Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	180505	A. BUILDING: _____ B. WING _____	08/18/2023

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an Initial survey on August 17, 2023 through August 18, 2023.	D 000	Response to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or the conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 6 medication aides (Staff C and Staff D) had a current medication clinical skills checklist completed prior to administering medications. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was previously hired at another facility on 07/03/22 as a medication aide (MA). -Her medication clinical skills checklist was completed on 09/22/22 at another facility.	D 125	Landings of Rocky Mount Mills shall ensure that staff who administer medications and their direct supervisors shall complete training, clinical skills validation, and pass the written exam within 60 days of completion of the 15 hour MA training class and the MA skills checklist. Business Office Coordinator (BOC) will create a tickler system to note compliance/completion dates for required items for staff files, i.e. Med Administration Skills Verification checklist. This will be completed for files of all staff, even staff previously hired at another facility. Executive Director (ED) will sign off on all new hires/transfers once required documents are received, to approve that their file is complete.	10/12/23 10/12/23

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Executive Director — (X6) DATE: 9/27/23

Reviewed and Acknowledged SCM 09/28/23

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D 125	Continued From page 1 -There was no documentation of hire date for this facility. -There was no documentation a medication clinical skills checklist was completed for this facility. Review of a July 2023 electronic medication administration record (eMAR) revealed there was documentation Staff C administered medications on 07/19/23, 07/22/23, 07/23/23, and 07/28/23. 2. Review of Staff D's personnel record revealed: -Staff D was previously hired at another facility on 10/03/22 at a medication aide MA. -Her medication clinical skills checklist was completed on 03/09/22 at another facility. -There was no documentation of hire date for this facility. -There was no documentation a medication clinical skills checklist was completed for this facility. Review of a July 2023 eMAR revealed there was documentation Staff D administered medications on 07/07/23, 07/25/23, 07/29/23, and 07/30/23. Interview with the Administrator on 08/18/23 at 2:00pm revealed: -Staff C and Staff D worked at the facility on a as needed basis (PRN). -The medication clinical skills checklist was completed at another facility. -She was not aware the medication clinical skills checklist was not transferable to this facility. -She did not know why the medication clinical skills checklist was not updated for the facility. Interview with the Divisional Director of Clinical Operations revealed on 08/18/23 at 4:20pm. -Staff C and Staff D completed the medication	D 125		

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D 125	Continued From page 2 clinical skills checklist at another facility. -The medication clinical skills checklist should have been completed for this facility. -There had been some staff changes that could have been the reason the medication clinical skills checklist was not completed for Staff C and Staff D.	D 125		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to provide increased supervision for 1 of 3 sampled residents (#2) for a resident who had recurrent falls. The findings are: Review of the facility's Safety Measures for Fall Reduction, dated September 2021, revealed: -When a fall/fall related accident/incident occurs a fall related accident/incident report will be completed by the Resident Care Coordinator (RCC) or designee in the electronic documentation system at which time the 72-hour fall management follow up will be added in the electronic documentation system. -Vital signs and observations for any changes are completed every shift by medication aides (MA)	D 270	Landings of Rocky Mount Mills staff shall provide supervision of Residents according to each Resident's assessed needs, care plan and current symptoms. Regional Director of Operations (RDO) in-serviced staff on Workplace Rules related to Resident Rights and Resident Care. 8/28/23 ED/ Special Care Coordinator (SCC) will ensure falls Incident Reports are discussed in management meeting daily, and are discussed during at risk/ falls meetings to ensure the interventions are appropriate and effective. 10/12/23 SCC completes post falls assessment and adds one new intervention after each resident fall. Each intervention has to be new and individualized to address the root cause of the fall, and attempt to minimize falls going forward. Increased supervision will be added as an intervention as appropriate. 10/12/23	

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D 270	Continued From page 3 post fall and documented. -Within 24-48 hours of each fall a manager will complete the post fall care plan evaluation of interventions. -A new intervention must be added for each additional fall. -The RCC or designee will add interventions to the orders in the electronic documentation system. Review of Resident #2's current FL-2 dated 06/29/23 revealed: -Diagnoses included dementia, muscle weakness, and other lack of coordination. -Resident #2's level of care was Special Care Unit (SCU). -He was intermittently confused and had wandering behaviors. -He was semi-ambulatory with a walker. Review of Resident #2's Care Plan dated 06/29/23 revealed he was independent with ambulation. Review of Resident #2's Resident Register revealed he was admitted to the facility on 06/29/23. Review of Resident #2's accident/incident (A/I) report dated 07/04/23 revealed: -Resident #2 had an unwitnessed fall with injury in his bathroom at 5:23am. -Resident #2 had an injury to the right side of his head and a scratch on his right ear. -Resident #2 was transported to the Emergency Room (ER) at 6:30am. -Under a section titled orders/flowsheet there was a description to check vital signs every shift for 72 hours. -There was a description to monitor status for 72	D 270	ED/SCC will make facility rounds no less than twice daily to ensure staff are providing appropriate supervision for Residents according to their care planned needs.	10/12/23

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D 270	Continued From page 4 hours for bruising, change in mental status/condition, pain, or other injuries related to fall. Review of Resident #2's hospital after visit summary dated 07/04/23 revealed diagnoses included fall, head injury, and bruise to face. Review of Resident #2's fall risk re-admission report dated 07/04/23 revealed: -The report was completed by the Special Care Coordinator (SCC). -There was a description to continue to monitor resident for 72 hours and if any changes notify primary care provider (PCP), frequent checks, and reminders to use walker. -Under observation details for have you fallen in the last 6 months "no" was checked. -Under observation details for have you had a new diagnosis in the last 6 months "no" was checked. -Under observation details for have you had any medication changes in the last 6 months "no" was checked. -Under observation details for have you had a change in unsteadiness in walking or standing in the last 6 months "yes" was checked. -Under observation details for do you have a worry or fear of falling "no" was checked. -Under observations in bold it stated if you answered yes to any of the questions, print and give to therapy for a therapy screening and complete the fall intervention care plan. Review of Resident #2's record on 08/18/23 revealed: -There was no therapy screening. -There was no fall intervention care plan for Resident #2's fall on 07/04/23.	D 270		

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D 270	Continued From page 5 Review of Resident #2's July 2023 electronic medication administration record (eMAR) revealed: -There was an entry to check vital signs every shift for 72 hours. -Vital signs were documented at 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am on 07/05/23 to 07/07/23. -There was an entry for monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall. -Monitoring of status was documented at 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am on 07/05/23 to 07/07/23. Review of Resident #2's A/I report dated 07/31/23 revealed: -Resident #2 had a fall without injury in his bathroom at 3:40pm. -Resident #2's family member was in the room with him when he fell. -Under a section titled orders/flowsheet there was a description to monitor status for 72 hours for bruising, change in mental status/condition, pain or other injuries related to fall. Review of Resident #2's fall risk intervention plan dated 07/31/23 revealed: -The intervention plan was completed by the previous Executive Director (ED). -A safety awareness emblem was placed on Resident #2's name plate on 07/31/23. -A fall risk banner was added to the electronic documentation system to alert staff that Resident #2 had fall risk interventions in place on 07/31/23. -Under interventions "increase supervision" was checked. Review of Resident #2's August 2023 eMAR	D 270		

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D 270	Continued From page 6	D 270		

revealed:
-There was an entry to monitor status for 72 hours for bruising, change in mental status/condition, pain, or other injuries related to fall.
-Monitoring of status was documented at 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am on 08/01/23 to 08/03/23.
-There was no entry for check vital signs every shift for 72 hours for 08/01/23 to 08/03/23.

Review of Resident #2's A/I report dated 08/08/23 revealed:
-Resident #2 had an unwitnessed fall without injury in his bathroom at 8:50pm.
-Under a section titled orders/flowsheet there was a description to check vital signs every shift for 72 hours.

Review of Resident #2's fall risk intervention care plan dated 08/10/23 revealed:
-The report was completed by the SCC.
-A safety awareness emblem was placed on Resident #2's name plate on 08/09/23.
-A fall risk banner was added to the electronic documentation system o alert staff that Resident #2 had fall risk interventions in place on 06/29/23.
-Under interventions "other- remind to use walker when up walking" was checked.

Second review of Resident #2's August 2023 eMAR revealed:
-There was an entry for check vital signs every shift for 72 hours.
-Check vital signs was documented at 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am on 08/09/23 to 08/11/23.

Review of Resident #2's A/I report dated 08/12/23 revealed:

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D 270	Continued From page 7 -Resident #2 had an unwitnessed fall with injury in his bedroom at 11:11pm. -Resident #2 had an injury to the right side of his head. -Resident #2 had a skin tear on his right wrist. -Resident #2 had bruising and a laceration with no location documented. -Resident #2 was sent to the ER. -Under a section titled orders/flowsheet there was a description "72-hour charting after fall". Review of Resident #2's hospital after visit summary dated 08/13/23 revealed diagnoses were fall, contusion of face, and abrasion of face. Third review of Resident #2's August 2023 eMAR revealed: -There was an entry for 72-hour charting after fall. -Vital signs were documented at 7:00am to 3:00pm, 3:00pm to 11:00pm, and 11:00pm to 7:00am on 08/13/23 to 08/16/23. Review of Resident #2's record revealed there was no fall risk intervention care plan for his fall on 08/12/23. Observation of Resident #2 on 08/17/23 at 8:34am revealed: -Resident #2 was at a table in the dining room eating breakfast. -Resident #2 had dark purple bruising under his right eye, on his right cheek, and to the right side of his chin. -Resident #2 had a small laceration to his right scalp. -There was a bright yellow band on his wrist which read "fall risk". Second observation of Resident #2 on 08/17/23 at 11:05am revealed:	D 270		

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D 270	Continued From page 8 -Resident #2 was in a wheelchair in a hall on the SCU. -He was pushing himself in the wheelchair using his feet. Third observation of Resident #2 on 08/18/23 at 11:10am revealed: -Resident #2 was ambulating in the hallway on the SCU. -Resident #2 did not have a walker but was using the handrails on the walls to support himself. -A personal care aide (PCA) approached Resident #2 and directed him that he needed to use his walker. -A physical therapy (PT) staff member walked with Resident #2 in the hall as he used the handrail. -Resident #2 told the PT staff "I use the handrail. If I feel like I might be going down, I catch myself." -The PT staff directed the resident to his room and gave the resident his walker. -Resident #2 used his walker to ambulate in the hall without difficulty. Interview with a facility contracted PT on 08/18/23 at 11:14am revealed: -Resident #2 was not on the PT caseload yet. -She received a referral for PT for Resident #2 the night of 08/17/23. -She had observed Resident #2 walking in the hall in the past because she was on the SCU often. -Resident #2 appeared to have good balance. -She did not know when she expected the facility to refer a resident for PT after a fall because it depended on why the resident fell. Interview with Resident #2 on 08/17/23 at 11:05am revealed:	D 270		

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D 270	Continued From page 9 -He had fallen but he was not sure when. -He did not know how many times he had fallen. Interview with Resident #2's family member on 08/17/23 at 3:30pm revealed: -She was aware that Resident #2 had multiple falls at the facility. -Resident #2 was having falls before he was admitted to the facility, and it was one of the reasons he was admitted because she could no longer care for him. Interview with a PCA on 08/17/23 at 4:19pm revealed: -Resident #2 walked all day so she was able to check on him all throughout the day. -She always "kept an eye on" Resident #2 when he was not in his room. -Residents that were in their rooms on the SCU were checked on every 10 to 15 minutes. -She knew which residents on the SCU needed to be checked on more closely. -Resident #2 needed to be checked on more closely because he wandered. -When Resident #2 ambulated in the hall he used a walker or the handrails on the wall. -If she saw Resident #2 walking in the hall she would ask where he was going and try to redirect him to his room. -If Resident #2 would not return to his room she would watch him to keep him from falling. Telephone interview with a second PCA on 08/18/23 at 4:20pm revealed: -She mainly worked on the Assisted Living (AL) side of the facility but sometimes she worked on the SCU. -All the residents in the SCU were checked on every 2 hours by staff. -When she checked on residents on the SCU she	D 270		

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D 270	Continued From page 10 checked to see if they were okay, if they were wet, and to make sure they were in the middle of the bed. Interview with a medication aide (MA) on 08/18/23 at 11:20am revealed: -She constantly walked around the SCU to check on residents. -Resident #2 constantly wandered on the SCU. -If she saw Resident #2 walking in the hall, she would make sure he had his walker with him. -If Resident #2 was in his room she "checked on him constantly". -She did not normally document when she checked on Resident #2, but an every 15 minute checklist was started on him on 08/17/23. -She did not know who started the checklist. Review of a 15-minute resident checks sheet in the SCU medication alcove on 08/18/23 at 11:29am revealed: -Resident #2's name was handwritten on the sheet. -Resident #2 was documented by the SCC as being in the hallway by room 411 at 7:00am on 08/17/23. -Resident #2 was documented by the SCC as being at the nurse's station at 7:15am on 08/17/23. -Resident #2 was documented by the SCC as being at the nurse's station at 7:30am on 08/17/23. -Resident #2 was documented by the SCC as being in the dining room at 7:45am on 08/17/23. -Resident #2 was documented by the SCC as being in the dining room at 8:00am on 08/17/23. -There was no other documentation on the sheet. Telephone interview with a second MA on 08/18/23 at 1:40pm revealed:	D 270		

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D 270	Continued From page 11 -She worked third shift on the SCU. -Third shift was from 11:00pm to 7:00am. -Residents were checked on every 2 hours on the SCU on third shift. -She was working when Resident #2 had a fall 1 to 2 weeks ago. -He was not injured in the fall. -Resident #2 wandered often. -Resident #2 used a walker sometimes or sometimes he was in a wheelchair. -If she saw Resident #2 walking without any assistance, she would try to redirect him to his wheelchair. Telephone interview with a third MA on 08/18/23 at 1:47pm revealed: -She was a MA, but she worked as a PCA sometimes. -She normally worked third shift. -Resident #2 wandered all night. -She constantly checked on Resident #2. -She would walk behind Resident #2 and redirect him because he sometimes tried to go into other resident's rooms. -Sometimes Resident #2 walked with a walker and sometimes he used a wheelchair. -Sometimes Resident #2 did not use his walker or wheelchair. -If she saw Resident #2 walking without a walker, she would take his hand to help him get in his wheelchair or to his walker because she did not want him to fall. -She was working as a PCA on the SCU when Resident #2 fell on 08/12/23. -Someone else was making rounds on the SCU that night and Resident #2 had locked the door to the room. -Someone unlocked the door and found Resident #2 on the floor. -Resident #2 had hit his head and was bleeding.	D 270		

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D 270	Continued From page 12 -The SCC told her to check on Resident #2 every 30 minutes since his last fall on 08/12/23. -The 30-minute checks for Resident #2 were not documented anywhere. Telephone interview with a fourth MA on 08/18/23 at 3:27pm revealed: -She worked as a MA on SCU but sometimes she worked as a PCA as well. -She normally worked third shift. -Resident #2 liked to walk all night. -She was working when Resident #2 fell on 07/04/23. -A co-worker found Resident #2 in the model room on SCU when she was doing her last rounds. -Resident #2 was found on the floor and had a contusion to his head. -She was working as a PCA on the SCU when Resident #2 fell on 08/12/23. -She was making rounds to make sure everything was okay and found that Resident #2's door was locked. -When staff unlocked the door, they found Resident #2 lying in the hallway between his room and the bathroom in a puddle of blood. -She thought Resident #2 might have tripped because his walker was next to him. -All residents on the SCU were checked on every 2 hours. -She had never been told to check on Resident #2 more often than every 2 hours after any of his falls. Interview with the SCC on 08/17/23 at 12:18pm revealed: -Residents in the SCU were checked on by staff every hour. -If a resident on the SCU had wandering behaviors they were checked on by staff every 15	D 270		

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D 270	Continued From page 13 minutes. -Resident #2 had wandering behaviors. -When staff in the SCU checked on residents they went into the room and made sure they were okay and to help them if they needed any help with anything. -When a resident fell, she got information from the staff who witnessed it. -She told the PCAs and MAs on the SCU to monitor Resident #2 more closely because of his falls. -She was not sure when she told the PCAs and MAs to monitor Resident #2 more closely. -She was not sure how often she told PCAs and MAs to check on Resident #2, but it was either every 15 minutes or every 30 minutes. -The more frequent checks for Resident #2 were not documented anywhere. -She did not know if a PT referral had been initiated for Resident #2 or not. Interview with the Administrator on 08/18/23 at 2:03pm revealed: -The SCC completed a fall risk readmission on Resident #2 on 07/04/23 because he went to the ER after his fall. -A PT order for an evaluation for Resident #2 should have been done after his fall on 07/04/23. -She did not start as the Administrator at the facility until 08/04/23 so she did not know why a PT order for an evaluation was not done after Resident #2's fall on 07/04/23. -A PT referral for Resident #2 was initiated on 08/17/23. -She would have expected Resident #2 to have every 15-minute checks after his falls. -She expected the increased check to be documented because "if it is not documented it is not done".	D 270		

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D 270	Continued From page 14 Telephone interview with Resident #2's primary care provider (PCP) on 08/18/23 at 2:30pm revealed: -Resident #2 had wandering behaviors. -She was aware Resident #2 had several falls. -She would expect Resident #2 to receive basic fall precautions after his falls such as having socks with grips on them. -She expected residents on the SCU to be checked on by staff at least twice per shift. -She expected residents on the SCU to be checked on by staff every hour for 3 days after a fall. -She expected the facility to implement these increased checks. -She expected the facility to contact her for an order for a PT evaluation after Resident #2's first fall on 07/04/23 because he was a newer resident. -She was not sure why Resident #2 was falling but it would be good to have him evaluated for dizziness and to see why he was falling. -If the facility had contacted her for an order for a PT evaluation after Resident #2's fall on 07/04/23 she would have ordered it. -The facility contacted her yesterday regarding a PT evaluation for Resident #2 and she ordered it.	D 270		
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule.	D 276	Landings of Rocky Mount Mills shall ensure documentation of written procedures, treatments, or orders from a Provider; and the implementation of procedures, treatments, or orders are in the Resident's record. ED/ SCC will ensure falls Incident Reports are discussed in management meeting daily, and are discussed during the at risk/ falls meetings to	10/12/23

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D 276	Continued From page 15 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to implement an order to place a fall mat when the resident is lying in bed for 1 of 3 sampled residents (#1) with an order for fall mat implementation. The findings are: Review of Resident #1's current FL-2 dated 05/23/23 revealed diagnoses of Alzheimer's, pernicious, anemia, and hypertension. Review of Resident #1's physician order sheet dated 07/11/23 revealed an order for a fall mat to be placed by the bedside when the resident was in bed. Observation of Resident #1's room on 08/17/23 at 4:19pm revealed: -Resident #1 was lying in bed. -The gray fall mat was under the resident's bed and not placed by the bedside while she was lying in the bed. Interview with the personal care aide (PCA) on 08/17/23 at 4:22 pm revealed: -The fall mat was placed at the bedside at night by a family member. -Staff had not placed the mat at the bedside at night as far as the PCA could recall. Telephone interview with a second PCA on 08/18/23 at 3:28 pm revealed: -The PCA found Resident #1 on the floor on the 3rd shift on 08/05/23 wrapped in a pink blanket. -There was no mat noted beside the resident's bed. -The PCA did not know the resident had a fall	D 276	ensure that the interventions are appropriate and effective. SCC will make facility rounds throughout the shift to ensure ordered falls prevention measures have been implemented per provider orders.	10/12/23

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D 276	Continued From page 16 mat. -The PCA heard co-workers talking about it but she was not aware of an order for a fall mat. Interview with Resident #1's family member on 08/18/23 at 11:50 am revealed: -The facility's Administrator told the resident's family member a week ago that the resident could not have the fall mat because it was against the facility's policy. -The previous Administrator asked for a picture of the fall mat. -The family member asked about other options including if Resident #1 could not use the current fall mat. -The Administrator told her that she might need to be discharged. -The resident's family member stated that the resident could not be placed in a skilled nursing facility because of excessive walking; she was either sleeping or walking. -After the last fall (08/05/23), the family hired a private sitter to stay with the resident at night. -The private sitter would be discontinued on Sunday (8/20/23) due to the expense. -The family was told they must use an agency to find a sitter and not a private sector. Interview with the Administrator on 08/17/23 at 4:30 pm revealed: -The family members visited all day, every day. -The mat should be used per the doctor's order. -For ambulatory residents in the Special Care Unit (SCU), it was a trip hazard. -For non-ambulatory residents in the SCU, it was not; the PCA or medication aide should have implemented the order.	D 276		

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D 280	Continued From page 17	D 280	Landings of Rocky Mount Mills shall ensure that participation by a Registered Nurse, OT or PT in the onsite review and evaluation of the Residents' health status, care plan and care provided as required by .0903(a) is completed within 30 days of admission or 30 days of development of the task, and quarterly thereafter.	
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure an on-site Licensed Support Personnel Support (LHPS) review and evaluation was completed by a licensed professional including a physical assessment within 30 days of admission for 1 of 3 (# 3) sampled residents who had a urinary catheter, ambulated with the assistance of a	D 280	Interim Area Clinical Director continues to maintain assessments and skills validations for Licensed health professional support task until permanent coverage can be obtained. ED/SCC will establish tickler system to maintain completion/ compliance dates of required items in the Residents charts, i.e. LHPS assessments upon admission, quarterly, and with significant change. ED/SCC/ or Designee will notify the ACD of new admissions to ensure the initial LHPS assessment is completed within 30 days per the rule.	10/12/23 10/12/23 10/12/23

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D 280	Continued From page 18 wheelchair, and required assistance in transferring. The findings are: Resident #3's current FL-2 dated 06/13/23 revealed: -Diagnoses included cerebral palsy, epilepsy, urinary incontinence, hypertension, frequent falls, hyperlipidemia, and chronic kidney disease. -The resident was non-ambulatory. -The resident had an indwelling catheter. (An indwelling catheter, also called a foley, drains urine from the bladder into a bag outside of the body through a rubber or plastic tube). -Functional limitations were contractures. Review of Resident #3's Resident Register revealed an admission date of 06/13/23. Review of Resident #3's care plan dated 06/13/23 revealed: -The resident had a foley. -The Licensed Health Professional Support (LHPS) tasks description section included positioning and emptying of the urinary catheter bag and cleaning around the urinary catheter, ambulation using assistive devices that required physical assistance, and transferring semi-ambulatory or non-ambulatory residents. Review of Resident #3 records revealed there was no LHPS tasks review and evaluation completed for the resident. Observation of Resident #3 intermittently on 08/17/23 through 08/18/23 from 9:00am to 4:30pm revealed: -He was in a wheelchair and was assisted by staff in ambulation.	D 280		

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D 280	Continued From page 19 -He had a catheter bag tied to his left leg. -He had a contracted right hand. Interview with Resident #3 on 08/18/23 at 4:00pm revealed: -He had a catheter for about 4 or 5 years because he could not urinate. -The staff emptied the catheter bag, but sometimes he emptied it. -A nurse came to the facility "about" once a month to change the catheter. -It was an indwelling catheter. -There was no pain, redness or tenderness related to the catheter. -There had been no problems with the catheter since he came to the facility in June 2023. -He required assistance with bathing and dressing. Interview with a personal care aide (PCA) on 08/17//23 at 4:05pm revealed the PCAs did not provide care to Resident #3's catheter, only the medication aides (MAs) were allowed to provide the care which included emptying the bag. Interview with the MA on 08/17/23 at 3:55pm revealed: -The only care the MAs provided for Resident #3's catheter bag was to empty it. -She was trained by a former staff, who was a Registered Nurse, when the facilty first opened in May 2023 on how to care for the catheter . -The care of the catheter included emptying the bag and providing privacy for the resident during care. -A home health (HH) nurse came to the facility about once month to change the catheter. Interview with the Special Care Coordinator (SCC) on 08/17/23 at 3:30pm revealed:	D 280		

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D 280	Continued From page 20 -The MAs emptied Resident #3's catheter bag. -She did not know who provided training to the MA's on how to care for the catheter bag. -Interview with the Administrator on 08/17/23 at 2:00pm revealed a LHPS review and evaluation was not completed for Resident #3 and should have been done. Interview with the Divisional Director of Clinical Operations (DDCS) on 08/18/2 at 4:20pm revealed: -A LHPS review and evaluation should have been done by the previous Area Clinical Director (ACD) who left the facility around 07/13/23. -She had planned to have a meeting next week to conduct an audit of clinical operations but there had been several staff changes. -She completed the LHPS review and evaluation for Resident #3 on 08/17/23. Interview with Resident #3's primary care provider (PCP) on 08/18/23 at 3:00pm revealed staff needed to be trained to ensure the catheter bag was correctly emptied and positioned.	D 280		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the	D 344	Landings of Rocky Mount Mills shall ensure contact with the Resident's provider for verification or clarification of orders for medications and treatments as appropriate. Verification/ Clarifications are to be documented in the Resident's record. Special Care Coordinator re-educated on the importance of clarifying orders upon admission, and anytime orders are not clear or complete. 8/19/23	

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D 344	Continued From page 21 forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure clarification of medication orders for 1 of 4 sampled residents (#4) including medications used to treat heart failure and fluid retention. The findings are: Review of Resident #4's current FL-2 dated 06/14/23 revealed: -Diagnoses included heart failure. -There was an order for carvedilol (used to treat heart failure) 25mg ½ tablet daily. -There was an order for bumetanide (used to treat fluid retention) 1mg 1 ½ tablet every morning. -It was signed by the facility's primary care provider (PCP). Review of Resident #4's Resident Register revealed she was admitted to the facility on the Special Care Unit (SCU) on 06/14/23. Review of Resident #4's physician order sheet dated 06/20/23 revealed: -There was no order for carvedilol. -There was no order for bumetanide. Review of Resident #4's June 2023 electronic medication administration record (eMAR) revealed: -There was no entry for carvedilol 25mg ½ tablet daily. -There was no entry for bumetanide 1mg 1 ½	D 344	SCC will monitor order processing system daily to ensure there are not medication orders awaiting clarification. If such orders are present, SCC will work to assist in expediting the process. SCC will pull EMAR compliance reports daily to review for accuracy and compliance. The report will be reviewed and discussed daily with the ED during management meeting for any needed follow-up. SCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate medication administration. Completed chart audits will be reviewed by the ED for compliance.	10/12/23 10/12/23 10/12/23

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D 344	Continued From page 22 tablet every morning. Review of Resident #4's record on 08/17/23 revealed there was no discontinue order for carvedilol or bumetanide. Interview with the Special Care Coordinator (SCC) on 08/17/23 at 3:20pm revealed: -When a resident was admitted to the facility she reviewed the FL-2 and faxed it to the pharmacy. -The pharmacy placed medications in the eMAR system. -Resident #2's carvedilol and bumetanide were never placed on the eMAR by the pharmacy to be administered to Resident #4. -She had contacted Resident #2's primary care provider (PCP) on 08/17/23 and received a discontinue order for the carvedilol and bumetanide. -Resident #2's PCP discontinued the carvedilol and bumetanide because the resident had not had any weight gain. Interview with the Administrator on 08/18/23 at 2:03pm revealed: -A resident's medications on the FL-2 should be compared with the resident's medications on the eMAR with each new admission and each update of the FL-2. -The SCC should compare the FL-2 to the eMAR. -The SCC should have compared Resident #4's FL-2 to the eMAR and notified the pharmacy that they had missed some of Resident #4's medications that were on the FL-2. -Resident #4's physician order sheet was printed by the facility. -The physician order sheet was printed based on what medications were on the eMAR. -The SCC should have compared the physician order sheet to what medications were ordered on	D 344		

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D 344	Continued From page 23 the FL-2 before she provided it to the PCP to sign. -She expected the SCC to contact Resident #4's PCP to clarify if she wanted to discontinue Resident #4's carvedilol and bumetanide since it was not on the physician order sheet. -It was important to clarify so Resident #4 did not miss medications that she may have needed. Telephone interview with Resident #4's PCP on 08/18/23 at 2:30pm revealed: -Resident #4's carvedilol and bumetanide were ordered to treat her heart failure. -When she saw Resident #2 on 06/20/23 she noted that she had some edema in her lower extremities, so she ordered compression hose for her. -She noted that she would order Lasix (a medication to treat fluid overload) if it was needed later. -She did not realize that Resident #4 was supposed to be receiving bumetanide when she saw her on 06/20/23. -She saw Resident #4 again in July 2023 and noted that she did not have any signs of fluid overload at that time. -She expected the facility to realize that Resident #4's carvedilol and bumetanide were left off the eMAR and contact the pharmacy to make them aware. -It was an oversight on her part that she did not notice that Resident #4's carvedilol and bumetanide were not on the physician order sheet that she signed on 06/20/23. -She expected the facility to call her and clarify Resident #4's carvedilol and bumetanide orders when they were not on the physician order sheet because it was clearly a mistake because there was not a discontinue order for those medications.	D 344		

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D 344	Continued From page 24 -The facility contacted her on 08/17/23 for a discontinue order for Resident #4's carvedilol and bumetanide. -She signed the discontinue orders for the medications because Resident #4 did not have any signs of fluid overload.	D 344		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to administer medications as ordered for 1 of 4 sampled residents (#4) including errors with medications to treat heart failure and fluid retention. The findings are: Review of Resident #4's current FL-2 dated 06/14/23 revealed: -Diagnoses included heart failure. -There was an order for carvedilol (used to treat heart failure) 25mg ½ tablet daily. -There was an order for bumetanide (used to treat fluid retention) 1mg 1 ½ tablet every morning. -It was signed by the facility's primary care provider (PCP).	D 358	Landings of Rocky Mount Mills shall ensure that the preparation and administration of medications and treatments by staff are given according to Provider orders, which are maintained in the Residents' records; according to the facility's policies and procedures; and according to the rules in Section .1004(a). Med Techs will complete MAR to cart audits per facility schedule to ensure availability and accuracy of medications on medication carts. The audits will be reviewed by the SCC upon completion for compliance, and to ensure accurate and adequate medications are on hand at all times. 10/12/23 SCC will complete cart audits weekly for overall QA of the medication carts to ensure the cart is stocked with appropriate and accurate medications. 10/12/23 SCC will complete a minimum of 2 chart audits weekly to ensure that all orders have been processed properly to allow for accurate med administration. Completed chart audits will be reviewed by the ED for compliance. 10/12/23	

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	180505	A. BUILDING: _____ B. WING _____	08/18/2023

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

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D 358	Continued From page 25 Review of Resident #4's Resident Register revealed she was admitted to the facility on the Special Care Unit (SCU) on 06/14/23. Review of Resident #4's physician order sheet dated 06/20/23 revealed: -There was no order for carvedilol. -There was no order for bumetanide. Review of Resident #4's June 2023 electronic medication administration record (eMAR) revealed: -There was no entry for carvedilol 25mg ½ tablet daily from 06/14/23 to 06/20/23. -There was not entry for bumetanide 1mg 1 ½ tablet every morning from 06/14/23 to 06/20/23. Observation of Resident #4 on 08/17/23 at 8:40am revealed: -She was sitting at a table in the dining room. -There was no increased swelling seen to her lower extremities. Interview with the Special Care Coordinator (SCC) on 08/17/23 at 3:20pm revealed: -When a resident was admitted to the facility she reviewed the FL-2 and faxed it to the pharmacy. -The pharmacy placed medications in the eMAR system. -Resident #2's carvedilol and bumetanide were never placed on the eMAR by the pharmacy to be administered to Resident #4. -During the time that Resident #4 was admitted to the facility the prior Executive Director (ED) was assisting her with her SCC duties, so she was not sure who missed that Resident #4's carvedilol and bumetanide were never placed on the eMAR. -She had contacted Resident #2's PCP on 08/17/23 and received a discontinue order for the	D 358	SCC will pull Medication Compliance Reports daily to ensure medications are administered per MD orders. Reports will be reviewed with the ED during management meeting daily for compliance. Any needed follow-up will occur promptly.	10/12/23

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D 358	Continued From page 26 carvedilol and bumetanide. -Resident #2's PCP discontinued the carvedilol and bumetanide because the resident had not had any weight gain. Interview with the Administrator on 08/17/23 at 3:22pm revealed: -The SCC should have compared Resident #4's medications in the eMAR to the medications on her FL-2. -Medication cart audits should have been implemented by the prior ED, but she did not think they were. -The facility was going to start doing medication cart audits. Second interview with the Administrator on 08/18/23 at 2:03pm revealed: -A resident's medications on the FL-2 should be compared with the resident's medications on the eMAR with each new admission and each update of the FL-2. -The SCC should compare the FL-2 to the eMAR. -The SCC should have compared Resident #4's FL-2 to the eMAR and notified the pharmacy that they had missed some of Resident #4's medications that were on the FL-2. -Resident #4's physician order sheet was printed by the facility. -The physician order sheet was printed based on what medications were on the eMAR. -The SCC should have compared the physician order sheet to what medications were ordered on the FL-2 before she provided it to the PCP to sign. Telephone interview with Resident #4's PCP on 08/18/23 at 2:30pm revealed: -Resident #4's carvedilol and bumetanide were ordered to treat heart failure.	D 358		

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D 358	Continued From page 27 -When she saw Resident #2 on 06/20/23 she noted that she had some edema (swelling) in her lower extremities, so she ordered compression hose for her. -She noted that she would order Lasix (a medication to treat fluid overload) if it was needed later. -She did not realize that Resident #4 was supposed to be receiving bumetanide when she saw her on 06/20/23. -She saw Resident #4 again in July 2023 and noted that she did not have any signs of fluid overload at that time. -She expected the facility to realize that Resident #4's carvedilol and bumetanide were left off the eMAR and contact the pharmacy to make them aware. -It was an oversight on her part that she did not notice that Resident #4's carvedilol and bumetanide were not on the physician order sheet that she signed on 06/20/23. -The facility contacted her on 08/17/23 for a discontinue order for Resident #4's carvedilol and bumetanide. -She signed the discontinue orders for the medications because Resident #4 did not have any signs of fluid overload. Telephone interview with a pharmacy technician at the facility's contracted pharmacy on 08/18/23 at 3:41pm revealed the pharmacy's system was down so they could not answer any questions about resident medications. Telephone interview with a second pharmacy technician at the facility's contracted pharmacy on 08/18/23 at 4:12pm revealed the pharmacy's system was still down. Based on observations, interviews, and record	D 358		

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D 358	Continued From page 28 reviews it was determine Resident #4 was not interviewable.	D 358		
D 464	10A NCAC 13F.1307 Special Care Unit Res. Profile & Care Plan 10A NCAC 13F .1307 Special Care Unit Resident Profile & Care Plan In addition to the requirements in Rules 13F .0801 and 13F .0802 of this Subchapter, the facility shall assure the following: (1) Within 30 days of admission to the special care unit and quarterly thereafter, the facility shall develop a written resident profile containing assessment data that describes the resident's behavioral patterns, self-help abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) The resident care plan as required in Rule 13F .0802 of this Subchapter shall be developed or revised based on the resident profile and specify programming that involves environmental, social and health care strategies to help the resident attain or maintain the maximum level of functioning possible and compensate for lost abilities. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to complete a resident profile within 30 days of admission for 2 of 2 sampled residents on the Special Care Unit (SCU) (#1, #2). The findings are: 1. Review of Resident #2's current FL-2 dated 06/29/23 revealed diagnoses included dementia and muscle weakness.	D 464	Landings of Rocky Mount Mills shall ensure that the SCU profile and Care Plan is completed on each Resident admitted to the Special Care Unit within 30 days of admission and quarterly thereafter. SCC re-educated on the importance of completing the SCU profile and Care Plan to ensure appropriate care and programming is planned for each individual Resident. 8/19/23 SCC will establish a tickler file system to ensure completion/ compliance of required items in the Residents' charts, i.e. SCU profile and care plan, within 30 days of admission and quarterly thereafter. 10/12/23	

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D 464	Continued From page 29 Review of Resident #2's Resident Register revealed he was admitted to the Special Care Unit (SCU) on 06/29/23. Review of Resident #2's record on 08/17/23 revealed there was no resident profile. Refer to interview with the Special Care Coordinator (SCC) on 08/17/23 at 12:18pm. Refer to interview with the Administrator on 08/17/23 at 4:33pm. 2. Review of Resident #1's current FL-2 dated 05/23/23 revealed diagnoses included Alzheimer's disease, pernicious anemia, and hypertension. Review of Resident #1's Resident Register revealed she was admitted to the Special Care Unit (SCU) on 5/23/23. Review of Resident #1's record on 08/17/23 revealed there was no resident profile. Refer to interview with the Special Care Coordinator (SCC) on 08/17/23 at 12:18pm. Refer to interview with the Administrator on 08/17/23 at 4:33pm. Interview with the Special Care Coordinator (SCC) on 08/17/23 at 12:18pm revealed she was not sure what a resident profile was. Interview with the Administrator on 08/17/23 at 4:33pm revealed: -It was the SCC's responsibility to complete a resident profile for residents admitted to the	D 464		

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D 464	Continued From page 30 Special Care Unit (SCU). -She was not sure why a resident profile was not completed within 30 days of Resident #1's and Resident #2's admission to the SCU.	D 464		