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 _____	R 10/23/2025

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 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on October 22, 2025 and October 23, 2025.	D 000		
D 367	10A NCAC 13F .1004 (j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR). This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure the medication administration records were accurate for 1 of 5 sampled residents (#3) including documentation for a medication to treat partial onset seizures	D 367		

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D 367	Continued From page 1 and bi-polar disorder. The findings are: Review of the facility's Medication Administration policy revised November 2018 revealed: -Five Rights, right resident, right drug, right dose, right route, right time are applied for each medication being administered. -A triple check of these 5 Rights is recommended at three steps in the process of preparation of medication for administration, when the medication is selected, when the dose is removed from the container, and finally just after the dose is prepared and put away. -Check #1, select the medication, label, container and contents are checked for integrity and compared against the medication administration record (MAR) by reviewing the 5 Rights. -Check #2, prepare the dose, the dose is removed from the container and verified against the label and the MAR by reviewing the 5 Rights. -Check #3, complete the preparation of the dose and re-verify the label against the MAR by reviewing the 5 Rights. -The MAR is always employed during medication administration. -Prior to administration of any medication, the medication and dosage schedule on the resident's MAR are compared with the medication label. -Documentation (including electronic), the individual who administers the medication dose records the administration on the resident's MAR directly after the medication is given. -At the end of each medication pass, the person administering the medications reviews the MAR to ensure necessary doses were administered and documented. -The resident's MAR is initialed by the person	D 367		

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administering the medication, in the space provided under the date, and on the line for that specific medication dose administration.
-If a dose of regularly scheduled medication is withheld, refused, not available, or given at a time other than the scheduled time, it is documented on the MAR or in the electronic health record (EHR), an explanatory note is also entered.

Review of Resident #3's current FL2 dated 04/02/25 revealed:
-Diagnoses included hypertension, major cognitive disorder, dementia, acute kidney injury, syncope, obsessive compulsive disorder, and psychosis.
-She was constantly confused.
-Her level of care was Special Care Unit (SCU).

Review of Resident #3's signed physician's order sheet dated 04/02/25 revealed an order for oxcarbazepine (a medication used to treat partial onset seizures and bi-polar disorder) 300mg, take one tablet twice daily.

Review of a handwritten physician orders sheet for Resident #3 dated 10/06/25 revealed;
-There was a written order by staff to hold oxcarbazepine 300mg, one tablet twice daily until arrives from the pharmacy.
-The order to hold oxcarbazepine 300mg, one tablet twice daily until arrives from pharmacy was signed by Resident #3's primary care provider (PCP) on 10/23/25.

Review of Resident #3's facility progress notes revealed:
-There was an entry dated 10/06/25 at 5:15pm, communication with pharmacy, named pharmacy personnel stated that on hold medication would be delivered in the next morning drop off for

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10/06/25.
-There was an entry dated 10/07/25 at 10:37am, communication with pharmacy, asked pharmacy personnel about resident's medication and when it would be delivered, she stated she received an order today and it should be delivered in the next medication drop off.

Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed:
-There was an entry for oxcarbazepine 300mg, take one tablet twice a day scheduled at 8:00am and 8:00pm.
-Oxcarbazepine 300mg was documented as not administered at 8:00am on 10/01/25 with the exception documented as "hospital".
-Oxcarbazepine 300mg was documented as administered at 8:00am 10/02/25 through 10/05/25.
-Oxcarbazepine 300mg was documented as administered at 8:00pm on 10/01/25 through 10/05/25.
-Oxcarbazepine 300mg was documented as not administered at 8:00am on 10/06/25 with the exception documented as "on hold".
-Oxcarbazepine 300mg was documented as administered at 8:00pm on 10/06/25.
-Oxcarbazepine 300mg was documented as administered at 8:00am on 10/07/25.
-Oxcarbazepine 300mg was documented as not administered at 8:00pm on 10/07/25 with the exception documented as "on hold".
Oxcarbazepine 300mg was documented as not administered at 8:00am on 10/08/25 with the exception documented as "on hold".
-Oxcarbazepine 300mg was documented as administered at 8:00pm on 10/08/25.
-Oxcarbazepine 300mg was documented as not administered at 8:00am on 10/09/25 with the

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exception documented as "on hold".
-Oxcarbazepine 300mg was documented as administered at 8:00am on 10/10/25 through 10/22/25.
-Oxcarbazepine 300mg was documented as administered at 8:00pm on 10/09/25 through 10/21/25.

Review of the packing slips from the facility's contracted pharmacy provider revealed:
-14 tablets of oxcarbazepine 300mg were delivered to the facility for Resident #3 on 09/24/25, the packing slip was signed by staff on 09/28/25.
-The packing slip dated 10/06/25 did not contain oxcarbazepine 300mg tablets for Resident #3, there was no staff signature on the 10/06/25 packing slip.
-14 tablets of oxcarbazepine 300mg were delivered to the facility for Resident #3 on 10/08/25, the packing slip was signed by staff on 10/09/25.

Attempted telephone interview with the facility's contracted pharmacy on 10/23/25 at 10:56am was unsuccessful.

Interview with a medication aide (MA) on 10/23/25 at 9:32am revealed:
-The facility received batch filled medications for the residents weekly.
-She always compared the resident's multidose medication pack to their eMAR to make sure they matched, and all the medications were available.
-The MAs signed off on the residents' eMARs only after a medication was administered.
-If a resident's medication was not received it was usually because the pharmacy needed a new prescription from the provider.
-If a medication was not available for a resident,

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the MAs were to contact the pharmacy to find out why the medication was not dispensed and to request the medication then they were to contact the resident's PCP if a new prescription was needed and to request a hold order for the medication until it was received.
-She did not know why oxcarbazepine was documented as administered to Resident #3 if it was not in the facility.
- "On hold" on the eMAR usually meant the medication was not on the medication cart,

Interview with the Resident Care Coordinator (RCC) on 10/23/25 at 12:53pm revealed:
-The facility received batch filled medications weekly from the pharmacy.
-The weekly batch filled medications were received every Thursday and were placed on the medication cart by the third shift MA on Sunday to start the cycle on Monday morning.
-If a resident's medications were not received in the weekly batch filled medications, it was usually because a new order or prescription was needed.
-If a medication was not available for a resident, the MAs contacted the pharmacy first then contacted the resident's PCP for a hold order until the medication arrived.
-She knew there was a two- or three-day delay earlier this month for Resident #3's oxcarbazepine.
-It was possible there was oxcarbazepine for Resident #3 in overstock, but she doubted it.
-If a medication was not available to administer, the MAs documented "on hold" on the eMAR.
-The MAs should not have documented that Resident #3 received oxcarbazepine when it was not available.
-The MAs needed to take their time when medications were passed and always compare the eMAR to the medication package and

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D 367	Continued From page 6 document accurately. Interview with the Administrator on 10/23/25 at 1:21pm revealed: -The facility received multidose packs of medications for the residents weekly on Thursday. -The multidose medication packs were checked by the third shift MA and placed on the medication cart on Sunday for the new cycle to start on Monday mornings. -The MAs should never document a medication as administered if it was not. -If medication was not available for a resident, it should be documented on their eMAR as not administered with a comment as to why it was not administered. Interview with Resident #3's PCP on 10/23/25 at 12:37pm revealed: -Resident #3 was new to her and she had only seen Resident #3 twice. -She was not sure why oxcarbazepine was prescribed for Resident #3. -She was notified by staff earlier this month by text that oxcarbazepine was not available for Resident #3 for a few days and she had given an order to hold oxcarbazepine until it arrived from the pharmacy. Based on observations, interviews, and record reviews, it was determined that Resident #3 was not interviewable.	D 367		