STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 and complaint investigation on March 18- March 20, 2025, March 31, 2025, and April 15, 2025 with a telephone exit on April 16, 2025. The complaint investigations were initiated by the Nash County Department of Social Services on February 13, 2025, February 21, 2025, and February 26, 2025.	D 000		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure that 2 of 6 sampled staff who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staff B), the medication aide clinical skills competency validation check list (Staff C), and the medication aide test (Staff B) prior to administering medications. The findings are: 1. Review of Staff B's personnel record revealed:	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 125	Continued From page 1 -Staff B was hired on 07/11/22 for a care services position. -She completed her clinical skills training on 10/10/24. -There was no documentation Staff B completed the state approved 5-hour and 10-hour, or 15-hour medication aide training. -There was no documentation Staff B completed the medication aide testing. Review of the medication administration record (MAR) for a resident revealed: -Staff B administered 3 medications on 01/20/25 at 8:00pm. -Staff B administered 2 medications on 01/22/25 at 8:00pm Observation of a MAR for a second resident revealed Staff B administered 3 medications on 01/22/25 at 8:00am. Observation of a MAR for a third resident revealed staff B administered one medication on 01/22/25 at 8:00pm. Interview with Staff B on 03/20/25 at 2:37pm revealed: -She completed her clinical skills training on 09/18/24. -The facility's Registered Nurse (RN) completed her clinical skills training. -She began passing medications independently around 11/15/24. -She was told on 02/12/25 by the Special Care Coordinator (SCC) that she could no longer administer medications until she passed the medication aide testing. -She believed that she had 90 days after the clinical skills training to take her medication training and pass the medication aide test in	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 125	Continued From page 2	D 125		

order to continue passing medications.
-She should not have been administering medications to residents after 11/18/24.

Interview with the SCC on 03/20/25 at 3:08pm revealed:
-New MAs must get signed off on clinical skills checklist by the facility RN.
-New MAs had 90 days after the clinical skills checklist to pass the medication aide test.
-Staff B was administering medication past her 90 day deadline without taking the medication training and passing the medication test.
-She did not realize that Staff B had continued to administer medications past the 90 day period.
-The Business Office Manager (BOM) and the Executive Director (ED)were responsible for ensuring MAs completed their testing before the 90 day period expired.

Interview with the facility RN on 03/20/25 at 4:00pm revealed:
-She was responsible for completing the clinical skills checklists for MAs in the facility.
-She signed off on Staff B's clinical skills checklist on 10/10/24.
-Staff B needed to take the medication aide training and pass the test within 60 days of the clinical skills checklist to continue administering medications.
-She should not have been administering medications to residents past 60 days after her clinical skills checklist.
-The BOM, ED and SCC were responsible for ensuring MAs had their training and testing completed.

Interview with the ED on 03/19/25 at 4:20pm revealed:
-Staff B was signed off on 10/10/24 for her clinical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 125	Continued From page 3	D 125		

skills checklist.
-Staff B had 60 days to complete her training and take the medication aide testing in order to continue administering medication to residents.
-Staff B should not have been administering medications to residents 60 after her clinical skills checklist was complete.
-The BOM was responsible for ensuring staff have their proper training and testing complete.
-She was not sure how this was overlooked.

2. Review of the Staff C's personnel record revealed:
-There was a hire date for 05/13/24 printed on the medication aide job description.
-There was documentation Staff C passed the medication aide test on 07/20/2005.
-There was documentation for the 15 hour medication training dated 01/20/25.
-There was no documentation of an employment verification form for Staff C.
-There was documentation Staff C completed the medication clinical skills competency validation checklist on 02/26/25.

Interview with Staff C, medication aide (MA) on 03/18/25 at 9:15am revealed:
-She had been employed at the facility for one to two months (no exact date of employment provided).
-She had been a MA for eight years.
-She worked at another facility for five years prior to employment at this facility.

Observations of Staff C, MA on 03/19/25 between 8:23am and 8:29am revealed:
-Staff C prepared medication for administration to a resident, including potassium chloride micro tablet 20 meq (a dietary supplement).
-Staff C placed the potassium chloride tablet in a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 125	Continued From page 4 plastic bag in preparation for crushing. Interview with Staff C on 03/19/25 at 8:29am revealed: -The potassium chloride was "the big white pill". -She had been crushing it to administer to the resident. -There were no printed instructions on the electronic medication administration record (EMAR) not to crush the potassium chloride tablet. Observation of Staff C, MA on 03/19/25 at 8:30am revealed the MA removed the potassium chloride tablet from the plastic bag prior to crushing the remaining pills. Review of residents EMARs for February 2025 revealed Staff C documented administering medication to residents on 02/10/25 - 02/13/25, 02/15/25, 02/16/25, 02/18/25-02/21/25, 02/24/25, and 02/25/25. Interview the MA on 03/20/25 at 2:25pm revealed: -She administered medications at the facility prior to completion of the medication aide clinical skills competency validation checklist. -She was a MA when she was hired at the facility. -She had been working at the facility since February 2025 (no specific date provided). -Another MA (not identified) worked with her when she administered medications prior to completion of the medication aide clinical skills competency validation checklist. Interview with the facility nurse (RN) on 03/20/25 at 11:50am revealed: -She completed medication aide clinical skills competency validation checklist. -The medication aide clinical skills competency	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 125	Continued From page 5 validation checklist was completed upon hire within 30 days and "before" the MAs worked on the floor. Interview with the Executive Director (ED) on 03/19/25 at 4:20pm revealed: -The Business Office Manager was responsible for ensuring staff had their proper training and testing complete. -She was not sure how this was overlooked.	D 125		
D 243	10A NCAC 13F .0704(a)(1) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Infomation on Facility and Resident Register (a) An adult care home administrator or their management designee shall furnish and review with the resident or the resident's authorized representative as defined in Rule .1103 of this Subchapter information on the facility upon admission and when changes are made to that information. The facility shall involve the resident in the review of the resident contract and information on the facility unless the resident is cognitively unable to participate in the discussion. A statement indicating that this information has been received upon admission or amendment as required by this Rule shall be signed and dated by each person to whom it is given and retained in the resident's record in the facility. The information shall consist of the following: (1) the resident contract to which the following applies: (A) the contract shall specify charges for resident services and accommodations, including the cost of different levels of service, description of levels of care and services, and any other charges or fees;	D 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 6 (B) the contract shall disclose any health needs or conditions that the facility has determined it cannot meet; (C) the contract shall be signed and dated by the administrator or management designee and the resident or the resident's authorized representative, a copy given to the resident or the resident's authorized representative and a copy kept in the resident's record; (D) the resident or the resident's authorized representative shall be given a written 30-day notice prior to any change in charges for resident services and accommodations, including the cost of different levels of service, description of level of care and services, and any other charges or fees, and be provided an amended contract or an amendment to the contract for review and confirmation of receipt; (E) gratuities in addition to the established rates shall not be accepted; and (F) the maximum monthly adult care home rate that may be charged to Special Assistance recipients as established by the North Carolina Social Services Commission and the North Carolina General Assembly. This Rule is not met as evidenced by: Based on interviews and record review, the facility failed to ensure the facility notified the resident/responsible party 30 days before a change in rate was initiated for 1 of 6 sampled residents (#5).	D 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 7 The findings are: Review of Resident #5's current FL-2 dated 11/14/24 revealed: -Diagnoses included unspecified dementia, unspecified severity, without behavioral disturbance, psychotic disturbance, and anxiety (primary admission); unspecified urinary incontinence; pure hypercholesterolemia; unspecified type II diabetes mellitus with hyperglycemia; unspecified glaucoma; essential (primary) hypertension; gastro-esophageal reflux disease without esophagitis; type 2 diabetes mellitus with hyperosmolarity without nonketotic hyperglycemic-hyperosmolar coma; acute respiratory failure with hypoxia. -The resident was intermittently disoriented. -The resident currently resided in memory care. Review of Resident #5's Resident Register revealed: -There was an admission date of 06/01/23. -There was a Resident Register for a "Review/Revision" dated 07/01/23 that documented a date of admission for 07/01/23. -The same designated responsible person/Power of Attorney (POA) was listed on both Resident Registers. -The signature on the two Resident Registers matched the name of the listed responsible person/POA. Review of a Resident Agreement dated 06/01/23 revealed there was a semi-private unit base rent of $4500.00 per month. Review of a Resident Agreement Addendum dated 07/01/23 revealed: -There was a monthly unit base rent of $1647.00 per month.	D 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 8	D 243		

-There was a signature for the facility and signature of representative for the resident dated 08/25/23.

Review of resident billing statements for Resident #5 revealed:
-On 11/30/24, there was a balance for $0.00.
-On 12/01/24, a charge of $313.42 was added with a description for "03/25/2024 to 03/31/2024 PCS PRIVATE-ALZ".
-On 12/01/24, charges of $1388.00 were added 04/2024 through 11/2024 with a description for dates from the first day of the month through the end of each month and "PCS PRIVATE-ALZ".
-On a resident statement with a billing date for 12/12/2024, the total balance due was documented as $12,805.42.

Review of a Resident Note Report for Resident #5 dated 12/12/24 revealed:
-The Administrator documented a telephone call between herself, the Business Office Manager (BOM), and a corporate representative (named) with the POA regarding denied personal care services (PCS) in March 2024.
-A NC Liability Fee was being added effective March 25, 2024.
-There would be an outstanding balance (amount not documented).

Interview with a representative for Resident #5 on 03/31/25 at 12:30pm revealed:
-The facility did not provide a 30-day notice for a change in payment for the residents' cost to stay in the facility.
-The representative for Resident #5 received a telephone call from the Executive Director (ED), BOM, and someone from the corporate office (name not provided) on 12/12/24 and received a certified letter from the corporate office on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 9 12/13/24 about a bill for $12,805.42. Interview with the Administrator on 03/21/25 at 9:25am revealed: -She was aware of the 30-day written notice that was supposed to be provided prior to a change in billing or charges for services. -She had not provided a 30-day written notice to representative for Resident #5. -She had asked the corporate support center about the 30-day written notice and the was told that the representative signed the contract on admission noting the patient liability fee could be added if the resident was PCS hours, and because it was in the admission contract, the representative for Resident #5 would not have to have a 30-day written notice. -The BOM was responsible for handling payments and bills. -Resident #5 was denied Medicaid PCSs twice per an assessment by an independent assessor. Second interview with the Administrator on 03/31/25 at 2:07pm revealed: -She did not provide 30-day written notices. -A 30-day written notice would come from the corporate office. -She did not get a copy of a 30-day written notice. -There was no amended contract for Resident #5. Third interview with the Administrator on 04/15/25 at 9:45am revealed: -Resident #5's POA was getting monthly invoices sent from the corporate office. -Resident #5 was denied Medicaid PCS services after a second assessment completed on 04/02/24. -When a resident was admitted to the facility the PCS team at the home office was notified. -The PCS team sent a form for the primary care	D 243		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 10	D 243		

provider (PCP) to sign.
-Once the form was returned the PCS team then sent it to the Medicaid department North Carolina Linking Individuals and Families to Long-Term Services and Supports (NCLIFTSS).
-NCLIFTSS coordinated to get resident assessments scheduled.
-Once the assessment was scheduled the facility received an email from the PCS team of the date and time of the assessment.
-A nurse contracted by NCLIFTSS came to the facility to complete the assessment with the ED or care manager present.
-The outcome of the assessment was not immediately known by the facility staff.
-Medicaid notified the representative payee of the outcome of the assessment.
-If the resident was denied the facility began the process for a second assessment.
-The PCS team was responsible for notifying the accounts receivable department for patient liability fee if PCS hours were denied by Medicaid.
-On 12/12/24 the Vice President (VP) of Operations, BOM, and ED called Resident #5's POA to inform them that they were being charged for the PCS hours that had not been paid since 04/02/25.
-They offered the POA the option to set up a payment plan to pay the PCS hours that totaled $12,805.42.
-The second assessment for Resident #5 was done on 03/01/24 and the PCS team was notified on 04/20/24 that Medicaid denied Resident #5's PCS hours.

Fourth interview with the Administrator on 04/15/25 at 2:30pm revealed:
-The accounts receivable representative at the home office was responsible for sending out a 30-day notice to POAs for any rate changes that

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 11	D 243		

occurred.
-The accounts receivable team also sent out the monthly invoices.

Interview with the BOM on 03/31/25 at 12:55pm revealed:
-She did not know about the 30-day written notice that should be provided to inform a resident/representative about a change in charges.
-She had not sent a 30-day written notice to Resident #5's representative.

Second interview with the BOM on 04/15/25 at 9:15am revealed:
-The facility sent monthly invoices to Resident #5's POA.
-Resident #5 was not being charged for the PCS hours since April of 2024.
-Resident #5 should have been charged an additional $1,388.00 each month for her PCS hours.
-The Administrator and VP of Operations were reviewing financials and realized that Resident #5 was not being charged for PCS hours.
-Resident #5's POA was first informed about the billing issue in a call and an email on 12/13/24.
-Resident #5's POA was informed that they owed the facility $12,805.42 because they had not been charged PCS hours due since 04/02/2024.
-The December 2024 invoice was sent to Resident #5's POA at the end of November 2024 and was for $1,700.
-Resident #5's POA was sent a second December invoice on 12/13/24 showing an additional 12,805.42 for Resident #5's PCS hours.

Third interview with the BOM on 04/15/25 at 2:40pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 12	D 243		

-The accounts receivable representative was responsible for sending 30-day notices if there were any rate changes.
-The home office sent invoices to the BOM to review before they were sent to POAs.
-When there were changes to rates the families should have signed a new contract.

Interview with the VP of Operations on 04/15/25 at 10:20am revealed:
-The contract that was signed by Resident #5's POA stated that the resident would be responsible for PCS hours if they were denied by Medicaid.
-The facility discussed this with Resident #5's POA upon admission.
-The facility's home office sent out monthly invoices to Resident #5's POA.
-The ED discussed setting up a payment plan with the POA which they accepted.

Telephone interview with a corporate representative on 03/31/25 at 2:30pm revealed:
-She had a telephone conversation with Resident #5's representative.
-She did not know if a written notice was mailed to Resident #5's representative.
-Resident #5's representative/responsible person was notified but it was a verbal notification.

Telephone interview with a Medicaid department NCLIFTSS representative on 04/15/25 at 12:50pm revealed:
-The facility needed to get a 3051 form completed for a resident in order to begin the Medicaid PCS hours assessment process.
-Once they received the form the facility then scheduled and assessment with contracted nurse.
-If the resident was denied PCS hours they had

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 243	Continued From page 13 the options of appealing the outcome or to begin the process for a second assessment. -Once a resident was denied PCS hours they sent a denial notice to the beneficiary or authorized representative to the address on file within 24 hours.	D 243		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure health care follow up was completed for 1 of 5 residents sampled (#5) related to a therapeutic diet. The findings are: Review of Resident #5's current FL-2 dated 11/14/24 revealed: -Diagnoses included unspecified dementia without behavioral disturbance, psychotic disturbance, mood disturbance, and anxiety; unspecified urinary incontinence, pure hypercholesterolemia, type 2 diabetes mellitus with hyperglycemia, unspecified glaucoma, essential hypertension, gastro-esophageal reflux disease without esophagitis, and acute respiratory failure with hypoxia. -There was a diet order of regular. Review of a physician's order for Resident #5 dated 12/17/24 revealed there were handwritten	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 273	Continued From page 14	D 273		

notations for "patient needs low carb diet" and "low on rice and bread".

Review of Resident #5's primary care provider (PCP) visit note dated 03/06/25 revealed:
-"Still using sliding scales as sugar per the niece still running high, diabetic diet is ordered" was documented in the history of present illness section.
-There was documentation of "educated to follow low cholesterol diet" for hyperlipidemia.
-There was no information for diet noted in the treatment section of the PCP visit note.

Review of Resident #5's care plan dated 03/05/25 revealed:
-The diet selection was regular.
-There was an "x" next to restrictions.
-There was a handwritten notation in the dietary restrictions section of "patient needs to be on diabetic diet (low carbs)".

Review of Resident #5's record revealed:
-On 03/05/25, there was an unsigned handwritten note from the facility requesting Resident #5's diet be clarified to regular or no added table salt (NATS), and the facility did not offer diabetic diets.
-There were no other requests or follow-up for a diet clarification for Resident #5 provided.

Telephone interview with Resident #5's power of attorney (POA) on 03/20/25 at 9:15am revealed:
-She transported Resident #5 to physician visits.
-Resident #5's doctor ordered a diabetic diet.
-The resident had a physician visit on 03/03/25 with the kidney doctor and was ordered a diabetic diet.
-The ordered diet did not specify what type of diabetic diet, and "just says diabetic diet needed".

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 273	Continued From page 15 -She expected the Memory Care Coordinator (MCC named) to reach out to the doctor for specifics regarding the diet. -The resident "eats what they put in front of her". Telephone interview with a representative for Resident #5's PCP on 03/20/25 at 10:53am revealed: -Resident #5 was seen by the kidney doctor, in the same practice as the PCP, on 03/03/25 as a new patient. -She was not able to access any additional information regarding the resident. -All messages were forwarded to the physician's nurse with a request for a return call. -She had not received any calls from the facility within the last two months until today (03/20/25) when a call was received from the Administrator (named). Telephone interview with the PCP's nurse for Resident #5 on 03/20/25 at 1:44pm revealed: -Resident #5 had a three month visit with the PCP on 03/06/25. -Education was provided to follow a low cholesterol diet for hyperlipidemia. -The resident was on a low cholesterol diet. -She did not see anything referencing a diabetic diet. -She thought the information written in the general comments on the visit report was information received from the resident's family member/POA. -The PCP typically ordered a low carb diet for the diabetic diet which included not having a lot of pasta and bread. Interview with the MCC on 03/20/25 at 2:48pm revealed: -Resident #5 was on a regular diet.	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 273	Continued From page 16 -The resident's family member wanted the resident to be served a no concentrated sweets diet. -She read the PCP's visit notes dated 03/06/25 and saw the information about the diabetic diet ordered. -She thought the PCP wanted Resident #5 to be served a diabetic diet, but the PCP did not send a physician's order. -She had reached out to the PCP but could not remember when. -The contact between the facility and Resident #5's PCP was conducted through the family member/POA. -She remembered contact with the PCP on 01/18/25 through the family member/POA. Interview with the Administrator on 03/20/25 at 5:15pm revealed: -The MCC was responsible for following up with health care needs, including diets. -She expected there to be follow-up with a family member on the same day when the family member transported a resident to an appointment, and if not the same day the follow-up was expected to occur on the next business day. -If the MCC did not hear back from a provider within five business days, she expected there to be another follow up attempt.	D 273		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages.	D 306		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 306	Continued From page 17	D 306		

This Rule is not met as evidenced by:
Based on observations and interviews the facility failed to ensure water was served at each meal for residents in addition to other beverages.

The findings are:

Observation of the lunch meal on 03/18/25 between 12:15pm and 12:50pm revealed:
-There were 27 residents in the dining room in the special care unit (SCU).
-Residents were served milk and tea only.
-There was no water served to the residents.
-Staff did not offer the residents water.

Interview with the personal care aide (PCA) on 03/18/25 at 12:.20pm revealed:
-The kitchen staff prepared and served the resident's beverages during meals.
-Some residents were served water if they requested it.
-The kitchen staff knew who wanted water and usually gave it to them.

Interview with a second PCA on 03/18/25 at 12:55pm revealed:
-The kitchen staff prepared and served the resident's beverages during meals.
-The residents usually got milk and tea with each meal.
-The residents got water for lunch if they asked for it.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 306	Continued From page 18 Interview with the Dietary Manager on 03/18/25 at 1:00pm revealed: -The kitchen staff prepared and served the resident's beverages during meals. -Some of the residents refused to drink water. -She was aware residents should have been served water with each meal. Interview with the Special Care Coordinator (SCC) on 03/19/25 at 5:15pm revealed: -She was aware that water was supposed to be served with each meal. -She had rarely seen residents in the SCU served water with meals. -She attempted to enforce the rule that water should be served with every meal. -Kitchen staff were responsible for ensuring water was served to all residents with each meal. Interview with the Executive Director (ED) on 03/19/25 at 5:45pm revealed: -She was aware that water was supposed to be served with each meal according to nutritional requirements. -She expected water to be served with each meal. -The Dietary Manager and cooks were responsible to ensure water was provided to residents with each meal. -She was not sure why residents were not served water.	D 306		
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	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 19	D 358		

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, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 4 of 6 residents (#3, #4, #6, #7) observed during the medication pass including errors with a blood pressure medication (#3), dietary supplements (#3, #6, #7), and a laxative (#6), and 1 of 5 residents sampled for record review (#3) including errors with documentation of administering discontinued medications for blood pressure, laxative, and dietary supplement.

The findings are:

1. The medication error rate was 17% as evidenced by 5 errors out of 28 opportunities during the 8:00am medication pass on 03/19/25.
a. Review of Resident #3's current FL-2 dated 05/15/24 revealed diagnoses included Alzheimer's disease with late onset, unspecified dementia, anemia, osteoporosis, essential hypertension, and transient cerebral ischemic attack.

Observation of the 8:00am medication pass on 03/19/25 revealed:
-The medication aide (MA) prepared three tablets from a pharmacy labeled multi-dose package (MDP) for administration to Resident #3.
-The MA administered losartan 50mg (used to treat hypertension) one tablet along with the resident's other medications at 8:04am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 20	D 358		

-The MA administered vitamin D3 50mcg (a dietary supplement) one tablet along with the resident's other medications at 8:04am.

Review of Resident #3's March 2025 electronic medication administration record (eMARs) revealed:
-There was a printed entry for Losartan tablet 50mg take one tablet once daily scheduled at 8:00am with documentation of administration on 03/19/25.
-There was a printed entry for Vitamin D3 tablet 50mcg (2000 units) take one tablet once daily scheduled at 8:00am with documentation of administration on 03/19/25.

Review of a hospice order for Resident #3 dated 01/06/25 revealed an order to discontinue three medications, including vitamin D3 and losartan.

Interview with the MA on 03/19/25 at 10:15am revealed:
-She administered medications based on what populated on the eMARs.
-If there was a change in a medication order for a medication packaged in the MDP, the MA was supposed to remove the discontinued medication, give it to the Memory Care Coordinator (MCC) who was supposed to put the discontinued medication in a "drug buster" container.
-There was no system in place that she knew of, to know when new physician orders were received by another staff member or to know when to remove a medication from the MDP that had been changed.

Telephone interview with the hospice nurse on 03/19/25 at 12:15pm revealed:
-The hospice agency physician was selected by Resident #3's guardian as the residents' primary

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 21	D 358		

care provider (PCP) upon admission to hospice on 06/29/24.
-The hospice physician managed Resident #3's medications.
-The most recent order discontinuing the Losartan 50mg tablet and Vitamin D3 50mcg tablet was written on 01/06/25 when a chart audit was performed, and medication orders were reconciled.
-There were no additional orders in Resident #3's profile for the Losartan 50mg tablet and Vitamin D3 50mcg tablet since 01/06/25.
-The hospice agency sent orders to the facility through a fax line.
-Resident #3's blood pressure was checked two times a week by hospice and expected to see some decline in the resident's blood pressure.
-The Losartan 50mg tablet was discontinued because Resident #3's blood pressure readings were getting low.

Interview with the Memory Care Coordinator (MCC) on 03/19/25 at 4:30pm revealed:
-She was "ultimately responsible" to ensure discontinued medications were removed from the eMARs.
-She could not provide an answer as to how discontinued medications for Resident #3 remained on the eMARs.

Interview with the facility Primary Care Provider on 03/20/25 at 4:30pm revealed:
-Hospice was the "primarily lead" for Resident #3.
-She saw Resident #3 as needed every three months.
-She was unaware of any medication changes for Resident #3.
-She assumed any medication changes for Resident #3 were made by the hospice provider.
-Losartan would decrease the blood pressure and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 22	D 358		

a low blood pressure could result in dizziness and unstable ambulation.
-Resident #3 was not ambulatory.
-There was not concern for the Vitamin D3 being administered after discontinuation because it would not hurt the resident.

Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable.

Refer to interview with the medication aide (MA) on 03/19/25 at 10:15am.

Refer to interview with the Memory Care Coordinator (MCC) on 03/19/25 at 3:57pm.

Refer to interview with the Administrator on 03/19/25 at 4:50pm.

Refer to interview with the Administrator on 03/20/25 at 5:30pm.

b. Review of Resident #7's current FL-2 dated 01/24/25 revealed diagnoses included Alzheimer's disease, dementia, unspecified dementia with anxiety, urinary incontinence, gait abnormality, and repeated falls.

Observation of the 8:00am medication pass on 03/19/25 revealed:
-The MA prepared six tablets from a pharmacy labeled multi-dose package and one medication from a pharmacy labeled blister pack for administration to Resident #7.
-The MA poured the medications into a small plastic bag, crushed the medications, and mixed the medications in applesauce.
-The MA administered two Vitamin B-12 1000 mcg tablets (a dietary supplement) to Resident #7

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 23 at 8:10am. Review of Resident #7's eMARs for March 2025 revealed: -There was a printed entry for Vitamin B-12 1000 mcg one tablet once daily scheduled at 8:00am with documentation of administration on 03/19/25. -There was a second printed entry for Vitamin B-12 tablet extended release 1000 mcg one tablet daily for supplement scheduled at 8:00am with documentation of administration on 03/19/25. Review of physicians orders for Resident #7 dated 02/03/25 revealed: -There was an order Vitamin B-12 ER 1000 mcg tablet, extended release tablet daily oral supplement take one tablet daily. -There was a quantity of 30 tablets dispensed to the facility and 4 refills remained. Interview with the MA on 03/19/25 at 10:00am revealed: -She administered two Vitamin B-12 tablets because two Vitamin B-12 tablets populated on the eMARs. -She administered medications based on what was populated on the eMARs. Interview with the Administrator on 03/19/25 at 11:25am revealed: -The contracted provider pharmacy duplicated the Vitamin B-12 order on the eMAR. -The MA administered what populated on the eMARs. Interview with the Primary Care Provider (PCP) for the facility on 03/20/25 at 4:22pm revealed: -Resident #7 was a hospice resident. -She saw hospice residents at the facility for acute needs.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 24	D 358		

-She conducted rounds on the residents every three months.
-She was not concerned that Resident #7 was administered Vitamin B-12 in a duplicate dose because the Vitamin B-12 would not cause any problems to the resident.

Based on observations, interviews, and record review, it was determined Resident #7 was not interviewable.

Refer to interview with the medication aide (MA) on 03/19/25 at 10:15am.

Refer to interview with the Memory Care Coordinator (MCC) on 03/19/25 at 3:57pm.

Refer to interview with the Administrator on 03/19/25 at 4:50pm.

Refer to interview with the Administrator on 03/20/25 at 5:30pm.

c. Review of Resident #6's current FL-2 dated 01/24/25 revealed diagnoses included vascular dementia, hyperlipidemia, chronic obstructive pulmonary disease, and osteoporosis.

Observation of the 8:00am medication pass on 03/19/25 revealed:
-The MA prepared three and one-half medications from a pharmacy labeled multi-dose package for administration to Resident #6, including a Loperamide (used to treat diarrhea) 2mg capsule.
-The MA did not remove any of the medications from the MDP prior to administration, including the loperamide 2mg capsule.
-The MA administered the medications to Resident #6 at 7:48am.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 25 -The MA returned to the medication cart and selected "given" on the eMAR for Resident #6. Review of Resident #6's eMARs for March 2025 revealed: -There was a printed entry for Loperamide capsule 2mg take one capsule daily scheduled at 8:00am. -There was an end date/discontinue date for 03/17/25. -There were no MA initials documenting the administration of the Loperamide 2mg capsule on 03/19/25 at 8:00am. Review of a physician's visit progress note for Resident #6 dated 03/13/25 revealed there was an order to change loperamide 2mg capsule daily to PRN (as needed) for diarrhea. Interview with the MA on 03/19/25 at 10:15am revealed: -She administered the Loperamide 2mg capsule on 03/19/25 because the Loperamide 2mg capsule was in the MDP and she did not know the order for the Loperamide 2mg tablet had changed to as needed. -If there was a change in a medication order and the medication was in the MDP, the MA was supposed to remove the medication from the MDP and give it to the MCC to be placed in a drug buster for disposal. Interview with the primary care provider (PCP) on 03/20/25 at 4:17pm revealed she was always concerned when an order was not followed. Based on observations, interviews, and record review, it was determined Resident #6 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 26 Refer to interview with the medication aide (MA) on 03/19/25 at 10:15am. Refer to interview with the Memory Care Coordinator (MCC) on 03/19/25 at 3:57pm. Refer to interview with the Administrator on 03/19/25 at 4:50pm. Refer to interview with the Administrator on 03/20/25 at 5:30pm. d. Review of Resident #4's current FL-2 dated 01/24/25 revealed diagnoses included muscle wasting, diabetes mellitus type II, dysphagia - oropharyngeal phase, cognitive communication deficit, edema, hypertension, and hyperlipidemia. Observation of the 8:00am medication pass on 03/19/25 revealed: -The MA prepared seven tablets from a pharmacy labeled multi-dose package (MDP) for administration to Resident #6, including Potassium Chloride Micro 20meq tablet (a dietary supplement). -The MA poured the medications into a small plastic bag in preparation for crushing the medications. -There were no instructions on the MDP label regarding crushing of medications, including the Potassium Chloride Micro 20meq tablet. Interview with the MA on 03/19/25 at 8:29am revealed: -The "big pill" was potassium. -She had been crushing the potassium prior to the administration to Resident #4. -She did not see any instructions on the eMAR that the potassium was not supposed to be crushed.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 27 Observation of the MA on 03/19/25 at 8:29am revealed she removed the potassium tablet from the medication container before crushing the remaining medications. Review of Resident #4's eMARs for March 2025 revealed: -There was a printed entry for Potassium Chloride tablet ER 20meq tablet twice daily scheduled at 9:00am and 8:00pm with documentation for administration 03/01/25 through 03/19/2025 at 9:00am. -There were no special instructions alerting the MA not to crush the Potassium Chloride tablet. Review of a physician order dated 01/16/25 revealed there was an order for may crush meds when allowed and "keep Potassium Chloride Tablet ER." Interview with the MA on 03/19/25 at 11:58am revealed: -She was not supposed to crush the Potassium Chloride tablet. -She reviewed order information in the medication administration computerized system that indicated the Potassium Chloride tablet was not supposed to be crushed. -She thought there should be instructions on the eMAR that the Potassium Chloride tablet should not be crushed. -The Potassium Chloride could "mess up their stomach". -Resident #4 had not complained of anything and had been having "normal bowel movements". Telephone interview with the PCP on 03/20/25 at 4:24pm revealed: -The Potassium Chloride tablet was not supposed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 28	D 358		

to be crushed.
-Crushing the Potassium would interfere with the digestion of the medication.
-The potassium would be absorbed all at one time when crushed.
-There could be heart palpitations with an increased absorption of potassium.
-Resident #4's potassium levels had been fine.
-There had been no reports of Resident #4 experiencing palpitations.

Refer to interview with the medication aide (MA) on 03/19/25 at 10:15am.

Refer to interview with the Memory Care Coordinator (MCC) on 03/19/25 at 3:57pm.

Refer to interview with the Administrator on 03/19/25 at 4:50pm.

Refer to interview with the Administrator on 03/20/25 at 5:30pm.

_____

Interview with the MA on 03/19/25 at 10:15am revealed:
-The MAs were responsible for faxing physician orders to the contracted provider pharmacy.
-The contracted provider pharmacy transcribed the orders to resident eMARs.
-Sometimes there could be a one delay in physician orders populating to the eMARs.
-Once physician orders were approved by the MCC or Administrator, the MAs could see the orders on the residents eMARs and administer the medications according to what populated on the eMARs.

Interview with the Memory Care Coordinator (MCC) on 03/19/25 at 3:57pm revealed:
-The MAs or MCC received physician orders.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 29	D 358		

-The MAs, MCC, or Administrator faxed orders to the contracted pharmacy.
-She and the Administrator approved physician orders that were transcribed to the eMARs by the contracted provider pharmacy.
-There was a delay with physician orders being transcribed to the eMARs sometimes because of the pharmacy cutoff time for order receipt.
-She used the computer and "just clicking to approve orders".
-She looked at the physician orders and compared the order with the written prescription.
-A physical physician's order was received from the hospice agency, but the majority of the time an electronic prescription was received.
-The contracted pharmacy provider was responsible for discontinuing orders off the eMARs.

Interview with the Administrator on 03/19/25 at 4:50pm revealed:
-The Memory Care Coordinator (MCC) was responsible for relaying new order information to the MAs and the information was relayed verbally.
-The MAs were responsible for placing an order change sticker on the pharmacy dispensed medication package or removing the medication if a medication was discontinued.
-The unit managers were responsible for overseeing weekly cart audits.
-The MAs were responsible for weekly medication cart audits.
-The MCC was responsible for reviewing discontinued and new physician orders daily against the eMARs.
-She did not know how often physician orders were reviewed by the MCC if there was no change in the physician orders.

Interview with the Administrator on 03/20/25 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 30 5:30pm revealed: -She expected the MAs to scan medication packages before administering the medications. -The MAs were expected to read the medication packages and match each medication to the eMAR. -She expected discontinued medications to be removed from the MDP prior to resident administration of medications. 2. Review of Resident #3's current FL-2 dated 05/15/24 revealed diagnoses included Alzheimer's disease, dementia, anemia, osteoporosis, and hypertension. Review of Resident #3's physician order dated 04/02/24 revealed: -There was an order for cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), take one tablet by mouth daily for a dietary supplement. -There was an order for losartan 50mg tablet, take one tablet by mouth daily for high blood pressure. Review of Resident #3's hospice physician order dated 01/06/25 revealed discontinue vitamin D3 and losartan effective 01/06/25. Review of Resident #3's January 2025 electronic medication administration record (eMAR) revealed: -There was an entry for cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), take one tablet by mouth daily for a dietary supplement. -The cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), was documented as administered 01/01/25-01/31/25. -There was an entry for losartan 50mg tablet, take one tablet by mouth daily for high blood pressure.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 31	D 358		

-The losartan 50mg tablet was documented as administered 01/01/25-01/31/25.
-Blood pressure on 01/13/25 was documented as 112/50.

Review of Resident #3's February 2025 eMAR for revealed:
-There was an entry for cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), take one tablet by mouth daily for a dietary supplement.
-The cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), was documented as administered 02/01/25-02/28/25.
-There was an entry for losartan 50mg tablet, take one tablet by mouth daily for high blood pressure.
-The losartan 50mg tablet was documented as administered 02/01/25-02/28/25.
-Blood pressure check on 02/13/25 documented as 107/50.

Review of Resident #3's March 2025 eMAR revealed:
-There was an entry for cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), take one tablet by mouth daily for a dietary supplement.
-The cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), was documented as administered 03/01/25-03/18/25.
-There was an entry for losartan 50mg tablet, take one tablet by mouth daily for high blood pressure.
-The losartan 50mg tablet was documented as administered 03/01/25-03/18/25.
-Blood pressure on 03/13/25 was documented as 107/50.

Review of Resident #3's medications on hand revealed:
-There was a bubble pack containing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 32	D 358		

cholecalciferol (vitamin D3) tablet 50mcg (2,000 unit), take one tablet by mouth daily for a dietary supplement on hand with a dispense date of 03/07/25.
-There was a bubble pack containing losartan 50mg tablet, take one tablet by mouth daily for high blood pressure dispensed on 03/07/25.

Interview with a hospice Registered Nurse (RN) on 03/19/25 at 12:15pm revealed:
-The hospice doctor was the primary care provider (PCP) for Resident #3.
-Start of care for Resident #3 was 06/29/24.
-Resident #3's guardian elected hospice to act as the PCP.
-On 11/28/24 Resident #3's Losartan was discontinued by the hospice PCP.
-There were no new orders for losartan and it was not in Resident #3's current medication profile.
-Hospice realized losartan was added back after an audit was done.
-On 01/06/25 hospice wrote a second discontinue order for losartan along with vitamin D3.
-When hospice discontinued a medication they wrote a reconciliation order and faxed it to the facility.

Second interview with the hospice RN on 04/15/25 at 11:05am revealed:
-Resident #3's losartan was discontinued because her blood pressure was lower and because the PCP wanted her to only continue taking Lasix (used to decrease fluid).
-She took Resident #3's blood pressure twice weekly.
-From January 2025 through March 2025 Resident #3's blood pressure ranged from 92/60 to 122/70.
-She did not consider Resident #3's blood pressure low because she was a hospice patient.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 33 Interview with the Memory Care Coordinator (MCC) on 03/19/2025 at 4:00pm revealed: -Medication aides (MA) received hospice medication orders mainly through electronic prescriptions, but sometimes they received physical copies. -Hospice faxed discontinue orders to the facility. -The pharmacy was responsible for removing discontinued medications off of the eMAR. -She was not aware that Resident #3 had medications that were discontinued on 01/06/25. -She did not know why the discontinued medications were still on Resident #3's eMAR. Interview with the Executive Director (ED) on 03/19/25 at 4:50pm revealed: -The MCC handled the discontinue process for medications. -Hospice discontinue orders were faxed to the facility and were received by the Administrator, MCC, Business Office Manager (BOM), and Sales Manager. -The MCC was responsible for faxing the discontinue orders to the pharmacy. -The MCC was responsible for verbally relaying the discontinue order to the MAs. -The MAs placed a medication change sticker on medication or pulled medication off the cart if it was discontinued. -The facility did not have current orders for losartan, or vitamin D3 for Resident #3. -She understood the facility was responsible for ensuring the eMAR matched the physician orders. -The MCC was responsible for overseeing medication cart audits weekly. -The MAs were responsible for doing medication cart audits when they received medication from the pharmacy.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL064034	A. BUILDING: _____ B. WING _____	R 04/16/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF ROCKY MOUNT MILLS	1365 RIVER DRIVE ROCKY MOUNT, NC 27803

(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 358	Continued From page 34 -The MAs were responsible for reporting any discrepancies with the medications to the MCC. -The MCC was responsible for following up with any medication issues. Interview with the facility pharmacy representative at 3:00pm on 04/15/25 revealed: -The pharmacy received faxed discontinue orders from the facility. -The pharmacy was responsible for removing discontinued medications from the eMAR. -The facility was capable of removing discontinued medications from the eMAR but the pharmacy advised against this because the facility would not be aware of the change. -They expected the facility to ensure all discontinue orders were faxed to the pharmacy so the medications could be removed from the eMAR. Interview with the facility's PCP on 03/20/25 at 4:30pm revealed: -She was not aware that hospice had discontinued Resident #3's losartan and vitamin D3. -Hospice usually discontinued medications because they were concerned with keeping patients comfortable, not treating patients. -Resident #3's losartan should have been discontinued if her blood pressure was low. -The losartan could have caused drowsiness and instability. -She was not concerned that the resident continued to be administered D3.	D 358		