

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL043024	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 01/29/2026
NAME OF PROVIDER OR SUPPLIER THE SPRINGS OF BALLENTINE		STREET ADDRESS, CITY, STATE, ZIP CODE 40 RAWLS CLUB ROAD FUQUAY VARINA, NC 27526		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and a follow-up survey on January 28 -29. 2026.	D 000		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure a medication order was clarified for a medication used to treat seizures or manage bipolar disorder for 1 of 5 sampled residents (#4). The findings are: Review of Resident #4's current FL-2 dated 08/12/25 revealed diagnoses included dementia, diabetes type II, hypertension (HTN), neurocognitive deficits, and a history of behavior disturbance. Review of Resident #4's signed physician's order dated 09/04/25 revealed there was an order for	D 344		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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D 344	Continued From page 1 Divalproex tablet 250mg, take 1 tablet with breakfast (Divalproex is used to treat seizures or manage manic episodes of bipolar disorder). Review of Resident #4's signed physician's order dated 09/22/25 revealed there was not an order for Divalproex tablet 250mg, take 1 tablet with breakfast. Review of Resident #4's November 2025 electronic medication administration records (eMAR) revealed: -There was an entry for Divalproex tablet 250mg, take 1 tablet with breakfast. -There was documentation Divalproex 250mg was administered from 11/01/25 to 11/30/25 at 8:00am. Review of Resident #4's December 2025 eMAR revealed: -There was an entry for Divalproex tablet 250mg, take 1 tablet with breakfast. -There was documentation Divalproex 250mg was administered from 12/01/25 to 12/30/25 at 8:00am. Review of Resident #4's January 2026 eMAR revealed: -There was an entry for Divalproex tablet 250mg, take 1 tablet with breakfast. -There was documentation Divalproex 250mg was administered from 01/01/26 to 01/27/26 at 8:00am. Interview with the Special Care Coordinator (SCC) on 01/29/26 at 12:42pm revealed: -She was responsible for ensuring the physician's orders matched the eMAR. -She conducted weekly audits which included comparing the eMAR to the physician's orders.	D 344			

Division of Health Service Regulation

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D 344	Continued From page 2 -She reviewed the physician's orders and faxed them to the pharmacy once they were signed by the primary care provider (PCP). -When she reviewed the signed physician's orders, she would ensure it matched the eMAR. -She was not aware the Divalproex 250mg for Resident #4 was not on his signed physician's orders dated 09/22/25. -If a medication was not on the physician's orders but was on the eMAR she would contact the PCP to ensure there was no mistake. Interview with the Administrator on 01/29/26 at 12:31pm revealed: -When physician's orders were signed it meant those were the prescribed medications. -If a medication was not on the signed physician's orders it meant the medication should not be administered to the resident. -The SCC was responsible for ensuring physician's orders were accurate and faxed to the pharmacy. -He did not know why Resident #4's signed physician's orders dated 09/22/25 were not checked. Interview with the PCP on 01/29/26 at 1:53pm revealed: -Divalproex was used to treat behaviors. -She did not manage psychiatric medication for Resident #4. Based on observations, interviews, and record reviews it was determined Resident #4 was not interviewable.	D 344		