STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL003005	A. BUILDING: _____ B. WING _____	R 03/03/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF CHESTNUT GROVE	158 CHESTNUT GROVE CHURCH ROAD SPARTA, NC 28675

(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 Alleghany County Department of Social Services conducted an annual and follow-up survey with a complaint investigation from 03/02/26 to 03/03/26.	D 000		
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 during the morning medication pass. The findings are: Observation of the morning medication pass on 03/03/26 between 8:00am and 8:40am revealed: -The medication aide (MA) administered medications to the residents. -The MA placed nine medication tablets/capsules in a medication cup and handed it to a resident. -The resident poured the medications into her hand and placed the empty medication cup on the stand beside her. -The resident dropped one medication tablet on the floor. -The MA picked the medication tablet up from the	D 371		

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D 371	Continued From page 1	D 371		

floor with a gloved hand and placed it in the empty medication cup on the stand next to the resident.
-After the resident finished taking the medications in her hand, the MA handed the resident the medication cup containing the one tablet that fell on the floor.
-The resident swallowed the medication and handed the empty cup back to the MA.

Interview with the MA on 03/03/26 at 8:08am revealed:
-The residents' medications were dispensed in multi-dose packages containing several different medications in one bubble pack.
-If she had wasted the medication dropped on the floor, she would have needed to open the following morning's medication multi-dose package to administer the dropped medication to the resident.
-She was trained to administer any dropped medications to the resident because it would "throw off" the weekly multi-dose packaging system.

A second interview with the MA on 03/03/26 at 11:21am revealed:
-She was trained by an experienced MA and a Registered Nurse (RN) about six months ago when she began training to become a MA.
-During the medication pass that morning (03/03/26) she was nervous and did not remember what she was trained to do if a resident's medication dropped on the floor.
-The RN probably told her what to do if medication dropped to the floor, but she could not remember.
-In hindsight, it was common sense not to administer the medication after it fell on the floor, but she was nervous.

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D 371	Continued From page 2 Interview with the Resident Care Coordinator (RCC) on 03/03/26 at 12:16pm revealed: -The MA who administered the medication that fell to the floor was trained by an experienced MA and a RN when she began administering medications. -She expected the experienced MA and the RN to teach new MAs what to do if a medication was dropped on the floor. -The MA should have discarded the medication that fell on the floor, pulled a new one from the resident's multi-dose pack and call the pharmacy for a replacement medication tablet. Interview with the Administrator on 03/03/26 at 12:28pm revealed: -New MAs were trained by an experienced MA and a RN. -New MAs shadowed an experienced MA for three days and then were observed for 3 to 5 days prior to administering resident medications independently. -She expected the experienced MA and the RN to educate the new MAs on what to do if a medication was dropped on the floor. -She expected MAs to dispose of any medications that fell on the floor and pull a new medication tablet from the multi-dose pack. -The MA were then expected to call the pharmacy for a replacement medication tablet and notify the RCC.	D 371		