STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL079002	A. BUILDING: _____ B. WING _____	02/19/2026

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HIGHGROVE LONG TERM CARE CENTER	2135 S SCALES STREET REIDSVILLE, NC 27320

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D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey from 02/17/26 to 02/19/26.	D 000		
D 067	10A NCAC 13F .0305 (h)(4) Physical Environment 10A NCAC 13F .0305 Physical Environment (h) The requirements for outside entrances and exits are: (4) in facilities with at least one resident who is determined by a physician or is otherwise observed by staff to be disoriented or exhibits wandering behavior, a continuously sounding device that is activated when the door is opened shall be located on each exit door that opens to the outside. The sound shall be audible in the facility. If a central system of remote sounding devices is provided, the control panel shall be powered by the facility's electrical system, and be in a location accessible by staff to operate the control panel. Notwithstanding the requirements of Rule .0301, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure all exit doors had engaged and continuously sounding, audible alarms that were accessible to two residents who were intermittently disoriented (#2, #5). The findings are: Observations of the facility on 02/17/26 at various times between 8:30am and 11:00am	D 067		

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D 067	Continued From page 1 revealed: -The main front door to the facility was not alarmed. -Residents, visitors and staff entered and exited the front door. -There was a back door that opened to an area with a porch for residents to smoke that was not alarmed; staff and residents went in and out during the day. 1. Review of Resident #2's FL2 dated 10/28/25 revealed: -Diagnosis included mild dementia, chronic heart failure, and hyperlipidemia. -She was intermittently disoriented. Review of Resident #2's care plan dated 10/28/25 revealed she was forgetful and needed reminders. Observation of Resident #2 on 02/17/26 at 8:50am revealed she was semi-ambulatory and ambulated with a walker. Telephone interview with Resident #2's responsible party on 02/18/26 at 8:51am revealed: -He visited the facility once a month. -The entry doors to the facility were not alarmed during the day. -He had not heard the alarm when he visited during the day. -He did not feel comfortable with Resident #2 going outside the facility without staff's knowledge. Attempted interview with Resident #2's Primary Care Provider (PCP) on 02/18/26 at 9:00am was unsuccessful.	D 067		

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D 067	Continued From page 2 Refer to the interview with a personal care aide (PCA) on 02/17/26 at 2:55pm. Refer to the interview with a medication aide (MA) on 02/17/26 at 2:40pm Refer to the interview with the Administrator on 02/19/26 at 11:00am. 2. Review of Resident #5's FL2 dated 11/20/25 revealed: -Diagnosis included mentally challenged, hypertension, and diabetes mellitus. -She was intermittently disoriented. Review of Resident #5's Resident Register dated 01/28/21 revealed she was forgetful and needed reminders. Observation of Resident #5 on 09/17/26 at 9:12am revealed she ambulated independently with no assistive device. Telephone interview with Resident #5's guardian on 02/18/26 at 11:50am revealed he did not have any concerns about Resident #5 leaving the facility without staff's knowledge. Attempted interview with Resident #5's Primary Care Provider (PCP) on 02/18/26 at 9:00am was unsuccessful. Refer to the interview with a personal care aide (PCA) on 02/17/26 at 2:55pm. Refer to the interview with a medication aide (MA) on 02/17/26 at 2:40pm Refer to the interview with the Administrator on 02/19/26 at 11:00am	D 067		

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D 067	Continued From page 3 Interview with a PCA on 02/17/26 at 2:55pm revealed: -She worked first shift. -Since she had worked at the facility, no exit doors were alarmed. -In her assigned section of the facility, there was never a time when staff could not locate a resident. Interview with a MA on 02/17/26 at 2:40pm revealed: -She typically worked first shift. -During her shift, she never heard any door alarms. -From her memory, no residents had ever left the facility without staff's knowledge. Interview with the Administrator on 02/19/26 at 11:00am revealed: -She was not aware that residents with intermittent disorientation required all exit doors be alarmed with a continuous audible sounding device. -The exit doors did have alarms, but she only turned them on at night. -She did not have any concerns about residents leaving the facility without staff's knowledge.	D 067		
D 113	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F.	D 113		

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D 113	Continued From page 4 Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews and record reviews, the facility failed to ensure the hot water temperatures were maintained at a minimum of 100 degrees Fahrenheit (°F) to a maximum of 116°F for 8 of 8 fixtures which were used by residents. The findings are: Review of the facility's local Environmental Health Section inspection report dated 07/24/25 revealed: -The hair salon faucet had a water temperature of 132°F. -The bathroom next to the hair salon had a water temperature of 133°F. -A bathroom on the main hall had a water temperature of 127°F. -A bathroom on the north hall had a water temperature of 133°F. -Resident room #22 has a water temperature of 118°F. Observation of a hand-washing sink in resident room #19 on 02/17/26 at 9:12am revealed: -A hot water temperature of 132°F. - There was visible steam coming from the water. Second observation of the hand-washing sink in	D 113		

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D 113	Continued From page 5 residents room #19 on 02/18/26 at 3:46pm revealed the water temperature was 112°F. Observation of a hand-washing sink in a bathroom across from the residents main dinning room on 02/17/26 at 9:16am revealed: -A water temperature of 131°F. -There was visible steam coming from the water. Second observation of the hand-washing sink in the bathroom across from the main dinning room on 02/18/26 at 3:46pm revealed the water temperature was 114°F. Observation of a hand-washing sink in resident room #26 on 02/17/26 at 9:17am revealed a hot water temperature of 120°F. Observation of a hand-washing sink in the shower room beside resident room #24 on 02/17/26 at 9:21am revealed a hot water temperature of 118.8°F. Observation of a hand-washing sink in the bathroom across from resident room #6 on 02/17/26 at 9:32am revealed a hot water temperature of 126.7°F. Observation of a hand-washing sink in the bathroom across from resident rooms #14 and #26 on 02/17/26 at 10:05am revealed a hot water temperature of 130.1°F. Observation of a hand-washing sink in a men's bathroom on the main hall on 02/17/26 at 10:08am revealed a hot water temperature of 126.7°F. Observation of a hand-washing sink in the bathroom across from resident room #4 on	D 113		

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D 113	Continued From page 6 02/17/26 at 10:13am revealed a hot water temperature of 127°F. Calibration of the surveyors' thermometers using an ice-water slurry on 02/17/26 at 10:30am revealed the thermometers read 32°F indicating no adjustment to hot water temperatures were required due to calibration Interview with the Administrator on 02/17/26 at 10:25am revealed: -She was made aware that the water temperatures in resident's hand-washing sinks were too hot. -She was aware the facility was having a problem with the water temperatures being too hot. -She was going to call the facilities plumber to come and fix the problem that day. Observations of the facility on 02/18/26 and 02/19/26 at various times between 8:00am and 5:00pm revealed: -Signs were posted on the doors of the hallway bathrooms indicating the water temperatures was too hot. -No signs were posted on resident rooms where the water at the hand-washing sinks were too hot. -An announcement was made over the intercom to inform staff and residents that the water temperatures were elevated. Interview with a personal care aide (PCA) on 02/17/26 at 2:51pm revealed: -She had not noticed that the water was too hot when she showered residents. -The residents had not complained about the water being too hot. -The residents had not gotten burned by hot water. -She regulated the water during showers.	D 113		

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D 113	Continued From page 7 Interview with a second PCA on 02/17/26 at 2:54pm revealed: -There were no residents in the facility who showered independently. -There were times when the water temperature was too hot to shower residents. -She would inform the Administrator when the water temperatures were too hot. Interview with a medication aide (MA) 02/17/26 at 2:39pm revealed: -The residents had not complained to her about the water being too hot at the sinks or during showers. -The residents had not had burns from hot water. -She had not noticed the water was too hot at the residents' sinks. Interview with a second MA on 02/17/26 at 2:51pm revealed: -She was concerned about the water temperatures being too hot. -She did notify management regarding the temperatures but she could not recall when. -She regulated the temperatures for the residents during personal care tasks. Interview with a resident on 02/17/26 at 9:30am revealed: -She did not have a hand-washing sink in her bedroom. -She used the bathrooms located in the hallways. -She felt the water got very hot quickly. -She was able to regulate the water temperature so she had not been burned. -She was worried about her roommate's ability to safely regulate the water temperature. -She did not recall her roommate ever being burned.	D 113		

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D 113	Continued From page 8 Interview with the resident who resided in room #19 on 02/17/26 at 10:12am revealed: -She was able to regulate the water temperature coming from the faucet. -The staff regulated the water temperature during personal care. -She noticed the steam coming from the water in the hand-washing sink but did not think too much about it. -She did have concerns of other residents not being able to regulate the water temperature. -She was not aware of any residents being burned from the hot water. Interview with a plumber from the facility's contracted plumbing company on 02/17/26 at 2:30pm revealed: -He was aware the facility was having issues with their hot water temperatures. -There was a problem with the water pressure in the facility which was causing the water temperature to be too high. -He had a work order to add a water pressure valve to ensure the water temperatures remained at an acceptable temperature. Interview with the Administrator on 02/17/26 at 3:24pm revealed: -That day, staff had complained of the water temperatures being too hot. -The residents had not complained to her about the water being too hot. -She was aware that water temperatures were to be maintained at a minimum of 100°F and a maximum of 116°F. -No signs were posted warning residents and staff about the hot water prior to surveyors making the facility aware. -There was a water temperature log that revealed	D 113		

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D 113	Continued From page 9 the facility was checking and recording hot water temperatures multiple times a month. -The water temperature, at various locations within the facility, was recorded from 01/14/26 to 02/08/26 and ranged from 101°F to 112°F. Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety issues memo revealed: -A hot water temperature of 120 degrees °F could cause first degree burns within 8 minutes and second degree burns within 10 minutes. -A hot water temperature of 124°F could cause first degree burns within 2 minutes and second degree burns within 4.2 minutes. -A hot water temperature of 125.6 °F could cause first degree burns within 45 seconds and second degree burns within 1.5 minutes (A first-degree burn was a superficial burn affecting the outer layer of skin. -A second-degree burn affected both the outer and second layer of skin and may cause blistering. _____ The facility failed to ensure that water temperatures were maintained at a minimum of 100°F and a maximum of 116°F related to sink temperatures ranging from 118.8°F to 132°F. The facility's failure was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a Plan of Protection in accordance with G.S. 131D-34 on 02/17/26 for this violation. THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2026.	D 113		

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D 269	Continued From page 10	D 269		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#1) who required extensive assistance with transferring and developed a pressure wound. The findings are: Review of Resident #1's FL2 dated 02/01/26 revealed: -Diagnoses included muscle weakness, abnormalities of gait and mobility. -She required assistance from staff with bathing and dressing. -She was semi-ambulatory. -Her skin was normal with no wounds indicated. Review of Resident #1's Resident Register revealed an admission date of 01/27/26. Review of Resident #1's admission skin check sheet dated 01/27/26 revealed she had no skin areas of concern. Review of Resident #1's care plan dated 02/05/26	D 269		

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D 269	Continued From page 11	D 269		

revealed:
-She required extensive assistance from staff with toileting, bathing, dressing, grooming and transferring.
-She required limited assistance from staff with eating and ambulation.

Review of Resident #1's Primary Care Provider (PCP) note dated 02/11/26 revealed to monitor a blister on the left heel and use cushion to keep the blister intact.

Review of Resident #1's progress notes from December 2026 through 02/16/26, revealed there was no documentation of the blister on her left heel.

Review of Resident #1's PCP after visit summary on 02/11/26 revealed there was a blister on her left heel that was caused by pressure related to being wheelchair bound.

Review of Resident #1's PCP after visit summary dated 02/19/26 revealed that the blister on her left heel was a deep tissue injury (a form of pressure-induced damage to underlying tissues).

Review of Resident #1's electric medication administration record (eMAR) for December 2026 through 02/16/26, revealed:
-There was no entry to monitor the blister on her left heel.
-There was no entry to cushion the blister to keep it intact.

Observation of Resident #1's left heel on 02/16/26, at 2:08pm revealed a large purple area that covered the bottom of her heel.

Interview with Resident #1 on 02/16/26, at

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D 269	Continued From page 12 2:10pm revealed: -She did not remember the blister being on her heel before moving into the facility. -She could walk short distances but mostly used the wheelchair. -No one at the facility was looking at her heel. -No one was keeping her heel cushioned. -She was worried about her heel becoming worse. -She had pain in her heel when something touched it. -She had a hard time adjusting in bed because of the pain in her heel. Interview with a personal care aide (PCA) on 0218/9 at 2:23pm revealed: -Resident #1 needed assistance with dressing, showering, ambulation and transfers. -She had assisted Resident #1 with showers. -She was not aware of the blister on her heel. -Staff do not fill out any type of skin check sheet when they completed resident's showers. Interview with a medication aide (MA) on 02/18/26 at 2:44pm revealed: -Resident #1 needed assistance with transfers. -She was not aware there was an order to monitor and cushion Resident #1's left heel. -She had never seen Resident #1's left heel. -The Supervisor reviewed all the new orders. Interview with a second MA on 02/18/26 at 3:18pm revealed: -She was not aware there was an order to monitor and cushion Resident #1's left heel. -She was not aware that Resident #1 had a wound on her left heel. Interview with Resident #1's Occupational Therapist (OT) on 02/19/26 at 10:03am revealed:	D 269		

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D 269	Continued From page 13 -His first time seeing Resident #1's left heel was on 02/18/26. -He had been working on upper body strength, so she did not ambulate with him prior to 02/18/26. -Resident #1 complained of her heel being sore during his visit on 02/18/26. -Resident #1 told him she was worried about her heel getting worse. -Resident #1's heel was cushioned on 02/18/26 but the resident wanted him to look at it. -Resident #1's left heel had a large purple area that did not appear to be open. -He placed a cushion bandage on her heel and wrapped her left heel. -He did not let anyone at the facility know about Resident #1's heel because it was already wrapped so he assumed they were aware. Interview with the Supervisor on 02/18/26 at 4:22pm revealed: -She reviewed all orders and sent them to the pharmacy to be entered on the eMAR. -She remembered seeing the order to monitor and cushion Resident #1's left heel and sent it to the pharmacy to be entered on the eMAR. -She did not have an audit in place to ensure the pharmacy entered the orders on the eMAR. -As the Supervisor, she was the only staff member that documented in the progress notes. -She was not sure why she did not put the left heel monitor and cushion on Resident #1's progress notes. -The first time she saw and cushioned Resident #1's left heel was on 02/17/26 after she complained that it was sore and not cushioned. -She saw Resident #1's left heel was purple, so she took a picture and sent it to the PCP. -The PCP ordered home health nursing, and they would be out on 02/19/26. -She told the MAs verbally on 02/11/26 about	D 269		

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HIGHGROVE LONG TERM CARE CENTER	2135 S SCALES STREET REIDSVILLE, NC 27320

(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 269	Continued From page 14 Resident #1's heel but did not have a schedule in place of who or when to monitor and cushion her heel. Interview with the Administrator on 02/19/26 at 10:50am revealed: -She was aware of the order to monitor and cushion Resident #1's left heel. -She first saw Resident #1's left heel on 02/11/26; it was large, raised and yellow in color. -The Supervisor and MAs were responsible for the treatment and monitoring of Resident #1's left heel. -When the treatments were completed, they should place a note in the progress notes. -She saw Resident #1's left heel again on 02/17/26, and it was large, raised had turned purple in color. -She expected the orders to be followed. Attempted telephone interview with Resident #1's PCP on 02/17/26 at 10:00am and 02/18/26 at 9:15am was unsuccessful. _____ The facility failed to provide personal care assistance for 1 of 5 sampled residents (#1) who was at risk for skin breakdown related to decreased mobility, and who developed a blister on her left heel, and the wound further progressed to become a deep tissue injury. This failure was detrimental to the health, safety, and welfare of the resident and constitutes a Type B Violation. _____ THE CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 5, 2026. 10A NCAC 13F .1004 (a) Medication Administration.	D 269		

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D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (#5) including a medication used to treat wax build up in the ear. The findings are: Review of Resident #5's current FL2 dated 11/20/25 revealed: -Diagnoses included diabetes mellitus, hypertension, mentally challenged and congestive heart failure. -There was an order for earwax removal (a medication used to manage earwax buildup) instill 10 drops into both ears two times weekly. Review of Resident #5's medication administration record (MAR) for December 2025 revealed: -There was an entry for earwax removal instill 10 drops in both ears twice weekly scheduled at 8:00am. -The earwax removal drops were documented as administered twice weekly on Tuesdays and Fridays.	D 358		

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D 358	Continued From page 16 Review of Resident #5's MAR for January 2026 revealed: -There was an entry for earwax removal instill 10 drops in both ears twice weekly scheduled at 8:00am. -The earwax removal was documented as administrated twice weekly on Tuesdays and Fridays. Review of Resident #5's MAR for February 2026 from 02/01/26 through 02/17/26 revealed: -There was an entry for earwax removal instill 10 drops in both ears twice weekly scheduled at 8:00am. -The earwax removal was documented as administrated twice weekly on Tuesdays and Fridays. Observation of medications on hand for Resident #5 on 02/18/26 at 11:24am revealed: -There was a box containing one opened bottle of earwax removal drops. -The bottle was opaque and felt half full. -The box had a dispensed date of 12/19/25. Telephone interview with a representative from the facility's contracted pharmacy on 02/18/26 at 11:36am revealed: -The earwax removal drops were used to treat earwax buildup in the ears. -Resident #5 had a current order for earwax removal drops since January 2025. -They had not received an order to discontinue the earwax removal drops. -The pharmacy dispensed a 52-day supply of earwax removal drops for Resident #5 on 01/16/25 and 12/19/25. -The earwax removal drops were not on a medication refill cycle; the facility must request to	D 358		

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refill it.
-They did not receive any requests to refill earwax removal from 01/16/25 through 12/19/25.

Interview with Resident #5 on 02/19/26 at 11:40am revealed:
-She always suffered from wax build up in her ears.
-She complained of her ears itching and feeling clogged.
-She felt awkward because she could not always hear when people were talking to her and often had to ask them to repeat what they said.
-She knew she was supposed to get earwax removal drops two times a week.
-The medication aide (MA) did not always administer her ear drops.
-She did not ask the MAs to administer the earwax removal drops if they did not give them to her.
-Her family did not bring in any earwax removal drops that she could remember.

Observation of Resident #5's right ear on 02/19/26 at 11:47am revealed:
-It was noticeably swollen inside the ear canal.
-She had a build-up of flakey dry skin inside her ear.
-There were areas of red inflamed skin in her ear.

Observation of Resident #5's left ear on 02/19/26 at 11:48am revealed dry flakey skin on the inside of her ear.

Interview with an MA on 02/18/26 at 1:40pm.
-She knew Resident #5 had an order for earwax removal drops.
-She administered the earwax removal drops as ordered.
-Resident #5 did not complain about her ears

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D 358	Continued From page 18 being itchy or being clogged. Interview with a second MA on 02/18/26 at 2:00pm revealed. -She worked as an MA but mostly worked as a personal care aide (PCA) in the facility. -She administered the earwax removal drops as ordered when she was working as an MA. -She did not recall Resident #5 complaining about her ears being itchy or clogged Interview with the supervisor on 02/18/26 at 3:10pm revealed: -Resident #5's family did not bring in any earwax removal drops. -Resident #5 did not complain about her ears being itchy or clogged. -She was not aware that Resident #5's earwax removal drops had not been administered as ordered. -She was not aware that Resident #5's earwax removal drops had not been requested from the pharmacy for 10 months. -She did not remember seeing a discontinue order for the earwax removal drops. -She expected the MAs to administer the earwax removal drops as ordered. Interview with the Administrator on 02/19/26 at 12:50pm revealed: -She was not aware Resident #5's earwax removal drops had not been requested from the pharmacy for 10 months. -She expected the MAs to administer the earwax removal drops as ordered by the provider. Attempted telephone interviews with Resident #1's PCP on 02/18/26 at 10:00am and 02/19/26 at 9:15am were unsuccessful.	D 358		

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D 371	Continued From page 19	D 371		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to ensure infection control measures were implemented as evidenced by a medication aide (MA), failing to use proper hand hygiene prior to the administration of the medications, and popping a pill into her bare hand prior to the administration of the medications. The findings are: Review of the facility's procedure for administrating oral tablets and capsules policy revealed: -MAs were to use proper hand-washing techniques before and after the administration of the drug to the residents. -If using blister packs, MAs were to empty medication into a cup and return blister pack to storage area. a. Observation of the morning medication pass on 02/18/26 between 8:05am and 8:30am revealed: -The MA removed a residents medication cards from the medicaiton cart drawer.	D 371		

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D 371	Continued From page 20 -She punched out 15 tablets/capsules into a medication cup. -She handed the medication cup and water to a resident. -The MA did not perform hand hygiene nor don gloves before preparing the medicaitons. Refer to interview with a MA on 02/18/26 at 11:29am. Refer to interview with a second MA on 02/18/26 at 11:37am. Refer to interview with the Administrator on 02/18/26 at 11:39am. b. Observation of the morning medication pass on 02/18/26 between 8:05am and 8:30am revealed: -At 8:07am, the MA removed a resident's blister pack from the medication cart. -The MA did not perform hand hygiene nor don gloves before preparing the medicaitons. -She opened the residents medication blister pack by punching her finger through the foil film meant to protect medications from environmental factors. -She poured the tablet from the blister pack into her bare hand and placed the tablet into a medication cup. -She handed the medication cup and water to a resident. -She administered the medication to a resident. Refer to interview with a MA on 02/18/26 at 11:29am. Refer to interview with a second MA on 02/18/26 at 11:37am.	D 371		

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D 371	Continued From page 21 Refer to interview with the Administrator on 02/18/26 at 11:39am. _____ Interview with the MA observed on 02/18/26 morning medication administration pass on 02/18/26 at 11:37am revealed: -She should have used hand hygiene before administering medications to the resident. -She was aware she should not touch pills with her bare hands; she made a mistake. -She was nervous because the surveyor was watching her pass medications. -She should have discarded the pills that she touched with her hands. -She did participate in the infection prevention trainings taught by the facilities RN upon hire and yearly. Interview with a second MA on 02/18/26 at 11:29am revealed: -She used hand hygiene before and after administering medications. -The facilities registered nurse (RN) provided yearly training to staff on infection prevention procedures. Interview with the Administrator on 02/18/26 at 11:39am revealed: -MAs were to sanitize their hands prior to and after the administration of medications. -The MAs should not touch residents' pills with their bare hands. -There could be a transfer of bacteria/germs from the MA's hand to the residents' pills. -The MA should have destroyed the medication that was touched and prepared the medications again for administration. -She expected MAs to use hand hygiene before and after administering medications.	D 371		

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D 378	Continued From page 22	D 378		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation and interviews, the facility failed to ensure all medications stored by the facility, were maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. The findings are: Review of the facilities provided policy on stocking of medications revealed all drugs (prescription and non-prescription, including topical preparations) would be stored in a well-lighted and well-ventilated locked cabinet, closet or cart. Observation of the medication cart on 02/17/26 at various times between 11:00am and 2:48pm revealed: -There was one antifungal powdered medication bottle with resident identifying information sitting on the top of the medication cart. -There were no medication aides (MAs) supervising the medication cart. -Multiple residents passed by the medication cart	D 378		

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D 378	Continued From page 23 while the medication bottle was left unsupervised. Interview with a MA on 02/17/26 at 2:48pm revealed: -She was aware that medication should not be left unsupervised as residents could easily access them. -She expected MAs to secure all medications when not in use. Interview with a second MA on 02/17/26 at 2:50pm revealed: -She was not sure why the medication had been left out and unsupervised. -She was aware that medications should not be left unsupervised as residents could easily access them. -She did not have any concerns about residents taking the unsupervised medication bottle. Interview with the Administrator on 02/17/26 at 3:22pm revealed: -Medications were not to be left on top of the medication cart unsupervised. -She expected staff to store medications appropriately when putting them in the mediation cart.	D 378		
D 393	10A NCAC 13F .1008 (b) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (b) Controlled substances may be stored together in a common location or container. If Schedule II medications are stored together in a common location, the Schedule II medications shall be under double lock.	D 393		

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D 393	Continued From page 24	D 393		

This Rule is not met as evidenced by:
Based on observations, record reviews and interviews, the facility failed to properly store Schedule II medications under double lock.

The findings are:

Observations of the facility's medication carts on 02/17/26 and 02/19/26 at 1:27pm and 9:41am revealed:
-The facility had 2 medication carts for the residents medications.
-The medication carts were lockable.
-The medication carts were not placed behind a locked door.
-The medication carts were left in the hallways.
-The medication carts did not contain a separate locked drawer for controlled medications.
-There was a blister pack that contained twelve oxycodone 5mg tablets.
-There was a blister pack in a yellow sleeve that contained twenty-four 15mg morphine tablets.
-There was a blister pack in a red sleeve that contained twenty-four 15mg morphine tablets.
-There was a blister pack in a blue sleeve that contained twenty-four 15mg morphine tables.
-There was a blister pack in a white sleeve that contained twenty-three 15mg morphine tablets.
-There was a blister pack in a yellow sleeve that contained ten 10mg oxycodone tablets.
-There was a blister pack in a blue sleeve that contained ten 10mg oxycodone tablets.
-There was a blister pack in a red sleeve that

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D 393	Continued From page 25 contained ten 10mg oxycodone tablets. -There was a blister pack in a white sleeve that contained eleven 10mg oxycodone tablets. Interview with a medication aide (MA) on 02/18/26 at 2:40pm revealed: -She was not aware that Schedule II medications should be stored under double lock. -She has worked at the facility for three years and the Schedule II medications had never been stored under double lock. Interview with a second MA on 02/18/26 at 3:18pm revealed: -She was aware the Schedule II medications should be stored under double lock. -She never asked why the Schedule II medications were not stored under double lock at the facility. Interview with the Supervisor on 02/18/26 at 3:40pm revealed that she was not aware that Schedule II medications should be stored under double lock. Interview with the Administrator on 02/18/26 at 4:10 pm revealed: -She was aware the Schedule II medications were not stored under double lock. -She thought that if the Schedule II medication was in a bubble pack with other medications it was ok to store them under a single lock.	D 393		