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 06/19/2026

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 a follow-up survey and complaint investigation on 06/17/26 - 06/19/26. Complaint investigations were initiated by the Nash County Department of Social Services on 05/11/26 and 05/13/26.	D 000		
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. 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: 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 11 sampled fixtures that were readily accessible and used by residents with water temperatures ranging from 77.9°F to 92°F in the assisted living (AL) side of the facility. The findings are: Review of the facility's current license effective 01/01/26 revealed the facility was licensed with a capacity of 60 beds which included 30 Special	D 113		

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 06/19/2026

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 113	Continued From page 1	D 113		

Care Unit (SCU) beds.

Review of the facility's census report dated 06/17/26 revealed:
-The facility's current census was 46.
-The census for the assisted living (AL) side of the facility was 17 residents.
-The census for the SCU was 29 residents.

Observations in AL room 201 on 06/17/26 revealed:
-The hot water temperature in the sink in the resident's bathroom was 77 degrees Fahrenheit (°F) at 9:30am and 77.9°F at 9:39am.
-The hot water temperature in the shower in the resident's bathroom was 73.9°F at 9:40am and 79°F at 9:49am.

Interview with a resident in AL room 201 on 06/17/26 at 9:23am revealed:
-The water temperature was fine, not too hot and not too cold.
-The water in the shower took a while to warm up in the mornings.

Observations in AL room 202 on 06/17/26 revealed:
-The hot water temperature in the sink in the resident's bathroom was 77.4°F at 9:55am and 80.1°F at 10:05am.
-The hot water temperature in the shower in the resident's bathroom was 79°F at 10:05am and 88.2°F at 10:15am.

Interview with a resident in AL room 202 on 06/17/26 at 9:51am revealed:
-She showered independently.
-The water temperature was comfortable for her.
-The water in the shower was cold when first turned on and she had to wait about 15 minutes

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 06/19/2026

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 113	Continued From page 2 for the shower to warm up. Observations in AL room 303 on 06/17/26 revealed: -The hot water temperature in the sink in the resident's bathroom was 75.2°F at 10:20am and 75.4°F at 10:30am. -The water temperature in the shower was unable to be checked due to resident's clothes hanging in the shower. Interview with a resident in AL room 303 on 06/17/26 at 10:16am revealed: -She showered independently. -The water temperature was fine. -She had to let the water run for about 2 to 3 minutes for the water to warm up. -The water in the shower was never cold. Observation of the bathroom in AL room 103 on 06/17/26 from 10:08am - 10:14am revealed: -The hot water temperature in the sink was 88°F. -The hot water temperature in the shower was 88°F. Interview with a resident residing in AL room 103 on 06/17/26 at 10:14am revealed: -It usually took the water "a while" to get warm after the water was turned on. -Staff usually came in her room and turned the water on in the shower and let it run "a while" before they helped her with bathing. -The water was warm when she took a shower because staff let the water run before her shower. -She could not say how long it had been that way. Observation of the kitchenette in AL room 107 on 06/17/26 from 10:24am - 10:27am revealed the hot water temperature in the sink was 92°F.	D 113		

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 06/19/2026

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 113	Continued From page 3 Interview with a resident residing in AL room 107 on 06/17/26 at 10:27am revealed: -There had been no problems with the water except the water had to run "a while" to get hot. -She was not sure how long it had been that way. -She had not taken any cold showers; the water eventually got warm. Interview with another resident on 06/18/26 at 1:41pm revealed: -He showered independently. -He got up between 2:30am and 3:00am to turn his shower water on so that it would get hot. -After turning the water on, he went back to bed and got back up around 5:00am. -The water was warm enough to shower when he got up at 5:00am. -He had been at the facility for approximately 2 months, and the water temperatures had been that way ever since. Telephone interview with a resident's family member on 06/17/26 at 1:58pm revealed: -The water temperature in their family member's room had been cold since February 2026. -The resident's family visited 4 to 5 times a week. -The resident's family turned the water on for the resident to wash her hands and the water was still ice cold after 8 to 10 minutes. -The resident refused to take showers due to the cold water, so they used the sink and wash cloths for baths. -Facility staff were informed of the water temperature approximately every other week. -The previous Administrator was informed of the hot water temperatures and advised that the hot water temperatures were an ongoing problem due to the water heaters being tankless. -The current Administrator was informed of the hot water temperatures and advised that the hot	D 113		

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 06/19/2026

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 113	Continued From page 4	D 113		

water temperatures were an ongoing problem due to the water heaters being tankless.
-The Special Care Coordinator (SCC) was informed of the hot water temperatures and advised that the hot water temperatures were an ongoing problem due to the water heaters being tankless.

Interview with a personal care aide (PCA) on 06/17/26 at 2:56pm revealed:
-She had been employed with the facility for two years.
-She assisted residents with showers daily.
-She had been off for the last two days, but the water temperature was not good in the facility.
-She turned the hot water on at 7:00am some days and it was still not warm at 8:00am depending on the room.
-The water temperature in the 100 hall rooms got warm faster than the water temperatures on 200 and 300 halls.
-The water temperature on the 200 and 300 halls took about an hour to warm up.
-The water temperatures had been cold since January 2024.
-She reported the water temperature issues to the Administrator, the Resident Care Coordinator (RCC) and an Environmental Services (EVS) staff member and was advised they were working on the issue.
-Residents had complained about the hot water temperatures to her and other PCAs.
-When residents complained to her about the hot water temperatures she reported it to the Administrator, the RCC and an EVS staff member.
-She used the spa bathroom to assist residents with shower because it was bigger and the water got warmer in that bathroom.

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 06/19/2026

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 113	Continued From page 5 Interview with a medication aide (MA) on 06/18/26 at 11:59am revealed: -She also worked as a PCA and assisted residents with showers. -She heard a resident say the water was cold, but she did not report it to anyone. -The hot water needed to run for a while to warm up sometimes; the hot water wasn't always cold. -The hot water had to run for a while to warm up early in the morning. -When there were hot water temperature issues staff took residents to the spa bathroom because the water warmed quickly in that area. -She knew there was an issue with the hot water tank yesterday (06/17/26) and that it was fixed. Interview with an EVS staff member on 06/17/25 at 2:45pm revealed: -He handled housekeeping but did a lot of maintenance tasks that included checking hot water temperatures. -He checked hot water temperatures once per week. -There was a second EVS staff member that checked water temperatures as well. -When checking water temperatures, he randomly checked about 4 resident rooms on each hall. -He documented the water temperatures on a note pad and reported them to the second EVS staff member. -The second EVS staff member reported the water temperatures to the Area Maintenance Director (AMD). -The AMD kept a log of the hot water temperatures. -Hot water temperatures were supposed to be within the range of 100°F to 116°F. -He arrived at work at 8:00am today (06/17/26) and found that the outlet tripped that the hot water	D 113		

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 06/19/2026

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 113	Continued From page 6	D 113		

heater was plugged into, and no one knew about it.
-He had to reset the outlet, but when the outlet tripped it caused all of the hot water on the assisted living side of the facility to be cold.
-There were two hot water tanks for the whole building, and both were plugged into the same outlet (one was plugged in the top outlet, and one was plugged into the bottom outlet).
-The outlet that tripped was for the AL side hot water heater.
-The hot water heaters were tankless water heaters for continuous hot water flow.
-Residents complained this morning (06/17/26) to the PCA about the water being too cold.
-He had only been employed with the facility for about one month, so he was unaware of any hot water temperature complaints prior to this morning (06/17/26).
-There were no known parts on order for the water system, and he was not aware of any other issues with the hot water heaters.

Interview with a second EVS staff member on 06/18/26 at 9:03am revealed:
-He had been employed with the facility since March 2026.
-When he started working at the facility there were two resident rooms that had cold water temperatures but he was unsure which rooms.
-The cold water temperatures for those rooms were fixed by a technician from another building.
-The hot water went out again for those same rooms and was fixed the second time by the AMD and the Regional Maintenance Director (RMD).
-He knew the hot water temperature range should have been between 100°F and 116°F.
-He checked water temperatures daily but, at some point, was told to only check water temperatures on Monday, Wednesday, 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 06/19/2026

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 113	Continued From page 7 Friday by management staff. -When he checked water temperatures, he checked four to five different rooms and documented the temperatures in a personal notebook; he did not have the personal notebook with him. -He found low water temperatures and documented them in the maintenance logbook and reported the temperatures to the Administrator. -He provided the water temperature logs to the Administrator and informed the Administrator when water temperatures were out of range, whether they were too hot or too cold. -The Administrator was responsible for contacting the regional maintenance director regarding any out-of-range water temperatures. -He was unsure how the water system worked. -He was responsible for overseeing housekeeping and light maintenance. -Yesterday morning (06/17/26) he was checking water temperatures with the other EVS staff member to make sure the temperatures were within range. -He did not know if anything was going on with the water system yesterday (06/17/26). -He had to let the water run for a while for it to get warm. -The water in certain rooms got hot within two minutes but he had to let the water run for 5 to 10 minutes in other rooms before the temperature got hot. -He documented how long it took for the water temperatures to get hot on the temperature logs. Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every Monday, Wednesday, and Friday.	D 113		

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 06/19/2026

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 113	Continued From page 8 -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/18/26, water temperatures were checked on the 100, 200, 300, 400 and 500 halls. -The water temperature for 14 out of 14 rooms was low, ranging from 73.0°F to 74.5°F. -There was a note in the comment section that read "All low temperatures". -There was a note at the bottom of the page dated "5/18" that read "Area Maintenance ALG came on site flush and reset system". Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every Monday, Wednesday, and Friday. -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/20/26, water temperatures were checked on the 100, 200, 300, 400 and 500 halls. -The water temperature for 3 out of 15 rooms was low, ranging from 74.8°F to 91.4°F. -There was a note in the comment section that read "207, 205, shower on spa was low". Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every	D 113		

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 06/19/2026

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 113	Continued From page 9 Monday, Wednesday, and Friday. -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/22/26, water temperatures were checked on the 100, 200, 400 and 500 halls. -The water temperature for 2 out of 13 rooms was low, ranging from 85.1°F to 98.2°F. -There was a note in the comment section that read "205 and 207 is low temps and they are empty rooms sink and shower temps about the same". Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every Monday, Wednesday, and Friday. -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/25/26, water temperatures were checked on the 100, 200, 400 and 500 halls. -The water temperature for 14 out of 17 rooms was low, ranging from 74.8°F to 98.7°F. -There was a note in the comment section that read "207 and 205 is empty rooms low temps" "check time 2-3 minutes". Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed:	D 113		

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 06/19/2026

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 113	Continued From page 10 -Water temperatures were to be checked every Monday, Wednesday, and Friday. -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/26/26, water temperatures were checked on the 100, 200, 400 and 500 halls. -The water temperature for 11 out of 15 rooms was low, ranging from 77.4°F to 93.1°F. -There was a note in the comment section that read "2-3 minute checks" "room showers are low temp 2-3 min check" "207 and 205 is empty rooms". Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every Monday, Wednesday, and Friday. -Staff were to check at least three rooms per hallway and the kitchen. -Staff were to ensure temperatures were not below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 05/28/26, water temperatures were checked on the 400 hall. -The water temperature for 6 out of 8 rooms was low, ranging from 77.7°F to 95.2°F. Review of the facility's Weekly Water Temperature Checks log dated May 2026 revealed: -Water temperatures were to be checked every Monday, Wednesday, and Friday.	D 113		

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 06/19/2026

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 113	Continued From page 11	D 113		

-Staff were to check at least three rooms per hallway and the kitchen.
-Staff were to ensure temperatures were not below 100°F and not above 115°F.
- Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director.
-On 05/29/26, water temperatures were checked on the 200, 300, 400 and 500 halls.
-The water temperature for 17 out of 38 rooms was low, ranging from 72.5°F to 98.5°F.

Review of the facility's Weekly Water Temperature Checks log dated June 2026 revealed:
-Water temperatures were to be checked every Monday, Wednesday, and Friday.
-Staff were to check at least three rooms per hallway and the kitchen.
-Staff were to ensure temperatures were not below 100°F and not above 115°F.
- Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director.
-On 06/01/26, water temperatures were checked on the 100, 200, 300, 400, and 500 halls.
-The water temperature for 6 out of 14 rooms was low, ranging from 72.3°F to 91.0°F.
-There was a note in the comment section that read "205-115 is low temp" "405 and 501 is low temp".

Review of the facility's Weekly Water Temperature Checks log dated June 2026 revealed:
-Water temperatures were to be checked every Monday, Wednesday, and Friday.
-Staff were to check at least three rooms per hallway and the kitchen.
-Staff were to ensure temperatures were not

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 06/19/2026

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 113	Continued From page 12 below 100°F and not above 115°F. - Staff were to report any temperatures out of range to the Administrator, create a work order for service and contact the Maintenance Director. -On 06/02/26, water temperatures were checked on the 100, 200, 400 and 500 halls. -The water temperature for 2 out of 22 rooms was low, ranging from 71.9°F to 73.1°F. -There was a note in the comment section that read "207 & 205 low temps empty rooms" "5-10 mins for water to get hot" "Room 404 & 405 low temps" "5-10 min water run to get hot". Interview with the AMD on 06/18/26 at 8:48am revealed: -He had been working with the facility for less than 90 days. -He worked on the water system on 05/16/26 because there was a leak in a pipe. -He had to shut the water off on 05/18/26 between 8:00am and 8:30am and the water was off for approximately 3 hours. -Once he turned the water and water heater back on, it took a while for the hot water to heat up but he was unsure how long it took. -He checked the water temperatures before he left the facility on 5/16/24 and the temperatures were normal; he left the facility at approximately 4:00pm. -Normal water temperature range was supposed to be between 110°F and 116°F. -On 06/17/26, he was at another site when he received a call about the facility's hot water temperature. -He talked the EVS staff member through the steps of trouble shooting the water system and it was discovered that the ground fault circuit interrupter (GFCI) tripped. (A GFCI is a electrical safety device designed to protect from severe or fatal electric shocks.)	D 113		

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 06/19/2026

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 113	Continued From page 13 -When a GFCI tripped, the circulation pump went off so the hot water stopped flowing but cold water continued to flow. -It took time for the hot water to circulate after the GFCI was reset. -The water system was serviced about a month ago. -Servicing the water system included deliming and flushing the system which removed lime and calcium buildup. -He was not aware of any residents complaining about cold water. -When floor staff encountered cold water, they were to report it to the Administrator and the Administrator would report to the RMD, who would send him to the facility if needed. -The hot water heaters were located on the far side of the building, closer to the SCU so it took a while to circulate through the entire building; cold water circulated first. Interview with the RMD on 06/18/26 at 8:16am revealed: -He was at the facility once or twice per month. -The facility had 8 to 10 tankless water heaters located outside -One of the water heaters acted as the master unit and communicated tasks to the other units. -All the water heaters were supposed to supply water to specific areas of the building. -He could not say which areas of the building each water heater distributed to because of the building design. -When there was an issue with the water, he could determine which water heater had the issue based on the area of the building the issue presented and an light emitting diode (LED) indicated error code on the water heater. -The facility had a new circulation pump installed over one year ago.	D 113		

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 06/19/2026

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 113	Continued From page 14 -The circulation pump pushed the water throughout the building. -The original circulation pump burned out, and the building was not getting hot water in certain areas. -A technician came to the facility on 5/18/26 due to the water not heating up. -The water heaters were drained and the hot water temperature returned to normal. -He visited the facility in May 2026, after the technician drained the water heaters, to balance out the water temperature because some of the water temperatures were too high. -He was able to get the hot water temperatures within the range of 100°F to 116°F. -One of the EVS staff members called the AMD yesterday (06/17/26) around 7:45am about low water temperatures. -Around 9:00am yesterday, (06/17/26), the AMD informed him that the facility was having an issue with low water temperatures. -He advised that low water temperatures were impossible because the AMD came to the facility on 06/16/26 to fix a pin hole leak underneath one of the tankless water heaters and he would have turned the water off and tested it before he left to ensure the water was getting hot. -After trouble shooting the problem with the AMD and the EVS staff, they found that the GFCI had tripped (instantly shut off the power supply). -Once the GFCI tripped, it caused the circulation pump to cut off so the hot water was not being distributed throughout the building. -He was not sure if any residents complained of the water being cold in the past year. -If floor staff found water temperatures to be cold, they were to report it to the RCC or the Administrator and that person would contact an EVS staff member to check the water temperatures and/or contact the AMD.	D 113		

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 06/19/2026

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 113	Continued From page 15 -The facility changed computer systems three times and documentation of all the maintenance on the water system had been lost during those changes. Interview with the SCC on 06/18/26 at 9:14am revealed: -He was learning the water system but did not know how it worked. -The EVS staff checked the water temperatures, but he was unsure how often. -Water temperatures were documented on the water temperature log and reported to the Administrator. -PCAs and MAs were to report cold water temperatures to their direct supervisor and that person was to report to the Administrator. -A breaker went out yesterday (06/17/26) causing cold water temperatures, but facility staff did not know that was the reason for the cold water. -The AMD was in the facility the day before (06/16/26) and water temperatures were within range. -He was unsure why the AMD was in the building on 06/16/26. -There had been no known water issues prior to this week that he was aware of. -A resident's family member mentioned to him that the water took some time to warm up but he did not remember when he was given this information. -He did no think there was a problem to correct because he was not told that the water never warmed up, but that the water took a while to warm up. Second interview with the SCC on 06/19/26 at 3:41pm revealed: -He was Interim Administrator in March 2026 and April 2026.	D 113		

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 06/19/2026

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 113	Continued From page 16 -He had not seen the water temperature logs for May 2026 and June 2026 because those were reported to the Administrator and he had not been Interim Administrator since April 2026. Second interview with the RMD on 06/19/26 at 9:39am revealed: -He was not aware of and had not seen the low temperatures documented on the water temperature logs in May 2026 and June 2026. -When water temperatures were cold, the staff person checking the temperatures was supposed to let the water run for a while. -If the water temperature remained low, the staff member was to notify the Administrator and continue checking the water temperature in other rooms. -The Administrator was responsible for notifying the AMD and/or the RMD of the low water temperatures. -The last water temperature logs he saw were sent to him by an EVS staff member for 05/20/26 and 06/07/26 and the temperatures on 06/07/26 were within range. -If the water temperatures were out of range on the logs he received, he made a visit to the facility. -If he had been made aware of the low water temperatures, he would have worked to find the problem and if he could not find/fix the problem he would have called an outside company for assistance. -He was never informed that the water temperature was still taking a long time to heat up after the new circulation pump was installed. Second observation of the water temperature in the bathroom of AL room 201 on 06/17/26 revealed: -The hot water temperature in the sink was	D 113		

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 06/19/2026

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 113	Continued From page 17	D 113		

107.8°F at 3:54pm.
-The hot water temperature in the shower was 101.8°F at 3:56pm.
-The water temperatures reached in range temperatures in less than 1 minute.

Second observation of the water temperature in the bathroom of AL room 202 on 06/17/26 revealed:
-The hot water temperature in the sink was 103.1°F at 3:59pm.
-The hot water temperature in the shower was 106°F at 4:01pm.
-The water temperatures reached in range temperatures in less than 1 minute.

Second observation of the water temperature in the bathroom of AL room 303 on 06/17/26 revealed the hot water temperature in the sink was 87.1°F at 4:09pm and 100°F at 4:14pm.

Second observation of the bathroom in AL room 103 on 06/17/26 from 3:54pm - 3:59pm revealed:
-The hot water temperature in the sink was 106°F.
-The hot water temperature in the shower was 106°F.

Second observation of the kitchenette in AL room 107 on 06/17/26 from 4:00pm - 4:02pm revealed the hot water temperature in the sink was 110°F.

Interview with the RCC on 06/19/26 at 10:17am revealed:
-She had been the RCC since June 2025.
-She knew hot water temperatures were supposed to be between 100°F to 116°F.
-She was aware of the low water temperatures on the AL side of the facility because she had complaints from residents with the last complaint

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 06/19/2026

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 113	Continued From page 18	D 113		

being at the beginning of June 2026.
-The cold water temperatures were mentioned to her prior to June 2026 a few times.
-The water temperatures were checked and the AMD explained to the management staff that the tankless water system took time to get the hot water through the pipes, so the water had to run for a few minutes to get warm.
-The information that was provided to the managers by the AMD was shared with the family who had concerns.
-The hot water in the spa bathroom heated up faster so all the residents were given the opportunity to use that bathroom for showers with assistance.
-She was not aware the hot water was taking between 10 minutes to 1 hour to get warm.
-When a resident complained about the water temperature, PCAs and MAs were to report that complaint to her and she reported the complaint to maintenance.
-She notified the Administrator of water temperature issues if maintenance was not available.
-Water temperature checks were to be done daily by EVS staff, documented on a log, and provided to the Administrator.
-She was unsure of what the process would be to correct the long wait time for the hot water to warm up.
-She was not aware of the low water temperatures on the May 2026 and June 2026 water temperature logs.

Interview with the Interim Administrator on 06/19/26 at 11:16am revealed:
-She became the Special Operations Director 05/07/26 but was filling in for the Administrator.
-She was not aware of the low water temperatures on 6/17/26 until the RMD came to

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 06/19/2026

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 113	Continued From page 19	D 113		

the facility.
-The low water temperatures had something to do with the circulation pump.
-The facility was large, so it took a while for the hot water to get to certain areas.
-Staff had to let the hot water run 2 to 4 minutes for it to warm up.
-She was not aware the hot water was taking up to 1 hour to warm up.
-EVS staff were responsible for checking water temperatures.
-EVS staff reported low water temperatures to the Administrator, and the Administrator notified the AMD.
-PCAs and MAs were supposed to inform the care managers (RCC and SCC) of water temperature issues, and the care managers were to report the issues to EVS staff.
-The Administrator was responsible for reviewing water temperature logs.
-The water temperature logs were reviewed this week, during the survey, and that is why the RMD had been in the building every day, to address the issue.
-She was not aware of any residents or family reporting cold water.
-Management was discussing how to correct the length of time it took for the hot water to get warm.

Interview with the Regional Vice President of Operations (RVPO) on 06/17/26 at 10:55am revealed:
-The breaker for the hot water heater tripped earlier in the morning on 06/17/26.
-The breaker had to be reset.
-After the breaker was reset, all the water had to run to help circulate the hot water faster.
-The facility had 3 hot water tanks.
-There had been no prior issues with the breaker

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 06/19/2026

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 113	Continued From page 20 for the hot water heaters tripping. -Water temperatures were supposed to be in the range of 100°F to 116°F.	D 113		
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: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on interviews and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#2) as related to failing to coordinate a cardiology referral for a resident who had a cardiac pacemaker. The findings are: Review of Resident #2's current FL-2 dated 05/06/26 revealed diagnoses included dementia, presence of cardiac pacemaker (implanted device used to regulate the heart's rhythm), cerebral infarction (stroke), hypercholesterolemia (high cholesterol), and long-term use of anticoagulants (blood thinners). Review of Resident #2's Resident Register revealed the resident was admitted to the facility on 05/17/24. Review of Resident #2's palliative care visit note	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 06/19/2026

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 21	D 273		

dated 02/26/26 revealed the resident's past procedures included implantation of cardiac pacemaker on 03/07/16.

Review of Resident #2's primary care provider (PCP) visit note dated 04/09/26 revealed an order for a referral to cardiology.

Review of Resident #2's provider visit notes and facility progress notes revealed no documentation of Resident #2 being seen by a cardiologist.

Review of Resident #2's facility progress notes for April 2026 revealed no documentation of staff scheduling an appointment for the cardiology provider prior to 04/29/26.

Review of Resident #2's facility progress note dated 04/29/26 at 10:21am revealed:
-An appointment was scheduled with Resident #2's cardiology provider for 05/20/26 at 10:00am.
-The appointment was scheduled by the facility's Transporter.

Review of Resident #2's facility progress notes dated 05/18/26 revealed:
-An appointment was scheduled with Resident #2's cardiology provider for 06/22/26 at 1:45pm.
-The provider had called to reschedule the appointment.

Telephone interview with a scheduler at Resident #2's cardiology provider's office on 06/19/26 at 3:44pm revealed:
-Resident #2 was last seen by the cardiology provider on 04/11/25.
-Resident #2 had an appointment on 12/03/25 that was cancelled by the cardiology provider due to the provider not being in the office.
-The appointment was rescheduled for 12/31/25

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 06/19/2026

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 22	D 273		

but the resident was a "no show" for the appointment meaning the resident did not come to the appointment or call to cancel or reschedule the appointment.
-Another appointment was scheduled by the facility on 04/29/26 for Resident #2 for an appointment on 05/20/26.
-The facility staff called their office on 05/18/26 and cancelled Resident #2's appointment for 05/20/26.
-She did not know the name of the person who cancelled the appointment and there was no documentation of why it was cancelled.
-Resident #2 had an appointment scheduled for 06/22/26.

Interview with the facility's Transporter on 06/19/26 at 3:59pm revealed:
-She had been working as the facility Transporter for about 1 to 2 months and a personal care aide (PCA) prior to that.
-She usually called providers on Fridays to confirm residents' appointments for the following week.
-The Resident Care Coordinator (RCC) or Special Care Coordinator (SCC) usually gave her referral orders, and she usually set up appointments for the referrals.
-She could not recall for certain why Resident #2's cardiology provider appointments were rescheduled.
-She thought she may have called to reschedule Resident #2's appointment for 05/20/26 but she did not know why or remember for certain.
-She thought she documented the cardiology provider cancelled the appointment in error because the facility had a new computer system and she was still learning how to document in the new system.

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 06/19/2026

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 23 Interview with Resident #2 on 06/19/26 at 12:46pm revealed: -She had a heart pacemaker, but she did not know who checked it or the last time it was checked. -She had seen a cardiology provider in the past, but she was not sure when she was last seen by the cardiology provider. -She denied any current symptoms of chest pain. Interview with the SCC on 06/19/26 at 5:11pm revealed: -When he received orders for referrals from a provider, he gave the order to the Transporter so she could make the appointment. -The Transporter usually documented the appointment in the electronic computer system. -The appointment list was reviewed by staff during daily stand-up meetings. -He and the RCC were responsible for making sure the Transporter made the referral appointments and any follow-up appointments. -Resident #2 was scheduled for an appointment with the cardiology provider because the PCP wanted to make sure the resident's pacemaker was okay. -He thought Resident #2 had missed a cardiology appointment on one occasion because the cardiology provider was on vacation. -He was not aware of Resident #2 missing any scheduled cardiology appointments after that. Interview with the Interim Administrator on 06/19/26 at 5:40pm revealed: -The RCC and SCC should ensure that referral appointments were made and the appointments were followed up. -If an appointment had to be rescheduled, staff should document the reason. -She was not aware Resident #2 had not been	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 06/19/2026

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 24 seen by a cardiology provider as ordered. Telephone interview with Resident #2's PCP on 06/19/26 at 10:20am revealed: -She found out in October 2025 that Resident #2 had a cardiac pacemaker. -The facility staff were not aware Resident #2 had a cardiac pacemaker until she brought it to their attention in October 2025. -She vaguely remembered the cardiology provider had rescheduled a past visit with Resident #2 and then she thought the resident missed the rescheduled visit (sometime around January 2026) because of transportation errors by the facility. -She was not aware Resident #2 had not been seen by a cardiology provider since the referral dated 04/09/26. -The facility staff had not reported to her that the resident's cardiology appointment had been rescheduled again. -Cardiac pacemakers usually lasted about 10 years and Resident #2 had her pacemaker for about 10 years, so it needed to be checked. -Resident #2 was not currently exhibiting any cardiac issues that would indicate any problems with her pacemaker. -It was important for Resident #2 to be seen by a cardiology provider to make sure the pacemaker was working correctly. Attempted telephone interview with Resident #2's cardiology provider on 06/19/26 at 3:54pm was unsuccessful.	D 273		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	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 06/19/2026

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 (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: FOLLOW-UP TO TYPE A2 VIOLATION. Based on these findings, the previous Type A2 Violation was not abated. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 5 residents (#7, #8) observed during the medication passes including errors with a transdermal patch used to treat high blood pressure (#7) and an oral medication for high blood pressure and heart failure (#8) and for 3 of 5 residents (#1, #2, #3) sampled for record review including errors with a blood thinner (#2), rapid-acting insulin (#1), and a medication for high blood pressure (#3). The findings are: 1. The medication error rate was 6% as evidenced by 2 errors out of 31 opportunities during the 8:00am and 9:00am medication passes on 06/18/26. a. Review of Resident #8's current FL-2 dated 05/28/26 revealed diagnoses included dementia, essential tremor, Parkinson's disease, muscle weakness, difficulty in walking, lack of coordination, neuralgia (nerve pain), and anxiety disorder.	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 06/19/2026

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 Review of Resident #8's primary care provider (PCP) order dated 06/16/26 revealed an order for Hydralazine 10mg 1 tablet twice a day, "hold if systolic blood pressure (SBP) is less than 120, diastolic blood pressure (DBP) less than 60". (Hydralazine is used to treat high blood pressure and heart failure.) Observation of the 8:00am and 9:00am medication passes on 06/18/26 revealed: -The Resident Care Coordinator (RCC) checked Resident #8's blood pressure at 8:45am and it was 140/59. -The RCC prepared and administered morning medications to Resident #8 at 8:52am, including one Hydralazine 10mg tablet. Review of Resident #8's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Hydralazine 10mg take 1 tablet twice daily, hold if SBP less than (<) 120, DBP <60. -Hydralazine was scheduled for administration at 8:00am and 8:00pm. -Hydralazine was documented as administered at 8:00am on 06/18/26 when the resident's DBP was 59. Observation of Resident #8's medications on hand on 06/18/26 at 8:36am revealed: -There was a supply of Hydralazine 10mg tablets dispensed on 06/09/26 with 3 of 18 tablets remaining. -The instructions were to take 1 tablet twice daily, hold if SBP <120, DBP <60. Interview with the RCC on 06/18/26 at 2:26pm revealed:	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 06/19/2026

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	D 358		

-She and the medication aides (MAs) or the Special Care Coordinator (SCC) were responsible for clarifying medication orders.
-She was not aware of any discrepancies with the hold parameters for Resident #8's Hydralazine order.
-She was not sure if Resident #8's Hydralazine should be held when both the SBP and DBP were below the parameters or if just one or the other was below the parameters.
-The order should have been clarified.

Interview with the Interim Administrator on 6/18/26 at 2:41pm revealed:
-The RCC should have held Resident #8's Hydralazine that morning, 06/18/26.
-The RCC and the MAs were responsible for clarifying medication orders.
-The MAs should notify the RCC or SCC if there were any discrepancies with medication orders.

Telephone interview with Resident #8's PCP on 06/19/26 at 10:14am revealed:
-There were parameters in place for Resident #8's Hydralazine to be held to prevent the resident's blood pressure from getting too low.
-Resident #8's Hydralazine should be held if the resident's SBP was <120 or if the DBP was <60.
-No one contacted her prior to yesterday, 06/18/26, to clarify the order.
-Not holding Hydralazine when Resident #8's SBP or DBP were low, could put the resident at risk of even lower blood pressure which could cause the resident to have dizziness, passing out, or unresponsiveness, which could result in a visit to the hospital emergency room (ER).

Based on observations, interviews, and record reviews, it was determined that Resident #8 was not interviewable.

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 06/19/2026

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 b. Review of Resident #7's current FL-2 dated 04/23/26 revealed: -Diagnoses included essential hypertension, chronic kidney disease, dementia, hypotension, restlessness, and agitation. -There was an order for Clonidine 0.2mg/24hr patch, apply 1 patch to skin on upper arm once a week on Thursday for hypertension. (Clonidine is a transdermal medication used to lower high blood pressure. According to the manufacturer, Clonidine patch should be applied on the upper, outer arm or upper chest to ensure consistent medication delivery/absorption.) Observation of the 8:00am and 9:00am medication passes on 06/18/26 revealed: -The medication aide (MA) removed a Clonidine 0.2mg/24hr patch from Resident #7's right upper back. -The MA then applied a new Clonidine 0.2mg/hr patch to Resident #7's left upper back at 8:01am instead of to the resident's upper arm as ordered. Review of Resident #7's June 2026 electronic medication administration records (eMARs) revealed: -There was an entry for Clonidine 0.2mg/24hr patch, apply 1 patch to skin on upper arm once a week on Thursday and it was scheduled for administration at 9:00am every Thursday. -Clonidine 0.2mg/24hr patch was documented as being applied on 06/04/26, 06/11/26, and 06/18/26. -There was no section on the eMAR to document where the Clonidine patch was being applied. -The resident's blood pressure ranged from 105/62 - 137/64 from 06/01/26 - 06/18/26. Observation of Resident #7's medications on	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 06/19/2026

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		

hand on 06/18/26 at 2:01pm revealed:
-There was a supply of Clonidine 0.2mg/24hr patches dispensed on 05/21/26.
-The instructions were to apply 1 patch to skin on upper arm once a week on Thursday for hypertension.

Interview with Resident #7 on 06/18/26 at 2:12pm revealed:
-The MAs usually applied the Clonidine patch to her back.
-Once in a while, the MAs applied the Clonidine patch to her arm or chest.
-Her blood pressure was "running good".

Interview with the MA on 06/18/26 at 2:04pm revealed:
-She was aware the order and instructions were to put the Clonidine 0.2mg/24hr patch on Resident #7's upper arm.
-She had never seen the Clonidine patch applied to the resident's upper arm.
-She was trained by a former MA to apply the Clonidine patch to Resident #7's upper back because the resident would remove the patch on her arm.
-She should have notified Resident #7's primary care provider (PCP) about the application of Resident #7's Clonidine patch.

Interview with the Resident Care Coordinator (RCC) on 06/18/26 at 2:32pm revealed:
-The MAs should apply Resident #7's Clonidine patch on the resident's upper arm, according to the instructions.
-No MAs had reported that they were applying Resident #7's Clonidine patch in a different location than specified in the order.
-She recalled MAs reported in March 2026 that Resident #7 would take off the Clonidine patch

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 06/19/2026

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	D 358		

when she was agitated but the resident's medications were adjusted and there had been no issues with agitation since March 2026.
-The MAs should have notified her or the PCP regarding Resident #7's Clonidine patch.

Interview with the Interim Administrator on 06/18/26 at 2:41pm revealed:
-The MAs should follow the order when they administered medications.
-If there was a discrepancy, the MAs should notify the RCC or Special Care Coordinator (SCC) and call the pharmacy or the Regional Nurse.

Telephone interview with Resident #7's PCP on 06/19/26 at 10:19am revealed:
-She was notified yesterday, 06/18/26, that the MAs put Resident #7's Clonidine patch on her back to prevent the resident from taking it off.
-She did not have a big concern about staff placing the Clonidine patch on the resident's back because there was still absorption of the medication in that area.
-Her main concern was facility staff should have notified her sooner so she could evaluate and change the order.

2. Review of Resident #2's current FL-2 dated 05/06/26 revealed diagnoses included dementia, presence of cardiac pacemaker, cerebral infarction (stroke), hypercholesterolemia (high cholesterol), and long-term use of anticoagulants (medications that thin the blood).

Review of Resident #2's primary care provider (PCP) order dated 01/19/26 revealed an order to obtain weekly International Normalized Ration (INR) lab draws. (INR is a lab value used to monitor Warfarin therapy. Warfarin is a blood thinner used to prevent blood clots. The target

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 06/19/2026

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 INR range is generally recommended to be 2.0 - 3.0 for most clinical situations and 2.5 to 3.5 with mechanical heart valves.] Review of Resident #2's lab results revealed: -The resident's INR was 4.23 on 03/30/26. -The resident's INR was 2.26 on 04/06/26. -The resident's INR was 3.88 on 04/15/26. -The resident's INR was 3.89 on 04/20/26. Review of Resident #2's PCP order dated 04/01/26 revealed: -There was an order to start Warfarin 6mg on Sunday, Monday, Wednesday, Thursday, Friday, and Saturday. -There was an order to start Warfarin 7.5mg on Tuesdays. Review of Resident #2's PCP order dated 04/22/26 revealed: -There was an order to hold Warfarin dose today (04/22/26). -There was an order to discontinue Warfarin 7.5mg and change to Warfarin 6mg 1 tablet daily. Review of Resident #2's April 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Warfarin 6mg 1 tablet once daily on Sunday, Monday, Wednesday, Thursday, Friday, and Saturday scheduled at 5:00pm. -Warfarin 6mg was documented as administered on Wednesday, 04/22/26 at 5:00pm, when it should have been held. Review of Resident #2's PCP visit note dated 04/23/26 revealed: -The resident was being seen for an acute visit to evaluate elevated INR and manage chronic	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 06/19/2026

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		

anticoagulation therapy in the setting of heart valve replacement.
-The resident's goal therapeutic INR range was 2.5 - 3.5.
-The resident's recent INR was 3.89, above goal therapeutic range.
-The resident was seen today and in no acute distress.
-No acute bleeding concerns were reported at this visit.
-Orders were given yesterday (04/22/26) to hold Warfarin due to elevated INR, however, upon review, Warfarin was not held as ordered.
-Due to continued need for prompt correction of supratherapeutic (above therapeutic range) anticoagulation, Warfarin was to be held today, 04/23/26.
-The Resident Care Coordinator (RCC) and facility's Director were notified of the missed hold order and updated plan.
-Given the elevated risk of thromboembolism (blood clot that travels and blocks a blood vessel) in the setting of a mechanical valve, anticoagulation would be resumed promptly after brief hold at the adjusted maintenance dose.
-There was an order to hold Warfarin today, 04/23/26.
-There was an order to resume Warfarin on 04/24/26 at 6mg 1 tablet daily.

Review of Resident #2's lab results revealed:
-The resident's INR was 3.39 on 04/27/26.
-The resident's INR was 4.72 on 05/04/26.

Review of Resident #2's PCP order dated 05/06/26 revealed there was an order to hold Warfarin for 1 day (05/06/26), then resume existing dosage.

Review of Resident #2's May 2026 eMAR

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 06/19/2026

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	D 358		

revealed:
-There was an entry for Warfarin 6mg 1 tablet once daily scheduled at 5:00pm.
-Warfarin 6mg was documented as administered on Wednesday, 05/06/26 at 5:00pm instead of being held.

Review of Resident #2's lab results revealed:
-The resident's INR was 5.17 on 05/11/26.
-The resident's INR was 2.71 on 05/18/26.

Interview with a medication aide (MA) on 06/19/26 at 4:11pm revealed:
-The pharmacy usually entered orders into the eMAR system and the RCC or Special Care Coordinator (SCC) approved orders in the eMAR system.
-Resident #2's PCP sometimes called the facility and told the MAs to hold the Warfarin
-The MAs would document it in the progress notes and the SCC would go into the eMAR system and put the order on hold.
-If a medication was marked as held in the eMAR system, it would not "pop up" on the computer screen to be administered so she would not administer the medication.
-If she administered Warfarin to Resident #2, her initials would be documented on the eMAR.
-She administered Warfarin to Resident #2 on 05/06/26 because there was no indication on the eMAR that the medication was to be held.

Interview with the SCC on 06/19/26 at 5:11pm revealed:
-He started working as the SCC around the end of May 2026.
-He or the RCC faxed orders received by the facility, including hold orders to the pharmacy.
-The pharmacy entered orders into the eMAR system.

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 06/19/2026

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	D 358		

-He and the RCC were responsible for approving orders in the eMAR system.
-He was not sure why Resident #2's Warfarin was not held as ordered.

Interview with the Interim Administrator on 06/19/26 at 3:00pm revealed:
-The MAs, RCC, or SCC were responsible for sending medication orders, including hold orders to the pharmacy.
-The pharmacy staff entered orders into the eMAR system.
-The RCC and SCC were responsible for approving orders in the eMAR system as soon as the orders were available for approval in the eMAR system.

Telephone interview with Resident #2's PCP on 06/19/26 at 10:20am revealed:
-Resident #2 had a mechanical heart valve so the resident's INR goal range was 2.5 - 3.5.
-Resident #2's Warfarin therapy had been extremely hard to manage.
-There had been incidents when Resident #2's Warfarin was not held as ordered.
-Not holding Warfarin when the resident's INR was too high put the resident at risk of bleeding such as nose bleeds.
-It also increased the resident's risk of bleeding out if she had a fall while the INR was too high.

Attempted telephone interview with a pharmacist at the facility's contracted pharmacy on 06/19/26 at 2:50pm was unsuccessful.

Based on observations, interviews, and record reviews, it was determined that Resident #2 was not interviewable.

3. Review of Resident #1's current FL-2 dated

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 06/19/2026

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 35 04/23/26 revealed diagnoses included cerebrovascular disease, chronic kidney disease stage IV, and hypertensive chronic kidney disease with stage 1 through stage 4 kidney disease. Review of Resident #1's signed physician order dated 05/14/26 revealed: -There was an order to check the resident's finger stick blood sugar (FSBS) three times a day with meals. -There was an order for insulin Lispro Kwikpen injection 100unit/mL, inject 2 units subcutaneously three times a day with meals. If FSBS is greater than 300, notify the primary care provider (PCP) if FSBS is less than 70 or greater than 400, notify the provider. (Lispro Kwikpen is a fast-acting insulin). Review of Resident #1's May 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Lispro Kwikpen injection 100unit/mL, inject 2 units subcutaneously with meals if FSBS was greater than 300, notify the PCP if FSBS is less than 70 or greater than 400. -On 05/15/26 at 5:00pm FSBS was 250. -On 05/15/26 at 5:00pm 2 units of Lispro Kwikpen were administered. -On 05/16/26 at 8:00am FSBS was 125. -On 05/16/26 at 8:00am 2 units of Lispro Kwikpen were administered. -On 05/16/26 at 12:00pm FSBS was 155. -On 05/16/26 at 12:00pm 2 units of Lispro Kwikpen were administered. -On 05/16/26 at 5:00pm FSBS was 290. -On 05/16/26 at 5:00pm 2 units of Lispro Kwikpen were administered. -On 05/17/26 at 8:00am FSBS was 232. -On 05/17/26 at 8:00am 2 units of Lispro Kwikpen	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 06/19/2026

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 36	D 358		

were administered.
-On 05/17/26 at 12:00pm FSBS was 244.
-On 05/17/26 at 12:00pm 2 units of Lispro Kwikpen were administered.
-On 05/25/26 at 8:00am FSBS was 72.
-On 05/25/26 at 8:00am 2 units of Lispro Kwikpen were administered.
-On 05/25/26 at 12:00pm FSBS was 217.
-On 05/25/26 at 12:00pm 2 units of Lispro Kwikpen were administered.
-On 05/26/26 at 5:00pm FSBS was 129.
-On 05/26/26 at 5:00pm 2 units of Lispro Kwikpen were administered.
-On 05/27/26 at 5:00pm FSBS was 167.
-On 05/27/26 at 5:00pm 2 units of Lispro Kwikpen were administered.
-On 05/28/26 at 8:00am FSBS was 124.
-On 05/28/26 at 8:00am 2 units of Lispro Kwikpen were administered.
-On 05/28/26 at 12:00pm FSBS was 168.
-On 05/28/26 at 12:00pm 2 units of Lispro Kwikpen were administered.
-On 05/29/26 at 8:00am FSBS was 151.
-On 05/29/26 at 8:00am 2 units of Lispro Kwikpen were administered.
-On 05/29/26 at 12:00pm FSBS was 200.
-On 05/29/26 at 12:00pm 2 units of Lispro Kwikpen were administered.
-On 05/30/26 at 8:00am FSBS was 176.
-On 05/30/26 at 8:00am 2 units of Lispro Kwikpen were administered.
-On 05/31/26 at 8:00am FSBS was 172.
-On 05/31/26 at 8:00am 2 units of Lispro Kwikpen were administered.
-On 05/31/26 at 12:00pm FSBS was 210.
-On 05/31/26 at 12:00pm 2 units of Lispro Kwikpen were administered.
-On 05/31/26 at 5:00pm FSBS was 198.
-On 05/31/26 at 5:00pm 2 units of Lispro Kwikpen were administered.

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 06/19/2026

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 37 -Lispro was administered 18 times in May 2026 when the resident's FSBS was less than 300. Interview with a medication aide (MA) 06/19/26 at 11:33am revealed: -She did not realize that she had administered 2 units of Lispro when Resident #1's FSBS was less than 300. -She should have followed the PCP order to hold the Lispro when Resident #1's FSBS was less than 300. -The resident could become hypoglycemic when her blood glucose dropped too low. -She made a mistake when she administered Lispro to the resident when her FSBS was below 300. Interview with the Resident Care Coordinator (RCC) 06/19/26 at 11:44am revealed: -She was not aware that MAs had administered Resident #1 Lispro when her FSBS was less than 300. -The MAs were supposed to follow the PCP orders to ensure the resident's safety. -When the MAs administered Resident #1 Lispro when her FSBS was less than 300 they placed the resident at risk of hypoglycemia. Interview with the Special Care Coordinator (SCC) on 06/19/26 at 5:20pm revealed: -The MAs, himself or the RCC should have noticed that Lispro was administered to Resident #1 when her FSBS was less than 300 during medication cart audits. -Medication cart audits were completed daily by the MAs and weekly by the RCC and/or SCC. Interview with the Interim Administrator on 06/19/26 at 2:57pm revealed: -The MAs should have followed the PCP's orders	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 06/19/2026

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 38	D 358		

for Resident #1 and not administered Lispro if her FSBS was less than 300 because MAs were expected to follow the PCP's orders.
-The resident should not have received 2 units of Lispro when her FSBS was less than 300 because the resident did not need the insulin.
-The resident's blood glucose could have dropped too low and she could have become unresponsive.
-MAs should have followed the PCP's order when Resident #1's FSBS was less than 300.

Telephone interview with Resident #1's PCP on 06/19/26 at 10:14am revealed:
-MAs should not have administered Lispro to Resident #1 unless her FSBS was greater than 300.
-When Lispro was administered while Resident #1's FSBS was lower than 300 it placed the resident at risk of her blood glucose dropping too low.
-If the resident's blood glucose dropped too low, she was at risk of becoming unresponsive.
-The MAs should have followed her orders.

4. Review of Resident #3's current FL-2 dated 04/23/26 revealed diagnoses included unspecified dementia, chronic kidney disease stage 4, and atrial fibrillation.

Review of Resident #3's signed physician order dated 05/14/26 revealed there was an order for Clonidine 0.2mg tablet, take one tablet once a day, check blood pressure before administration and hold if systolic blood pressure is less than 120 or diastolic blood pressure is less than 60 (Clonidine is a medication used to treat high blood pressure).

Review of Resident #3's May 2026 electronic

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 06/19/2026

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 39	D 358		

medication administration record (eMAR) revealed:
-There was an order for Clonidine 0.2mg tablet, take one tablet twice a day, check blood pressure before administration and hold the medication if systolic blood pressure was less than 120 or diastolic blood pressure was less than 60.
-The resident's blood pressure was 120/59 at 8:00am on 05/17/26.
-Clonidine 0.2mg was documented as administered at 8:00am on 05/17/26 when the systolic blood pressure was 120 and the diastolic blood pressure was less than 60.

Review of Resident #3's June 2026 eMAR revealed:
-There was an order for Clonidine 0.2mg tablet, take one tablet twice a day, check blood pressure before administration and hold the medication if systolic blood pressure was less than 120 or diastolic blood pressure was less than 60.
-The resident's blood pressure was 100/52 at 8:00am on 06/03/26.
-Clonidine 0.2mg was documented as administered at 8:00am on 06/03/26 when the systolic blood pressure was less than 120 and the diastolic blood pressure was less than 60.

Review of Resident #3's signed physician order dated 06/09/26 revealed there was an order for Clonidine 0.2mg tablet, take one tablet once a day, check blood pressure before administration and hold if systolic blood pressure was less than 110, diastolic blood pressure was less than 60 or heart rate was less than 60.

Review of Resident #3's June 2026 eMAR revealed:
-There was an order for Clonidine 0.2mg tablet, take one tablet twice a day, check blood pressure

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 06/19/2026

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 40	D 358		

before administration and hold the medication if systolic blood pressure was less than 110, diastolic blood pressure was less than 60, or heart rate was less than 60.
-The resident's heart rate was 54 at 8:00am on 06/13/26.
-Clonidine 0.2mg was documented as administered at 8:00am on 06/13/26 when the heart rate was less than 60.

Interview with a medication aide (MA) 06/19/26 at 11:33am revealed:
-The physician orders required staff to check the resident's blood pressure and heart rate before she administered Clonidine.
-MAs were supposed to follow physician orders.
-She made a mistake when she administered Resident #3 Clonidine when her heart rate was less than 60.

Interview with the Resident Care Coordinator (RCC) 06/19/26 at 11:44am revealed:
-MAs should have followed the PCP orders and parameters for Resident #3's Clonidine.
-If an MA administered Clonidine and the Resident #3's blood pressure and heart rate were already low, they placed the resident at risk of her blood pressure dropping even further.
-If the Resident #3's blood pressure or heart rate dropped too low it could be "catastrophic," the resident could expire.

Interview with the Interim Administrator on 06/19/26 at 2:57pm revealed:
-MAs should not have administered Resident #3 Clonidine based on the PCP's orders.
-When Clonidine was administered and Resident #3's blood pressure and heart rate were already low it placed the resident at risk of her blood pressure or heart rate dropping even lower which

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 06/19/2026

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 41 could lead to the resident being hospitalized or even death. Telephone interview with Resident #3's PCP on 06/19/26 at 10:14am revealed: -She was not aware that MAs had administered Clonidine to Resident #1 when her blood pressure or heart rate were too low. -When Clonidine was administered to Resident #3's and the MAs did not follow the order, they placed the resident at an increased risk of her blood pressure dropping too low which could lead to a fall or unresponsiveness. -She expected the MAs to follow orders to ensure the residents' blood pressure did not drop too low. _____ The facility failed to administer medications as ordered to Resident #8 observed during the medication pass on 06/18/26 whose medication for high blood pressure was not held for a low diastolic blood pressure (DBP) putting the resident at risk of even lower blood pressure which could cause the resident to have dizziness, passing out, or unresponsiveness, and could result in a visit to the hospital emergency room (ER). The facility failed to administer medications as ordered to 3 of 5 residents (#1, #2, #3) sampled for record review. Resident #2's blood thinner was not held as ordered on 04/22/26 and 05/06/26 putting the resident at risk of bleeding including nose bleeds and at risk of bleeding out in the event of a fall. Resident #1's rapid-acting insulin was administered on 18 occasions in May 2026 when insulin should not have been administered due to the blood sugars being less than 300, putting the resident at risk of her blood sugar dropping too low which could cause the resident to become unresponsive. Resident #3 was administered medication for high blood pressure on 3 occasions in May 2026 and June	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 06/19/2026

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 42 2026 when it should have been held due to low blood pressure and/or low heart rate putting the resident at an increased risk of her blood pressure dropping too low, which could lead to a fall or unresponsiveness. This failure of the facility put the residents at substantial risk of serious physical harm or death and constitutes an Unabated Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 06/19/26 for this violation.	D 358		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure the 5-Working Day Investigative Report for the Health Care Personnel Registry (HCPR) was completed as required and in a timely manner for 1 of 1 staff who was yelled at a resident (#5). The findings are: Review of the facilities undated Resident Abuse, Neglect and Exploitation policy revealed: -In the event of physical and/or verbal abuse, neglect, fraud, or exploitation of a resident or resident's property or allegations of physical or verbal abuse, neglect, fraud or exploitation of the	D 438		

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 06/19/2026

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 438	Continued From page 43	D 438		

resident or community property by community staff, the community will complete the Health Care Personnel Registry (HCPR) 24-Hour Initial Report referred to as the Initial Report.
-Upon notification of any of the above allegations the community should begin an investigation and document findings on the HCPR 5-day report referred to as the Investigation Report and submit to the HCPR.
-In the event of any accusation of abuse; of a resident by staff, visitors, or other residents' community management should direct staff to assure the immediate safety of the resident.
-If resident on resident altercation/abuse residents would be separated or relocated to another room as needed.
-The physician should be notified for any additional orders which may include referral to outside resources for further medical evaluation, and the family, responsible party and or guardian should be notified and advised of their right to request notification of local authorities.
-If there was any physical harm or injury present the resident would be sent to the hospital for further evaluation unless the resident or responsible party declines further evaluation.
-The Regional Vice President of Operations (DVPO) should be notified immediately, and all required reporting should be completed as required not limited to local law enforcement and the Department of Social Services (DSS).
-The community should complete the HCPR 24-Hour Initial Report and start an immediate investigation.
-The investigation process should include the immediate suspension of the accused individual (staff) if named or suspected parties pending investigation, complete the HCPR 24-Hour Initial Report within 24 hours of discovery or knowledge of alleged abuse, and community management

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 06/19/2026

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 438	Continued From page 44 should begin the investigation to substantiate or unsubstantiate the allegations for reporting on the HCPR 5 day working report. -The investigation procedure included the completion and submission of the 5-Working Day Investigative Report either substantiated or unsubstantiated. Review of Resident #5's current FL-2 dated 06/09/26 revealed: -Diagnoses included Alzheimer's late onset and unspecified dementia. -The resident was constantly disoriented. -The resident was ambulatory. -The resident was incontinent of bowel and bladder. -The resident required assistance with bathing and dressing. -The resident's recommended level of care was the Special Care Unit (SCU). Review of Resident #5's 24-Hour Initial Report for the HCPR dated 04/13/26 revealed: -The incident type was documented as resident abuse. -The incident date was documented as 04/11/26 and the facility became aware of the alleged abuse on 04/13/26 at 10:00am. -The allegation was documented as a medication aide (MA) reported that a personal care aide (PCA) told Resident #5 to shut up during patient care. -There was documentation that no physical or mental harm was reported. -The 24-Hour Initial Report was completed, signed and dated 04/13/26 by the Interim Executive Director/Special Care Unit Coordinator (SCC). Review of Resident #5's record revealed there	D 438		

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 06/19/2026

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 438	Continued From page 45	D 438		

was no documentation of a 5-Working Day Investigative Report being completed and sent to the HCPR for the verbal abuse on 04/11/26.

Review of Resident #5's record revealed there was no accident/incident report or facility progress notes regarding the incident on 04/11/26.

Interview with a medication aide (MA) on 06/19/26 at 5:00pm revealed:
-She observed a PCA helping Resident #5 put on her shoes in the resident's room.
-She heard the PCA tell the resident to "shut up, he didn't have time for it" and proceeded to put the resident's shoes on.
-This was the first time she heard the PCA speak inappropriately to any residents.
-She told the PCA "you can't yell at her like that."
-She observed the resident right after the PCA spoke to her inappropriately and the resident appeared to be "unphased" by what the PCA yelled at her.
-It upset her when she heard the PCA yell at the resident and she reported the incident to the Interim Executive Director/SCC.

Interview with the Regional Vice President of Operations (RVPO) on 06/19/26 at 11:55am revealed:
-The Interim Executive Director/SCC completed the 24-Hour Initial Report on 04/13/26.
-The Interim Executive Director/SCC did not complete the 5-Working Day Investigative Report because he received a letter from HCPR dated 04/17/26 that an investigation would not be conducted on the case after receiving and reviewing the 24-Hour Initial Report.
-The Interim Executive Director/SCC thought he did not need to complete the 5-Working Day

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 06/19/2026

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 438	Continued From page 46 Investigative Report after he received the letter from HCPR that they decided not to conduct an investigation after reviewing the 24-Hour Initial Report. -She reviewed with the Interim Executive Director/SCC that he should have completed the 5-Working Day Investigative Report regardless. Interview with the Interim Executive Director/SCC on 06/19/26 at 5:20pm revealed: -He completed the 24-Hour Initial Report on 04/13/26. -When he received a letter from the HCPR dated 04/17/26 that an investigation would not be conducted he assumed he did not need to complete the 5-Working Day Investigative Report. -He should have completed the 5-Working Day Investigative Report even after he received that letter from the HCPR on 04/17/26 to complete the investigation process. Attempted telephone interview with Resident #5's responsible party on 06/19/26 at 3:53pm was unsuccessful. Based on observations, interviews, and record reviews it was determined that Resident #5 was not interviewable.	D 438		