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
	HAL078082	A. BUILDING: ______ B. WING ______	R **08/07/2025**

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
CROMARTIE SPRING VILLAGE REST HOME	**508 WORTH STREET** **SAINT PAULS, NC 28384**

(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 follow-up survey from 08/06/25 to 08/07/25.	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 observations, interviews, and record reviews, the facility failed to ensure the electronic medication administration records were accurate for 1 of 3 sampled residents (#2). The findings are:	D 367		

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D 367	Continued From page 1	D 367		

Review of Resident #2's current FL-2 dated 01/23/25 revealed diagnoses included schizoaffective disorder, mild intellectual disability and dementia.

Review of Resident #2's physician's order dated 07/29/25 revealed an order for Divalproex ER 250mg tablet, (extended release), take 2 tablets two times a day.

Review of Resident #2's July 2025 electronic medication administration records (eMAR) revealed:
-There was an entry for Divalproex DR (delayed release) 500mg, take 1 tablet twice per day.
-There was documentation the Divalproex DR 500mg tablet was administered from 07/30/25.
-There was an entry for Divalproex ER 500mg tablet, take 1 tablet twice per day.
-There was documentation the Divalproex ER 500mg tablet was administered on 07/30/25 and 07/31/25.

Review of Resident #2's August 2025 eMAR revealed:
-There was an entry for Divalproex DR 500mg, take 1 tablet twice per day.
-There was documentation the Divalproex DR 500mg tablet was administered from 08/01/25 to 08/06/25.
-There was an entry for Divalproex ER 500mg tablet, take 1 tablet twice per day.
-There was documentation the Divalproex ER 500mg tablet was administered on 08/01/25 and 08/02/25.

Observation of Resident #2's medications on hand on 08/07/25 at 9:29am revealed:
-There was a roll pack that contained Divalproex

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D 367	Continued From page 2 DR 500mg, take 1 tablet twice per day. -There was no Divalproex ER. Interview with a medication aide (MA) on 08/07/25 at 9:30am revealed: -He knew Resident #2's Divalproex was on the eMAR multiple times, but he did not inform the Administrator or anyone else. -He did not administer the Divalproex ER to Resident #2. -He should have verified the order, contacted the pharmacy and had the Divalproex ER removed from Resident #2's eMAR. Telephone interview with the Pharmacist at the facility's contracted pharmacy on 08/06/25 at 12:58pm revealed: -Resident #2 was previously prescribed Divalproex DR 500mg. -Divalproex DR 500mg, take 1 tablet twice per day was dispensed on 07/29/25 for Resident #2. -The current order on file for Resident #2's Divalproex was Divalproex ER 250mg tablet, extended release, take 2 tablets two times a day. -The Divalproex DR 500mg was sent in error. -She called the prescribing physician to obtain clarification for the order, and he wanted Resident #2 to continue the Divalproex DR 500mg. -There were no concerns with Resident #2 being prescribed ER and receiving DR instead. Interview with the Administrator on 08/06/25 at 2:05pm revealed: -He expected staff to notify him, the pharmacy, and or the primary care provider if a medication was on the eMAR multiple times. -The supervisor in charge (SIC) was responsible for ensuring the medications for residents matched their eMAR.	D 367		

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D 367	Continued From page 3 Attempted interview with Resident #2 was unsuccessful on 08/07/25 at 10:00am.	D 367		