Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL043024	A. BUILDING: _____ B. WING _____	R 01/29/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE SPRINGS OF BALLENTINE	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	Responsible to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts in the Statement of deficiencies of Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State Law.	3/16/26
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 [illegible], 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	All Medication Aides will receive training regarding the requirements to clarify unclear, incomplete, or confusing orders. Training will emphasize identifying missing information on orders for psychotropic/seizure medications.	

REVIEWED AND ACKNOWLEDGED 02/25/26 BY NURSE CONSULTANT Janet B. Nielsen

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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	The Care Manager or Executive Director will audit all new admissions, readmissions, and monthly pharmacy reports for 100% compliance with order clarification for the next 90 days. The Consultant Pharmacist will review psychotropic medication orders during their quarterly reviews to check for proper documentation of dosages and behavioral indications. The Care Manager will do daily monitoring for new orders for the first 30 days. The Executive Director will do weekly audits of all residents MARs for the next 60 days to ensure clarity.	3/10/26 3/10/26 3/10/26 3/10/26

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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		