

Division of Health Service Regulation

PRINTED: 08/10/2017  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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 the Robeson County Department of Social Services conducted an annual and follow-up survey on July 25 - 27, 2017.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair;  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the walls and floors in two residents' bedrooms, the community bathroom, the kitchen, and the hallway were kept clean and in good repair.  The findings are:  Observation of the dining room at 11:00am on 7/25/17 revealed: - The tiles in the right front corner of the dining room, next to the room's entrance door from the central hallway, were beige, medium brown and off-white in color. - The off-white tiles were covered in gray and black smudges. - There was a 1/4th inch gap between 7 tiles in this area. - There were scrapes and peeling paint on the walls where the table tops touched the walls of	D 074		
			D 079-a Repaired / replaced and cleaned all floor covering in identified areas mentioned.	08/16/17
			D 079-b Any areas that required refinishing (drywall repair, painting etc.) done.	08/03/17

Division of Health Service Regulation  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6889 IOXR11

TITLE  
*Alban My*

(X8) DATE  
**8-27-2017**  
If continuation sheet 1 of 11

*Reviewed & Accepted  
for J. Chencharick - DR  
9/22/17*

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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 074	<p>Continued From page 1</p> <p>the dining room.</p> <ul style="list-style-type: none"> <li>- The air-conditioning unit vents were dusty and dirty.</li> </ul> <p>The floor of the dining room had rust, gray, and brown stains throughout the dining room.</p> <p>Observation of the kitchen at 11:30am on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- The kitchen walls were dirty and had multiple scrapes on the walls.</li> <li>- The pantry door had 2 large areas with peeling paint, one spot above a hinge lock and a larger spot at eye level on the door.</li> <li>- The molding around the pantry door had scrapes, black smudges, and peeling paint.</li> </ul> <p>Observation of the center hallway at 12pm on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- The central hall's wall to the right of the dining room had black smudges and two horizontal gray lines the length of the hall, at approximately 15 inches and 30 inches from the floor.</li> <li>- A large industrial mop and wheeled bucket was stored at the end of the hall, next to the rear exit door.</li> <li>- The lines on the wall corresponded to the top of the mop bucket and a plastic ledge halfway down the height of the bucket.</li> <li>- Handprints and black-gray smudges and stains were present on the walls.</li> </ul> <p>Observation of Room 3 at 2:00pm on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- A hole was punched into the wall behind the door by the door's rectangular door pull.</li> <li>- The door had gray-black smudges from handprints.</li> <li>- The room's heating unit with a wire grid on front was dusty and dirty. Gray-black dirt accumulated on the metal frame and the surrounding wall.</li> </ul>	D 074	<p>cont.from page 1 Reconditioning wood works in cited areas.</p> <p>(D 074-c ) AC / HTG units cleaned and recorked and painted wall in an around the cited areas .</p> <p>D 074-a</p> <p>D 079-b</p> <p>D 074-b</p> <p>D 074-b</p> <p>D 074-b</p> <p>D 074-d Staff inservice on housekeeping, appropiated storageing of supplies and paraphernali .Also to discuss all areas cited for compliance.</p> <p>D 074-b</p> <p>D 074-b</p> <p>D 074-b</p> <p>D 074-c</p>	<p>08/27/17</p> <p>08-27-17</p> <p>08/ 13/17</p> <p>08/17/17</p> <p>08/17/17</p> <p>09/10/17</p> <p>08/30/17 09/20/17 10/25/17</p> <p>08/17/17</p> <p>08/17/17</p> <p>08/17/17</p> <p>08/29/17</p>



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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 074	<p>Continued From page 3</p> <ul style="list-style-type: none"> <li>- The air-conditioner had not been dusted and cleaned yet this summer.</li> <li>- The floors were mopped daily, but mopping did not get rid of the black marks from residents' shoes.</li> <li>- Walls had not been washed.</li> <li>- There was no deep-cleaning schedule for the facility.</li> </ul> <p>Interview with the Administrator at 4:00pm on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- He was in charge of Maintenance of the facility.</li> <li>- The residents were always smudging the walls with their hands, wheelchairs or walkers.</li> <li>- Many residents have problems with walking, stability, and coordination, so they use the walls to keep from stumbling and falling.</li> <li>- He knew he needed to repaint the facility. He planned to buy a better quality paint, so it could be scrubbed.</li> <li>- He planned to repair the scrapes and gouges in the walls. Most gouges were caused by residents rearranging furniture or by opening doors with too much force.</li> </ul> <p>Interviews with residents who resided in Rooms 2 and 3 at 4:45pm on 7/25/17 revealed they had no complaints about the walls or floors in the facility.</p> <p>Confidential interviews with three residents on the condition of the community bathroom's walls and floors revealed no complaints.</p> <p>Daily checks of the walls and floors in two residents' bedrooms (#2 and #3), the community bathroom, the kitchen, and the hallway revealed:</p> <ul style="list-style-type: none"> <li>- All floors were mopped on 7/25/17, 7/26/17, and 7/27/17.</li> <li>- Repairs to the walls and floors had not been made.</li> </ul>	D 074		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>		
(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 074	Continued From page 4  Interview with the Administrator on 7/27/17 at 5:30pm revealed: - Walls will be repainted, he will buy a higher quality paint that can be scrubbed. - Floors will be repaired to ensure resident safety. - No timelines were set by the Administrator for cleaning and repairs of the walls and floor. - He stated "Repairs and maintenance here never ends".	D 074	D 074-b  D 074-a  D 074-b	09/15/17  09/15/17  99/15/17
D 076	10A NCAC 13F .0306(a)(3) Housekeeping And Furnishings  10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (3) have furniture clean and in good repair; This Rule shall apply to new and existing facilities.  This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the chair in the community bathroom, the chest of drawers and nightstand in Room 3, and the chest of drawers and nightstand in Room 2 were kept clean and in good repair.  The findings are:  Observation of Room #3 at 2:00 pm on 7/25/17 revealed: - The chest of drawers on the left wall was missing a drawer. - Two shirts were in the slot where the missing drawer should have been. - The bedside table had a peeling finish on the top.	D 076	The missing draw was replaced ,repaired (D 076-a  Bedside table was replace or refinished D 076-b	08/17/17  09/07/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>		
(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 076	Continued From page 5  Interview with a resident who resided in Room #3 at 2:20pm on 7/25/17 revealed: - He informed the Administrator of the damaged furniture. - He would like to get a drawer to replace the one that was missing. - The nightstand was scarred with beige spots where the dark, shiny finish had been damaged. - The nightstand was pretty small, but it was all he had next to the bed to keep reading material and personal possessions. - The furniture was not too sturdy.  Observation of Room #2 at 2:30pm on 7/25/17 revealed: - The chest of drawers on the left side had a broken handle on the right side of the bottom drawer. - The small nightstand had the finish worn away on all four sides of the 2 drawers.  Interview with a resident who resided in Room #2 at 4:45pm on 7/25/17 revealed: - The furniture was old, and not very sturdy. - A second chest of drawers in the room had scratches and patches of bare wood, where the finish had worn away. - He informed the Administrator and other facility staff of the furniture damage. - New furniture would be nice.  Observation of the community bathroom at 3:00pm on 7/25/17 revealed: - A side chair was located under the vanity. - The chrome tube frame was rusted. - The chair had an upholstered seat. The tweed fabric of the seat was stained with liquids, brown stains of unknown origin, and stains of red dots similar to paint or nail polish on the cushion and on the chair's woven rattan back and frame.	D 076		
			D 076-a	09/15/17
			D 076-b	08/30/17
			D 076- a,b	09/15/17
			D 076-a	09/15/17
			D 076-b	09/15/17
			D 076-a,b	09/15/17
			The chair in this area to be cleaned ,re paired, or replaced	09/15/17

Division of Health Service Regulation

PRINTED: 08/10/2017  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	---	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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 076	<p>Continued From page 6</p> <p>Interviews with two female residents at 5:00pm on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- They liked to use the chair when using the vanity.</li> <li>- The chair needed cleaning all over.</li> <li>- The stains on the chair were terrible.</li> <li>- New cushions for the chair would be appreciated, something washable would be good for a bathroom chair.</li> </ul> <p>Interview with the Administrator at 2:30pm on 7/26/17 revealed:</p> <ul style="list-style-type: none"> <li>- He was aware some of the furniture needed repairs.</li> <li>- Furniture will be cleaned.</li> </ul>	D 076		
D 282	<p>10A NCAC 13F .0904(a)(1) Nutrition and Food Service</p> <p>10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes:</p> <p>(1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination.</p> <p>This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to assure the kitchen appliances, equipment, and microwave cart were kept clean and in good repair.</p> <p>The findings are:</p> <p>Observations at 11:30 am on 7/25/17 of the kitchen revealed:</p> <ul style="list-style-type: none"> <li>- The microwave cart in the kitchen had a broken door on the left side of the cart.</li> </ul>	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>		
(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 282	Continued From page 7  <ul style="list-style-type: none"> <li>- The door was propped in place, there were no working hinges to hold it to the cabinet.</li> <li>- The bottom of the door was damaged, and did not match the right door.</li> <li>- The handle for the left door was broken.</li> <li>- A pot estimated to be 6-8 quarts in capacity had brown and black grease burned onto the outside walls and bottom of the pot.</li> <li>- The stovetop was smeared with food and grease.</li> <li>- The oven's interior and exterior were dirty and greasy.</li> <li>- The exterior of the oven had smeared grease and food residue on it.</li> <li>- The interior of the oven had stains of yellow fat, black and brown stains of burnt food, and crumbs of food on the floor of the oven and on the interior window.</li> </ul> <p>Interview with the Cook at 1:45pm on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- The Administrator knew the door was broken on the microwave cart.</li> <li>- The Administrator made decisions regarding furniture purchases.</li> <li>- The cabinet was still functional.</li> <li>- She worked as a Cook and a Medication Aide for the facility today.</li> <li>- Meal preparation and service and medication administration were a higher priority than cleaning at this time of the day.</li> <li>- She knew the stove top and oven needed to be thoroughly cleaned.</li> <li>- There was no deep cleaning schedule for the kitchen.</li> </ul> <p>Interview with the Administrator at 5:45pm on 7/27/17 revealed:</p> <ul style="list-style-type: none"> <li>- He was aware the left door on the microwave cart was damaged.</li> </ul>	D 282	<p>This supply cabinet (microwave cabinet) will be repaired, or replaced.</p> <p>D 282-a Existing kitchen staff ( a 4 hr worker 4 days a week ) whose primary responsibility is the cleaning of the kitchen as reference to the surveor during the visit will have to be readdress that position and increase monitior to a weekly. meeting with an asso. check list. to assure that quality services are met in this area.</p>	09/07/17  08/21/17 08/28/17 " " " " 08/15/17	
		D 282-a		09/15/17	



STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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 282	Continued From page 8  - The staff who prepare and serve food were responsible for cleaning the kitchen and the equipment used after each meal. - He will have the staff deep-clean the kitchen, including appliances, storage cabinets, storage shelves, and pots and pans.	D 282	D282-a	09/15/17
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements  G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements  (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory, annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5  This Rule is not met as evidenced by: Based on observations, personnel record reviews and interviews, the facility failed to assure 2 of 3 sampled Medication Aides ( Staff A and Staff B) completed the state mandated annual infection control course.  The findings are:  1. Review of Staff A's personnel record revealed:	D934	D934 A in service was held on 08/03/17 all staff were present and account and issued certificated accordly for Infection Control	

Division of Health Service Regulation

PRINTED: 08/10/2017  
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____		(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>		
(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
D934	<p>Continued From page 9</p> <ul style="list-style-type: none"> <li>-Staff A was hired on 12/01/10 as a Medication Aide.</li> <li>-Staff A completed the state mandated annual infection control course in 2015.</li> <li>-There was no documentation of completion of the state mandated annual infection control course for Staff A since 2015.</li> </ul> <p>Interview with Staff A on 7/25/17 at 2:35 p.m. revealed:</p> <ul style="list-style-type: none"> <li>- Staff A had not completed the state mandated annual infection control course since 2015.</li> <li>- Staff A was unaware of the facility's monitoring plan for state mandated annual infection control course.</li> </ul> <p>2. Review of Staff B's personnel record on 7/25/17 revealed:</p> <ul style="list-style-type: none"> <li>- Staff B was hired on 12/21/09 as a Medication Aide.</li> <li>- Staff B completed the state mandated annual infection control course in 2015.</li> <li>- There was no documentation of completion of the state mandated annual infection control course for Staff B since 2015.</li> </ul> <p>Interview with Staff B on 7/25/17 at 3:15 p.m. revealed:</p> <ul style="list-style-type: none"> <li>- Staff B had not completed the state mandated annual infection control course since 2015.</li> <li>- Staff B was unaware of the facility's monitoring plan for state mandated annual infection control course.</li> </ul> <p>Interview with Administrator on 7/26/17 at 10:15 a.m. revealed:</p> <ul style="list-style-type: none"> <li>- The Administrator was not aware that Staff A and Staff B had not received state mandated annual infection control course (Refer to interviews, above, with the two staff members.)</li> </ul>	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>HAL078082</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>07/27/2017</b>
--	--	--	---

NAME OF PROVIDER OR SUPPLIER  <b>CROMARTIE SPRING VILLAGE REST HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>508 WORTH STREET SAINT PAULS, NC 28384</b>
---	--

(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
D934	<p>Continued From page 10</p> <ul style="list-style-type: none"> <li>- The Administrator reviewed the personnel records regularly to ensure training mandates were met.</li> <li>- The state-mandated annual infection control course for all staff has been scheduled for 8/3/17.</li> </ul>	D934	Tentative dates have been made for next years in-service to assured that the Infection Control Program is maintained by all necessary staff person nel.	08/30/2017