlled substances dated 07/11/25 revealed there were 7.5mls (30 prefilled syringes) of Morphine Concentrate 100mg/5mL received by the facility on 07/11/25.

Review of Resident #6's July 2025 facility progress notes revealed:
-On 07/10/25 at 8:41pm: per hospice and family request, all the resident's medications would be

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 392	Continued From page 47	D 392		

discontinued except for Lorazepam (for anxiety) and an order for Morphine would be added to be administered every 4 hours.
-On 07/11/25 at 7:12pm: the resident's Morphine Concentrate was received at 7:00pm and the Resident Care Coordinator (RCC) gave the first dose; the primary care provider (PCP) was made aware and the resident was in bed calm and resting.

Interview with Resident #6's family member on 07/31/25 at 10:35am revealed:
-He observed the RCC administer Morphine in an oral syringe to Resident #6 on the evening of 07/11/25.
-He thought it was around 6:00pm or a little after 6:00pm, but he was not sure of the exact time.

Review of Resident #6's July 2025 electronic medication administration record (eMAR) dated 07/01/25 - 07/29/25 revealed there was no entry for Morphine Concentrate 100mg/5ml on the July 2025 eMAR and none was documented as administered.

Review of Resident #6's electronic controlled substance record (eCSR) for Morphine Concentrate 100mg/5ml revealed:
-A quantity of 30 Morphine Concentrate prefilled syringes were documented as received on 07/11/25 at 7:09pm.
-There was one dose of Morphine Concentrate documented as "wasted" on 07/11/25 at 7:11pm, leaving a balance of 29 prefilled syringes.
-The reason for wasting a dose was documented as "other" and there was no documentation in the comment section.
-The eCSR did not accurately reflect the administration of Morphine Concentrate.

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 392	Continued From page 48 Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed: -The pharmacy staff usually entered orders into the eMAR system. -They received an electronic prescription for Resident #6's Morphine Concentrate on 07/10/25 at 9:15pm. -There were 30 prefilled syringes (7.5ml) of Morphine Concentrate 100mg/5ml dispensed and delivered on 07/11/25. -The facility had to verify medication orders before they became active in the eMAR system. Interview with the RCC on 07/31/25 at 9:19am revealed: -Resident #6's Morphine Concentrate was delivered around 7:01pm on 07/11/25. -She counted the Morphine Concentrate prefilled syringes to make sure it matched the invoice and then immediately went to the resident's room and administered one prefilled syringe to the resident. -Once she administered the Morphine Concentrate, she tried to verify and approve the order in the eMAR system but there was nowhere on the eMAR to document the administration of the Morphine. -She had to put in the quantity received into the eCSR system since she was not able to document the administration on the eMAR. -She had to document the dose that was administered as wasted in the eCSR system in order to decline the count to 29 to match the remaining quantity on hand at that time. Refer to interview with a medication aide (MA) on 07/30/25 at 4:59pm. Refer to telephone interview with a second MA on 07/31/25 at 8:45am.	D 392		

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 49 Refer to interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am. Refer to interview with the Executive Director (ED) on 07/31/25 at 3:25pm. _____ Interview with a medication aide (MA) on 07/30/25 at 4:59pm revealed: -The MAs usually counted the controlled substances at the change of each shift. -One MA would count the medication and the other MA would enter the information into the electronic controlled substance record (eCSR) system. -If it did not match, they had 3 times to try again before it would "kick" them out of the system and lock up the electronic medication administration records (eMARs). -After the third time, the MAs had to call the Resident Care Coordinator (RCC) and the RCC would have them to count again. -The RCC had access to revise the eCSR and once it matched, the system would unlock. -Sometimes the count was off because a MA may have entered a number incorrectly or a MA may have documented a prn (as needed) medication instead of a scheduled medication. -The MAs were supposed to document the administration of controlled substances on the eMAR and the eCSR system when the medication was administered. Telephone interview with a second MA on 07/31/25 at 8:45am revealed: -The MAs were supposed to document the administration of controlled substances on the eMAR and the eCSR system when the medication was administered. -The MAs did a controlled substances count at	D 392		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 50	D 392		

each shift change.
-Most of the time, the count matched what was on hand.
-If the count did not match after 3 attempts, the MAs had to call the RCC.
-The RCC would check to see what was going on and then the RCC would correct the count.
-Sometimes the count was not correct because a MA would enter a prn instead of a scheduled medication.

Interview with the RCC on 07/31/25 at 9:19am revealed:
-The MAs were supposed to document the administration of controlled substances on the eMAR and eCSR at the same time.
-The MAs did shift counts of the controlled substances.
-If the count did not match after 3 times, the MAs called her because the system would lock up.
-She usually checked to see why it did not match.
-She checked to see when it was last administered and to make sure it was documented on the eMAR and eCSR.
-If there was documentation of received 1 tablet on the eCSR, it was usually because a MA clicked they administered a medication but did not.
-It could also mean that a MA clicked a prn dosage of a medication instead of a scheduled dosage and the eCSR would deduct from the wrong record.
-There were also times when the internet was down, and it would cause glitches in the system and doses would not be deducted because of the system being down.
-She would have to correct the number in the system once she determined the cause in order for the numbers to match and unlock the system.
-She was not aware of a system to check the

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 392	Continued From page 51 eMARs against the eCSR for accuracy. Interview with the Executive Director (ED) on 07/31/25 at 3:25pm revealed: -Her facility title was ED but she was also a licensed Administrator. -The MAs were supposed to document the administration of controlled substances on the eMAR and the eCSR at the time of administration. -There was no system to check the eCSR to make sure they were accurate and matched the eMARs.	D 392		
D 394	10A NCAC 13F .1008 (c & d) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (c) Controlled substances that are expired, discontinued or no longer required for a resident shall be returned to the pharmacy within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The facility shall document the resident's name; the name, strength and dosage form of the controlled substance; and the amount returned. There shall also be documentation by the pharmacy of the receipt or return of the controlled substances. (d) If the pharmacy will not accept the return of a controlled substance, the administrator or the administrator's designee shall destroy the controlled substance within 90 days of the expiration or discontinuation of the controlled substance or following the death of the resident. The destruction shall be witnessed by a licensed pharmacist, dispensing practitioner, or designee of a licensed pharmacist or dispensing	D 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 394	Continued From page 52 practitioner. The destruction shall be conducted so that no person can use, administer, sell or give away the controlled substance. Records of controlled substances destroyed shall include the resident's name; the name, strength and dosage form of the controlled substance; the amount destroyed; the method of destruction; and, the signature of the administrator or the administrator's designee and the signature of the licensed pharmacist, dispensing practitioner or designee of the licensed pharmacist or dispensing practitioner. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure controlled substances destroyed at the facility for 1 of 1 sampled resident (#6) was witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner. The findings are: Review of the facility's Medication/Controlled Substance Destruction Record Policy dated September 2021 revealed: -The Medication Destruction Record was completed for any medication and/or controlled	D 394		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

(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 394	Continued From page 53	D 394		

substance requiring facility destruction.
-This record would be scanned into the electronic health record and maintained in the resident record.
-There was no additional information about the destruction of medications listed in the facility's policy.

Review of Resident #6's current FL-2 dated 01/29/25 revealed diagnoses included dementia, cognitive communication deficit, type 2 diabetes mellitus with hyperglycemia, hypertensive heart and chronic kidney disease, acute on chronic diastolic congestive heart failure, presence of cardiac pacemaker, chronic obstructive pulmonary disease, and paroxysmal atrial fibrillation.

Review of Resident #6's facility progress note dated 07/11/25 at 8:54pm revealed staff spoke with the on-call hospice nurse to inform them that the resident had passed.

Observations of medications on hand on 07/29/25 at 8:27am and 07/30/25 at 11:53am revealed there were no medications on hand for Resident #6.

Interview with the Executive Director (ED) on 07/30/25 at 9:00am.
-Her title was ED and she was also a licensed Administrator.
-The facility's contracted pharmacy would not accept any returned medications, including controlled substances.
-The facility used "Drug Buster" to destroy all medications onsite at the facility. (Drug Buster is a drug disposal system with a solution designed to neutralize and dissolve medications, making the safe for disposal.)

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	HAL071015	A. BUILDING: _____ B. WING _____	07/31/2025

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D 394	Continued From page 54 a. Review of Resident #6's current FL-2 dated 01/29/25 revealed an order for Oxycodone 5mg 1 tablet every 4 hours as needed (prn) for pain. (Oxycodone is a controlled substance used to treat moderate to severe pain. Review of Resident #6's hospice verbal orders dated 07/10/25 at 11:20am revealed: -There was an order to discontinue Oxycodone 5mg 1 tablet every 4 hours prn for pain. -There was an order to start Oxycodone 10mg 1 tablet every 4 hours prn for pain. Review of Resident #6's July 2025 electronic medication administration record (eMAR) dated 07/01/25 - 07/29/25 revealed: -There was an entry for Oxycodone 5mg 1 tablet every 4 hours prn for pain. -Oxycodone 5mg was documented as discontinued on 07/10/25. Review of Resident #6's electronic controlled substance record (eCSR) for Oxycodone 5mg revealed: -There was a quantity of 39 Oxycodone 5mg tablets documented as "wasted" on 07/10/25 at 3:53pm, leaving a balance of 0. -The reason for wasting the 39 doses was documented as "other" and there was no documentation in the comment section. -The user (person who wasted) column had the Executive Director's (ED) name the verifier (person who witnessed) column had the Resident Care Coordinator's (RCC) name. Review of Resident #6's Medication Destruction Record dated 07/10/25 revealed: -There were 2 prescription numbers listed for 2 supplies of Oxycodone 5mg tablets.	D 394		

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D 394	Continued From page 55 -The quantities listed for the 2 supplies of Oxycodone 5mg were 30 tablets and 9 tablets. -A total of 39 Oxycodone 5mg tablets were documented as being destroyed on 07/10/25. -The Method of Destruction was documented as "Drug Buster". -The column for Facility Administrator Designee was signed by a medication aide (MA). -The column for MA/Witness was signed by a second MA. -There was no documentation of the destruction of the medication being done by the Administrator or the Administrator's designee. -There was no documentation of the destruction witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner. Interview with a MA on 07/30/25 at 4:59pm revealed: -She worked from 3:00pm to 11:00pm on 07/10/25 and another MA also worked that day from 7:00am to 7:00pm. -The other MA asked her to witness the destruction of Resident #6's Oxycodone around 3:05pm on 07/10/25 because the medication had been discontinued. -There were two bubble cards with Oxycodone 5mg tablets, with 30 tablets in one card and 9 tablets in the other card. -Both MAs counted the Oxycodone 5mg tablets and got the same number. -She then got the container of "Drug Buster" from a cabinet in the medication room. -The other MA punched the Oxycodone 5mg tablets from the bubble cards and all 39 tablets were put in the "Drug Buster" container. -The bubble cards were torn up and thrown away. -The "Drug Buster" container was locked in the medication room.	D 394		

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D 394	Continued From page 56 -She thought the other MA called the facility's contracted pharmacy before they destroyed the Oxycodone 5mg tablets to report she was destroying the medication. -She was not sure if the other MA documented contact with the pharmacy. -She did not recall clicking on anything in the eCSR system as the verifier (witness) to the destruction. -The MAs always had to have a witness when destroying medications whether the medication was a controlled substance or not. -The witness could be another MA, a personal care aide (PCA), a supervisor, or the RCC. -The MAs were responsible for completing the Medication Destruction Record form. -She signed in the wrong column for Resident #6's Oxycodone 5mg tablets. -She should have signed as the witness since she witnessed the other MA destroy the medication. Telephone interview with a second MA on 07/31/25 at 8:45am revealed: -The hospice provider changed Resident #6's Oxycodone order on 07/10/25. -She asked the RCC on 07/10/25 if it was okay to destroy Resident #6's Oxycodone 5mg since the resident had a new order. -The RCC told her it was okay to destroy the Oxycodone 5mg that had been discontinued. -The MAs were not supposed to administer medications that had been discontinued. -The pharmacy staff had told her previously not to send any medications back to the pharmacy but to destroy them at the facility. -The MAs destroyed all medications at the facility because the pharmacy would not take the medications back. -She contacted the facility's contracted pharmacy	D 394		

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D 394	Continued From page 57	D 394		

on 07/10/25 before she destroyed the medication to let them know how many she was destroying.
-She did not know who she spoke with at the pharmacy, and she did not document the phone call.
-She got a second MA to assist with the destruction of the Oxycodone 5mg tablets.
-She and the other MA counted the Oxycodone 5mg tablets which were in bubble cards, and they got the same number when they counted.
-They removed the 39 Oxycodone 5mg tablets from the bubble cards and put all 39 tablets in the "Drug Buster" container.
-The "Drug Buster" container was used to dissolve the tablets.
-She and the other MA signed the Medication Destruction Record form.
-She did not notice they signed in the wrong column.
-Right after they destroyed the Oxycodone 5mg tablets on 07/10/25, the ED and RCC came to the nurses' station and the ED signed the Medication Destruction Record form.

Interview with the RCC on 07/31/25 at 9:19am revealed:
-On 07/10/25, according to a hospice nurse and the facility's Licensed Health Professional Support (LHPS) nurse, Resident #6 was transitioning.
-There was a hospice order on 07/10/25 to discontinue Oxycodone 5mg and an order for Oxycodone 10mg was written.
-Once the discontinued order for the Oxycodone 5mg was faxed to the pharmacy, it was discontinued on the eMAR.
-She verified the discontinued order, then she and a MA removed the Oxycodone 5mg tablets from the medication cart.
-There were 2 bubble cards with a total of 39

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 394	Continued From page 58 tablets. -The MA got the "Drug Buster" container from the medication room and the MA put all 39 tablets in the "Drug Buster" container. -There was another MA present and the ED. -Both MAs signed the Medication Destruction Record form, but she and the ED should have signed as witnesses. -She did not see anyone contact the pharmacy about the destruction and that was not part of the process to her knowledge. -She and the ED signed out the destruction of the Oxycodone 5mg tablets in the eCSR system to make sure it was removed from the system. -In hindsight, the MA who destroyed the Oxycodone 5mg tables should have also documented on the eCSR system. Interview with the ED on 07/31/25 at 3:25pm revealed: -Her facility title was ED but she was also a licensed Administrator. -On 07/10/25, two MAs were at the nurses' station as well as herself, the RCC, and the LHPS nurse was nearby as well. -One of the MAs told her that they were going to destroy some controlled substances, but she could not recall if the MA gave the name of the resident. -She told the MA okay, and she observed the MAs punch the medications out of bubble cards and put them in the "Drug Buster" container. -One of the MAs filled out the Medication Destruction Record form and both MAs signed the form. -She signed the bottom of the Medication Destruction Record form. -The Medication Destruction Record form was given to the RCC.	D 394		

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D 394	Continued From page 59	D 394		

Telephone interview with Resident #6's primary care provider (PCP) on 07/29/25 at 3:26pm revealed:
-The facility documented that two MAs had destroyed Resident #6's Oxycodone 5mg tablets after it was discontinued on 07/10/25.
-She was not made aware that the facility was going to destroy the Oxycodone 5mg tablets.
-She did not designate anyone to destroy or witness the destruction of Resident #6's Oxycodone 5mg tablets.

Refer to telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm.

Refer to interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am.

Refer to interview with the Executive Director (ED) on 07/31/25 at 3:25pm.

b. Review of Resident #6's physician's order dated 01/29/25 revealed an order for Lorazepam 0.5mg 1 tablet 3 times a day. (Lorazepam is a controlled substance used to treat anxiety.)

Review of Resident #6's hospice verbal orders dated 07/10/25 at 8:49pm revealed:
-There was an order to change Lorazepam 0.5mg to 1 tablet every 4 hours scheduled.
-There was an order to start Morphine 100mg/5ml take 0.25ml (5mg) every 4 hours scheduled. (Morphine is a controlled substance used for moderate to severe pain.)

Review of Resident #6's Medication Destruction Record dated 07/14/25 revealed:
-There were 3 prescription numbers listed for 3 supplies of Lorazepam 0.5mg tablets.

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 394	Continued From page 60 -The quantities listed for the 3 supplies of Lorazepam were 26 tablets, 45 tablets, and 90 tablets. -A total of 161 Lorazepam 0.5mg tablets were documented as being destroyed on 07/14/25. -There was a prescription number listed for a supply of Morphine Concentrate prefilled syringes. -There were 29 prefilled syringes of Morphine Concentrate documented as being destroyed on 07/14/25. -The Method of Destruction was documented as "Drug Buster". -The column for Facility Administrator Designee was signed by the Executive Director (ED)/Administrator. -The column for Medication Aide (MA)/Witness was signed by the Resident Care Coordinator (RCC). -The facility's Licensed Health Professional Support (LHPS) Nurse had signed her name beside all 4 rows on the right side of the page. -There was no documentation of the destruction witnessed by a licensed pharmacist, dispensing practitioner, or a designee of the licensed pharmacist or dispensing practitioner. Interview with the RCC on 07/31/25 at 9:19am revealed: -On 07/14/25, she and the ED and the LHPS nurse destroyed Resident #6's Lorazepam and Morphine at the facility. -All medication was put in the "Drug Buster" container and the empty oral Morphine Concentrate syringes were put in the Sharp's container. -They all worked together to destroy and as witnesses to the destruction. Telephone interview with Resident #6's primary	D 394		

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D 394	Continued From page 61 care provider (PCP) on 07/29/25 at 3:26pm revealed: -Resident #6 passed away on 07/11/25. -The facility's LHPS nurse destroyed the resident's Morphine Concentrate and all the resident's other medications. -She did not designate anyone to destroy or witness the destruction of Resident #6's Morphine Concentrate or any of the resident's medications. Refer to telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm. Refer to interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am. Refer to interview with the Executive Director (ED) on 07/31/25 at 3:25pm. _____ Telephone interview with the Director at the facility's contracted pharmacy on 07/30/25 at 4:11pm revealed: -The pharmacy's policy was not to take any returned medications from assisted living facilities. -The facility had its own policy for destruction of all medications at the facility. -To his knowledge, no one from the facility had called the pharmacy to get approval or to ask for witnesses for the destruction of any medications. -He was not aware of that being a requirement for the facility to destroy medications. Interview with the Resident Care Coordinator (RCC) on 07/31/25 at 9:19am revealed: -The facility's contracted pharmacy would not take any returned medications, so they destroyed all medications onsite at the facility.	D 394		

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 394	Continued From page 62 -She or the Executive Director (ED) were supposed to destroy and/or witness controlled substances with a medication aide (MA). -The MAs usually destroyed any other medications that were not controlled substances. -The destruction of medications was supposed to be documented on the Medication Destruction Record form. Interview with the ED on 07/31/25 at 3:25pm revealed: -Her facility title was ED but she was also a licensed Administrator. -The facility did not have any other written policy for the destruction of medications except for the Medication Destruction Record form policy. -All medications, including controlled substances, had to be destroyed at the facility because the facility's contracted pharmacy would not accept any returned medications. -Either the MAs or the RCC would destroy medications by putting them in the "Drug Buster" container. -Whoever destroyed the medications was supposed to fill out the Medication Destruction form and the witness also had to sign the form. -The MAs or RCC were supposed to scan the Medication Destruction Record form into the electronic computer system and keep a hard copy. -No one contacted a licensed pharmacist or dispensing practitioner to have the destruction of the medications witnessed or to get a designee of the pharmacy or dispensing practitioner. -She was not aware of the rule requirement for a licensed pharmacist or dispensing practitioner or their designee to witness destruction of medications at the facility.	D 394		

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POPLAR GROVE	300 WEST ASHE STREET BURGAW, NC 28425

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D 451	Continued From page 63	D 451		
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 evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to notify the county department of social services (DSS) of an incident resulting in injury requiring a medical evaluation for 1 of 5 sampled residents (#3). The findings are: Review of Resident #3's current FL-2 dated 02/05/25 revealed diagnoses included Alzheimer's disease, legal blindness, hypertension, osteoarthritis, hyperlipidemia, and urinary incontinence. Review of Resident #3's facility progress not dated 07/08/25 revealed: -The resident's primary care provider (PCP) was notified of swelling to her index finger. -There was a verbal order to obtain a mobile x-ray. Review of Resident #3 physician's progress note dated 07/16/25 revealed:	D 451		

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D 451	Continued From page 64 -The x-ray result was negative for the index finger. -The family reported a fall to the Department of Social Services (DSS). Review of Resident #3's x-ray report dated 07/09/25 revealed no hand fracture. Interview with Resident #3 on 07/31/25 at 10:50am revealed: -She fell getting off the toilet and hurt her hand, but it felt better now. -The facility staff helped her up, but she did not know who helped her. Interview with the Resident Care Coordinator (RCC) on 07/30/25 at 9:15am revealed: -She was made aware of Resident #3's swollen finger when DSS got involved on 07/08/25. -She was told on 07/08/25 that Resident #3 fell. -She was not aware of Resident #3 falling. -She interviewed Resident #3 regarding the fall. -Resident #3 stated she fell but did not remember who helped her or when. -The staff who helped her should have notified the medication aide (MA) on duty. -The MA would then assess the resident, notify the provider, complete an incident and accident report. -The Executive Director (ED) would send the incident and accident report to DSS. Interview with the ED on 07/30/25 at 11:03am revealed: -She was not aware Resident #3 fell. -The family told her Resident #3 told them she fell. -When she was made aware Resident #3 fell, the facility contacted the PCP and obtained a verbal order for mobile x-ray.	D 451		

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D 451	Continued From page 65 -She asked Resident #3 if she was in pain and she stated not anymore. -She thought an incident and accident report was completed after they became aware of the fall. Second interview with the ED on 07/31/25 at 10:55am revealed: -The facility staff who helped Resident #3 when she fell should have notified someone and ensured an incident and accident report was completed. -When she was made aware on 07/08/25 of Resident #3's fall she asked the RCC to complete an incident and accident report.	D 451		