STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey and complaint investigation on 04/16/24 - 04/17/24. The complaint investigation was initiated by the Henderson County Department of Social Services on 03/20/24.	D 000	Resonses to the cited deficiencies do not constitute an admission by the facility of the truth of the facts alleged or conclusions set forth in the statement of deficiencies or corrective action report. The plan of correction is prepared soley as a matter of compliance with state laws.	
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 supervision based on current symptoms for 1 of 5 sampled residents (Resident #2) who had a diagnosis of dementia and a history of wandering and eloped from the facility without staff knowledge. The findings are: Review of Resident #2's current FL2 dated 03/11/24 revealed: -Diagnoses included Alzheimer's Disease and dementia without behavioral disturbance. -Resident #2 was constantly disoriented and ambulatory. -Level of care was Special Care Unit (SCU). Review of the Resident Register for Resident #2	D 270	10A NCAC 13F. 0901 (b) Personal Care and Supervision Special Care Coordinator or his/her designee will inservice staff on communicating through progress notes of changes in resident's behavior related to exit seeking/elopment. Special Care Coordinator will review all progress notes for residents daily and initiate any needed increased supervision orders needed for elopement type behaviors.	6/1/2024 6/1/2024

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Joy Elliott | TITLE: Licensed Administrator | (X6) DATE: 5/9/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 270	Continued From page 1 revealed an admission date of 01/17/24. Review of Resident #2's Care Plan dated 01/29/24 revealed: -Resident #2 had a history of wandering behavior. -Resident #2 was always disoriented with significant memory loss and required direction. -Resident #2 was independent with ambulation and transferring. Review an Incident Report for Resident #2 dated 03/18/24 revealed: -Resident #2 eloped on 03/18/24 at 4:00pm to the facility parking lot. -The incident was not witnessed, and another resident's family member brought the resident to the front door of the facility after finding him walking in the parking lot. Telephone interview with a medication aide (MA) on 04/16/24 at 3:41pm revealed: -She was working in the SCU on 03/18/24 when Resident #2 eloped from the facility. -She did not know how Resident #2 got out of the facility. -Another staff informed her that another resident's family member was walking Resident #2 back into the facility. -All residents in the SCU are visualized every two hours unless behaviors dictated an increase. -Resident #2 was visualized every two hours. Interview with a second MA on 04/16/24 at 4:20pm revealed: -She was in training as a MA and worked in the SCU. -She observed at times Resident #2 pushing at the exit doors to get out of the facility. -She did not know how often staff were required to check on the resident.	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 270	Continued From page 2 Interview with a third MA on 04/17/24 at 8:45am revealed: -All residents were visualized every two hours in the SCU which was standard procedure. -Resident #2 was admitted to the SCU with wandering and elopement behaviors. -Resident #2 had exit seeking behaviors and she observed the resident two times daily pushing at the exit doors. -Resident #2 should have been checked on more frequently than every two hours. -The Special Care Coordinator (SCC) was notified that Resident #2 was having exit seeking behaviors. Interview with a personal care aide (PCA) on 04/16/24 at 3:50pm revealed: -The policy in the SCU was to visualize the residents every two hours. -She knew Resident #2 was having exit seeking behaviors because she observed him pushing at the exit doors. -She did not think Resident #2 was required to be supervised more than every two hours. Interview with the Special Care Coordinator (SCC) on 04/17/24 at 7:55am revealed: -She was working on 03/18/24 when Resident #2 eloped from the SCU. -Resident #2 lifted the "squealer box" on the override switch and went out the exit door. -The alarm on the squealer box did not sound. -Another resident's family member saw Resident #2 in the parking lot and walked him back in to the facility. -Resident #2 was out of the SCU no more than 5 minutes. -She did not observe Resident #2 to have exit seeking behaviors and staff did not report that to	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 270	Continued From page 3	D 270		

her.
-She did not know Resident #2 was documented to have wandering behaviors on his Care Plan.
-She did not know how much supervision Resident #2 required prior to the elopement.

Interview with the Resident Care Coordinator (RCC) on 04/16/24 at 2:15pm and 4:10pm revealed:
-Resident #2 eloped out of the exit door of the SCU because the override switch that turned off the magnetic lock on the door was switched off.
-She did not know how the override switch was turned off.
-All doors leading out of the SCU had an override switch inside of a locked clear plastic box with a breakaway plastic lock located near each exit door.
-All exit doors on the SCU were checked every two hours to ensure they were locked.
-Staff did not know Resident #2 eloped until he was found near the parking lot.
-All residents in the SCU were visualized every two hours unless they were having behaviors and then supervision was increased based on what type of behavior they were displaying.
-Resident #2 was on the "standard" supervision checks of every two hours prior to the elopement.
-She did not know that Resident #2 was exhibiting exit seeking behaviors.
-She did not observe Resident #2 push against the exit doors and staff did not inform her.

Observation of Resident #2 on 04/16/24 at 12:05pm revealed:
-Resident #2 was pacing back and forth from the dining room to the living room.
-Staff instructed Resident #2 to sit down at the dining room table for lunch and he would comply but then would immediately get up to walk out of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 270	Continued From page 4 the dining room. Interview with the Maintenance Director on 04/16/24 at 2:45pm revealed: -All the locked exit doors in the SCU had an override switch with a break away plastic lock. -When the switch was turned off and the doors could be opened an alarm would sound but there could be "a lot going on and staff may not hear it". -He checked all doors in the SCU every day at 7:00am and 3:00pm and staff that worked 2nd and 3rd shifts were responsible for checking the doors during their shifts. Interview with the Administrator on 04/16/24 at 3:05pm and 04/17/24 at 8:15am revealed: -Resident #2 eloped from the facility through a SCU exit door that had a broken "squealer box" that covered the magnetic lock override switch. -Resident #2 was found outside several feet away from the door near some bushes. -Resident #2 was outside of the facility no more than 15 minutes. -Lifting the squealer box up and breaking the breakaway lock to access the override switch would prompt an alarm to sound. -The squealer box was not lifted up, but broken on the side where the switch could be accessed by placing a hand inside the box, therefore an alarm did not sound. -She did not know how the squealer box was broken. -The SCU exit doors are checked every two hours to ensure they were locked. -The squealer boxes were checked weekly to ensure they were in working order. -She did not know Resident #2 exhibited exit seeking behaviors, but she knew he had wandering behaviors. -Staff did not document the exit seeking	D 270		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 270	Continued From page 5 behaviors. -Resident #2 was on supervision checks every two hours. -Resident #2 should have been supervised more frequently if he was having exit seeking behaviors. Based on observations, interviews, and record review, Resident #2 was not interviewable.	D 270		
D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (2) Facilities with a licensed capacity of 13 or more residents shall ensure food services comply with Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes and Other Institutions set forth in 15A NCAC 18A .1300 which are hereby incorporated by reference, including subsequent amendments, assuring storage, preparation, and serving of food and beverage under sanitary conditions. This Rule is not met as evidenced by: Based on observations, interviews and record reviews the facility failed to ensure the rules governing the sanitation of adult care homes were maintained related to dirty kitchen floors and dish machine floor drains.	D 283	10A NCAC 13F .0904(a)(2) Nutrition and Food Service. Dietary Manager and Executive Director will develop cleaning schedules for all positions within the dietary department to include kitchen floor cleaning, floor drain maintenance and all other needed cleaning tasks. Each employee will sign their schedules daily to show completion of all assigned tasks. Dietary Manager or his/her designee will review signed schedules daily to ensure all tasks have been completed as assigned and make corrections acoordingly	6/1/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 283	Continued From page 6 The findings are: Observations during intial tour on 04/16/24 at 10:15am revealed: -The kitchen floor had large areas that were covered with a sticky substance. -There was food debris under shelves and in corners. -The grate covering the dish machine floor drain had a large build-up of food debris. Observations in the kitchen on 04/17/24 at 8:06am revealed: -The kitchen floor had the same areas covered in a sticky substance, plus additional sticky areas since the previous day. -The surveyors shoes stuck to the floor when walking in the kitchen. -The dishmachine floor drain was in the same condition as the previous day. -There was more food debris and trach under shelves, on the floor and in corners. -The mops, brooms and hoses in the moproom were in the exact position as they had been the previous day. Interview with the lead cook on 04/16/24 at 10:15am and 04/17/24 at 10:11am revealed: -The Food Service Director (FSD) was not working on 04/16/24 and he was the person in charge. -He was assuming the duties of FSD effective 04/17/24. -The FSD was responsible for ensuring staff adhered to the list outlining the aide duties that was posted above the handwashing sink. -He was busy on 04/16/24 and left early and assumed the dietary aide would sweep and mop the floor. -He tried to sweep and mop the floor when he	D 283		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 283	Continued From page 7 had time but did not remember what day he last did it. Review of the dietary aide job duties posted above the kitchen handwashing sink revealed: -The duties were to be completed every day. -Sweep and mop at the end of the shift. -Complete extra cleaning as needed. Interview with the Administrator on 04/17/24 at 8:15am revealed: -The FSD was responsible for developing the cleaning schedule and ensuring staff adhered to the schedule. -Dietary aides were responsible for sweeping and mopping at the end of their shift. -She did not know the kitchen floor and grate covering the dishmachine drain were not being cleaned daily.	D 283		
D 298	10A NCAC 13F .0904(d)(2) Nutrition And Food Service 10A NCAC 13F .0904 Nutrition And Food Service (d) Food Requirements in Adult Care Homes: (2) Foods and beverages shall be offered in accordance with each residents' prescribed diet or made available to all residents as snacks between each meal for a total of three snacks per day and shown on the menu as snacks. This Rule is not met as evidenced by:	D 298	10A NCAC 13F .0904(d) (2) Nutrition and Food Service Dietary Manager and/or his designee will ensure snacks are available for care staff to take to each resident's room three times daily to be approximately 10 a.m., 3 p.m., and 8 p.m. and that each snack is offered for all diets. Dietary Manager and/ or Care Coordinators will observe a snack pass once weekly at random to ensure all snacks are being passed out accordingly.	5/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 298	Continued From page 8	D 298		

Based on observations, interviews, and record reviews, the facility failed to offer or make available to all residents snacks between each meal for a total of three snacks per day.

The findings are:

Observation of the assisted living nursing station on 04/16/24 at 3:43pm revealed there were no available snacks in the snack basket for residents.

Interview with a personal care aide (PCA) on 04/16/24 at 3:47pm revealed:
-She had begun her shift at 3:00pm.
-She did not know if the 7:00am to 3:00pm staff had offered residents an afternoon snack.
-The routine snack time on the 3:00pm to 11:00pm shift was at bedtime.

Interview with a medication aide (MA) on 04/16/24 at 4:07pm revealed:
-The dining room staff were responsible for keeping snacks stocked in a basket kept at the nurses station.
-The snacks were left out so residents could get what they wanted for snack whenever they wanted a snack.

Interview with a resident on 04/16/24 at 4:15pm revealed:
-She was not offered a snack that afternoon.
-She was "a little bit" hungry at that moment and was looking forward to the evening meal.
-The last time she heard anything about a snacks being made available was two weeks ago when a friend told her there were snacks "up there."
-She did not know where to go to get a snack.

Interview with a second resident on 04/16/24 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 298	Continued From page 9 4:20pm revealed: -He was not offered a snack that afternoon. -He would have taken a snack if one had been offered. -He often got hungry between lunch and supper. -Staff did not routinely offer or make available a bedtime snack either. -He did not receive a snack unless there were some snacks available at the bistro area at the entrance to the facility. -The bistro was empty of snacks "right now." -One of his friends had gotten 4 bags of chips "the other day" from the snacks put out by the facility staff. -"Some" residents were taking more snacks than they should and some of the residents were not getting any snacks. Interview with a third resident on 04/16/24 at 4:37pm revealed: -Staff did not offer her a snack that afternoon (04/16/24). -There were snacks available at times in a basket at the nurses station. -She had taken a snack from the basket at the nurses station "a couple of times" but it had been "awhile." Interview with the same MA on 04/16/24 at 4:50pm revealed: -The dietary staff were responsible for keeping snacks stocked in the snack basket at the nurses station. -If there were snacks available in the basket, she would take them around to residents during the bedtime medication pass. Observation of the bistro on 04/16/24 at 5:00pm revealed: -There was 1 apple out in a container on the	D 298		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 298	Continued From page 10	D 298		

counter.
-There were no other food snacks available.

Interview with the facility's Executive Director (ED) on 04/16/24 at 5:01pm revealed:
-They did not keep snacks at the bistro, but "occasionally."
-She preferred staff take the snack cart around to resident rooms and offer a snack to each resident.

Review of the facility's weekly menu revealed:
-Snacks were to be available mid morning, mid afternoon, and evening.
-Staff were to see the posted snack list for snack options to serve.

Review of the posted snack list revealed there were 35 different food item snacks listed on the snack list.

Review of the dietary aide duties revealed:
-The dietary aide was responsible to keep snack trays stocked daily.
-The dietary aide was responsible to keep the bistro stocked with coffee cups, water cups, creamers and sugars, at least 2 trays of baked goods at all times, coffee to be put out after breakfast, and ice water to be put out everyday.

Review of the dietary cook job duties revealed the dietary cook was to assist aides in cooking/preparing snacks and drinks for the bistro daily.

Interview with the Dietary Manager on 04/17/24 at 9:07am revealed:
-The dietary aide was responsible to get fresh snacks made and put out for the residents three times a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 298	Continued From page 11	D 298		

-The dietary aide would pick a few items off the snack list to put out.
-The assisted living snacks were placed in a basket at the nurses station so they were accessible to the residents.
-The dietary staff made baked goods like cookies, muffins, and brownies daily and placed them at the bistro for residents.
-The dietary staff also put out apples, oranges, and other sealed fruits at the bistro for residents.

Interview with a resident on 04/17/24 at 9:25am revealed:
-As long as he had lived there, he had never known the facility to put out snacks.
-He did not know where snacks were being made available.

Interview with a second resident on 04/17/24 at 9:35am revealed:
-Staff did not come around and offer her snacks three times a day.
-She did not know where snacks were being made available to her in the facility.

Interview with a PCA on 04/17/24 at 9:45am revealed:
-Resident snack time on the day shift was "after lunch."
-No one was responsible for passing out snacks to the residents.
-The dietary staff was responsible to put snacks out at the nurses station and at the bistro.

Interview with the Resident Care Coordinator (RCC) on 04/17/24 at 9:55am revealed:
-The PCAs were responsible for taking snacks around to residents to ensure residents were getting snacks appropriate to their diets.
-Snacks were supposed to be offered to residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 298	Continued From page 12 at 10:30am-10:45am, at 3:45pm-4:00pm, and at bedtime. -The dietary staff were responsible for making the snacks and the PCAs were responsible for picking the prepared snacks up from the kitchen. -The PCAs were also responsible to help dietary staff with preparation of the snacks if they needed help. -Resident snacks included a beverage and a food snack. -Snacks were kept in a basket in the nurses station. -The PCAs were responsible for taking the snack cart around to residents in between meals and at bedtime to all residents. -The 3:00pm to 11:00pm staff were responsible for passing out the afternoon snacks to residents. -She was unaware snacks were not passed out to residents in the afternoon on 04/16/24. Interview with the facility ED on 04/17/24 at 11:50am revealed: -She expected staff to take snacks around to all residents at 10:00am, 2:00pm, and 7:00pm. -Dietary staff were responsible for prepping the snacks. -The PCAs were responsible for taking the snacks around three times a day to offer them to residents. Interview with the Administrator on 04/17/24 at 12:00pm revealed the staff were supposed to take snacks around room to room and offer them to residents three times a day.	D 298		
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
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 13 (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 5 sampled residents (Resident #3) related to a discontinued antipsychotic medication. Review of the facility's Medication Administration Policy and Procedure dated September 2021 revealed: -All orders were reviewed by the Resident Care Coordinator (RCC) or designee. -The RCC would fax the order to the pharmacy and scan the order into the electronic scan. -Remove a discontinued medication from the medication cart. -Review the discontinued order and compare it to the electronic Medication Administration Record (eMAR) to assure it was correctly discontinued. Review of Resident #3's current FL2 dated 01/01/24 revealed diagnoses included dementia and anxiety disorder. Review of Resident #3's Resident Register revealed an admission date of 01/12/24. Review of physician's orders for Resident #3 revealed olanzapine (antipsychotic medication used to treat anxiety and agitation) 2.5mg, ½ tablet (1.25mg) twice daily at 12:00pm and	D 358	10 NCAC 13F .1004(a) Medication Administration Care Coordinators and/or his/her designee will review all physician orders and progress notes of providers to ensure all orders have been processed accordingly. Executive Director and/or his/her designee will audit select group of orders weekly to ensure all orders are processed correctly.	5/20/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 14 5:00pm. Review of physician's progress notes for Resident #3 dated 02/23/24 revealed discontinue olanzapine. Review of Resident #3's electronic Medication Administration Record (eMAR) for 02/23/24 - 02/29/24 revealed: -There was an entry for olanzapine 2.5mg take ½ tablet twice daily with administration times of 12:00pm and 5:00pm. -There was documentation the olanzapine was administered 02/23/24 - 02/29/24 at 12:00pm and 5:00pm. Review of Resident #3's eMAR for March 2024 revealed: -There was an entry for olanzapine 2.5mg take ½ tablet twice daily with administration times of 12:00pm and 5:00pm. -There was documentation the olanzapine was administered 03/01/24 - 03/31/24 at 12:00pm and 5:00pm. Review of Resident #3's eMAR for 04/01/24 - 04/16/24 revealed: -There was an entry for olanzapine 2.5mg take ½ tablet twice daily with administration times of 12:00pm and 5:00pm. -There was documentation the olanzapine was administered 04/01/24 - 04/16/24 at 12:00pm and 5:00pm. Observations of Resident #3's medications available for administration on 04/17/24 at 10:08am revealed: -There was a multidose package of medication for Resident #3. -A printed label on the multidose package of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 15	D 358		

medication listed all medications in the daily package which included olanzapine 2.5mg, ½ tablet.

Telephone interview with a pharmacist at the facility's contracted pharmacy revealed:
-The pharmacy received a signed physician's order from the facility via fax on 02/02/24 for olanzapine 2.5mg, take ½ tablet twice daily for Resident #3.
-The pharmacy did not receive any orders from the facility to discontinue the olanzapine and it was still an active order.

Telephone interview with Resident #3's mental health provider (MHP) on 04/17/24 at 10:00am revealed:
-He ordered the olanzapine for Resident #3 on 02/02/24 to treat her agitation.
-He discontinued the olanzapine on 02/23/24 because he thought the medication was ineffective with treating her agitation.
-He did not know staff continued to administer the olanzapine to Resident #3.

Interview with the Medication Aide (MA) on 04/17/24 at 10:10am revealed:
-She did not know the olanzapine was discontinued and continued to administer it to Resident #3.
-All progress notes were reviewed by the Special Care Coordinator (SCC) or Resident Care Coordinator (RCC) and they were responsible for faxing the progress notes with medication orders to the pharmacy.
-When the SCC or RCC were not in the facility the MA was responsible for faxing the orders to the pharmacy then places the order in their file box for review.
-She did not know why the olanzapine was not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 16 discontinued. Interview with the RCC on 04/17/24 at 10:15am revealed: -She received physician's progress notes via email which she checked several times daily. -She emailed or faxed the progress notes with medication orders to the pharmacy. -Medication cart audits were conducted weekly on Thursdays by the RCC and the SCC. -She did not know why the olanzapine was missed. Interview with the Executive Director (ED) on 04/17/24 at 10:20am revealed: -The physician's progress notes were emailed or faxed to the facility from the provider. -The SCC and the RCC would review the progress notes. -All medication orders were emailed or faxed to the pharmacy. -The SCC or the RCC were responsible for removing the discontinued medication from the medication cart. Interview with the Administrator on 04/17/24 at 10:30am revealed: -Physician's progress notes were emailed to the facility. -The SCC or the RCC were responsible for faxing the medication orders to the pharmacy. -The pharmacy entered the discontinue order into the eMAR system. -The SCC or the RCC would verify the order and write on the multidose package of medications the medication that was discontinued. -She did not know why the olanzapine was not discontinued. Based on observations, interviews and record	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal045127	A. BUILDING: _____ B. WING _____	04/17/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF MILLS RIVER	4143 HAYWOOD ROAD MILLS RIVER, NC 28759

(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 17 review, Resident #3 was not interviewable.	D 358		