STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on 07/12/24. The complaint investigations were initiated by the Johnston County Department of Social Services on 05/10/24 and 06/10/24.	D 000	Responses to sited deficiencies does not constitute an admission or agreement by the facility of the truth of alleged or conclusions set forth in this statement of Deficiencies of Corrective Action Report; the plan is 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 observations, record reviews, and interviews, the facility failed to ensure documentation for 5 of 5 sampled medication aides (MA) who administered medications to residents completed the state approved 5-hour and 10-hour or 15-hour medication aide training (Staffs A, B, C, D, and E) and 1 of 5 sampled medication aides (Staff B) who had not passed the written MA exam within 60 days of completion on the medication aide clinical skills checklist. The findings are: 1. Review of the personnel record for Staff B, medication aide (MA) on 07/11/24 revealed:	D 125	10A NCAC 13F .0403 Qualifications of Medication Staff Community will assure that all staff who administer medications shall complete training, clinical skill validation, and pass the written examination as set forth in G.S. 131D – 4.5B. 08/30/24 The 5, 10 and/or 15 hr training will be a combination of online 5hr training, the 10hr training by a licensed RN and written examination. The RN will complete a clinical skill validation before the staff member is permitted to administer medication. 8/30/24	

Reviewed and Acknowledged KC 09/05/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 1 -Staff B was hired on 01/08/24 as a medication aide/personal care aide. -There was a medication aide clinical skills checklist dated 02/09/24. -There was a certificate for completion of a 15-hour continued education unit (CEU) medication aide training course dated 02/08/24. -There was a statement on the 02/08/24 certificate documenting "completion of this course fulfilled 15.00 hours of continuing education". -There was a signature with licensing credentials for a "Ph.D. - Program Director." -There was an undated signature with licensing credentials for the facility's registered nurse (RN). -There was no documentation Staff B had passed the medication aide written examination. -There was no documentation Staff B had completed the 5-hour and 10-hour or 15-hour North Carolina State approved medication administration training program. Second review of Staff B's personnel records on 07/12/24 revealed: -There was a registered nurse (RN) signature on the certificate for completion of the 15-hour C.E.U. medication aide training course dated 02/08/24. -There was a certificate of completion for the 15-hour North Carolina state approved medication administration training program dated 02/08/24 with a RN signature of trainer. Interview with the Administrator on 07/12/24 at 10:59am revealed: -The Business Office Manager (BOM) was responsible to perform medication aide certification checks upon hire. -She did not have any documentation, until 07/11/24, indicating a check for Staff B's status regarding the written medication examination.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 2 -She had not found information that Staff B had taken and passed the medication aide written examination. Telephone interview with Staff B on 07/12/24 at 12:43pm revealed: -She was employed as a medication aide/personal care aide in February 2024 at the facility. -Her medication aide training at the facility consisted of an online computer training and training with another medication aide before she administered medications. -She remembered signing a medication administration clinical skills checklist competency evaluation but did not remember the RN watching her perform a medication pass or check her off for competency related to the medication aide checklist. -She remembered having a previous medication administration clinical skills checklist competency evaluation at another facility and a medication pass was observed by the RN. -She did not pass the medication administration written examination when she worked at another facility and was scheduled to retake the medication administration written examination on 07/19/24. Review of May 2024, June 2024, and July 2024 medication administration records (MARs) revealed Staff B documented administering medications 05/01/24 through 05/12/24, 05/15/24 through 05/23/24, 05/25/24 through 05/31/24, 06/01/24 through 06/05/24, and 07/01/24 through 07/07/24, including controlled substances and measured topical medication ointments. Refer to interview with the Administrator on 07/11/24 at 5:10pm.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 3 Refer to interview with the Regional Supervisor on 07/12/24 at 9:00am. Refer to interview with the Regional Supervisor on 07/12/24 at 2:25pm. Refer to interview with the Registered Nurse on 07/12/24 at 2:05pm. Refer to interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm. Refer to interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm. Refer to interview with the Administrator on 07/12/24 at 6:03pm. 2. Review of the personnel record for Staff A, medication aide (MA) on 07/11/24 revealed: -Staff A was hired on 04/17/24 as a medication aide/supervisor. -There was a medication aide clinical skills checklist dated 06/26/24. -There was a certificate for completion of a 15-hour C.E.U. medication aide training course dated 06/05/24. -There was a statement on the 06/05/24 certificate documenting "completion of the course fulfilled 15.00 hours of continuing education for home health aides". -There was a signature with licensing credentials for a "Ph.D. - Program Director." -There was no signature with licensing credentials for a registered nurse or pharmacist. -There was no documentation Staff A had completed the 5-hour and 10-hour or 15-hour North Carolina State approved medication administration training program.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 4 Second review of Staff A's personnel records on 07/12/24 revealed: -There was a registered nurse (RN) signature on the certificate for completion of the 15-hour C.E.U. medication aide training course dated 06/05/24. -There was a certificate of completion for the 15-hour North Carolina state approved medication administration training program dated 06/05/24 with a RN signature of trainer. Interview with Staff A on 07/10/24 at 4:37pm revealed: -She had been employed at the facility for four months as a MA. -She sometimes worked as a personal care aide (PCA) and was working as the MA on 07/10/24. Interview with Staff A on 07/11/24 at 5:00pm revealed: -She had just finished administering medications to three named residents. -She completed a "50-hour training" at a facility in another town. -Upon hire at this facility she had to take a test before she was able to administer medications. -The Business Office Manager (BOM) should have her 5/10-hour or 15-hour medication aide certificate. Telephone interview with Staff A on 07/12/24 at 1:03pm revealed: -She completed an online medication administration training that included watching a movie and taking a test. -There was no nurse in attendance with her when she completed the online medication administration training at the facility. -If she had a question about anything, she would	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 5 have to call someone by telephone. -She had to complete the online medication administration training before she was assigned to administer medications. -She had not had a chance to take the North Carolina medication aide test. Review of June 2024 and July 2024 MARs revealed Staff A documented administering medications 06/15/24, 06/16/24, 06/29/24, 06/30/24, and 07/08/24 including an insulin injection and fingerstick blood sugar check on 07/08/24. Refer to interview with the Administrator on 07/11/24 at 5:10pm. Refer to interview with the Regional Supervisor on 07/12/24 at 9:00am. Refer to interview with the Regional Supervisor on 07/12/24 at 2:25pm. Refer to interview with the Registered Nurse on 07/12/24 at 2:05pm. Refer to interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm. Refer to interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm. Refer to interview with the Administrator on 07/12/24 at 6:03pm. 3. Review of the personnel record for Staff C, medication aide (MA) on 07/11/24 revealed: -Staff C was hired on 08/07/23 as a medication aide/personal care aide. -There was documentation Staff C passed the	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 6 medication aide written examination on 10/04/22. -There was a medication aide clinical skills checklist competency evaluation dated 08/16/23. -There were infection control skills check-off lists dated 08/16/23 for handwashing, alcohol-based hand rub, putting on and removing gloves, putting on and removing gowns, and putting on and removing masks. -There was a certificate for completion of a 15-hour C.E.U. medication aide training course dated 08/15/23. -There was a statement on the 08/15/23 certificate documenting "completion of this course fulfilled 15.00 hours of continuing education". -There was a signature with licensing credentials for a "Ph.D. - Program Director." -There was an undated signature with licensing credentials for the facility's registered nurse (RN). -There was no documentation Staff B had completed the 5-hour and 10-hour or 15-hour North Carolina State approved medication administration training program. Second review of Staff C's personnel records on 07/12/24 revealed there was a certificate of completion for the 15-hour North Carolina state approved medication administration training program dated 08/15/23 with a RN signature of trainer. Review of documentation for medication administration revealed: -There was documentation of medication administration by Staff C on 06/07/24, 05/14/24, 05/16/24, 05/23/24, 05/28/24, 05/30/24, 06/01/24, 06/06/24, 06/10/24, 06/19/24, 06/21/24, 06/24/24, 06/27/24, 06/30/24, 07/04/24, 07/08/24, and 07/10/24 (fingerstick blood sugar check, insulin). -There was documentation Staff C did not administer Nitrofurantoin (a long term	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 7 anti-infective) on 07/10/24 to a resident due to unavailability of medication. Refer to interview with the Administrator on 07/11/24 at 5:10pm. Refer to interview with the Regional Supervisor on 07/12/24 at 9:00am. Refer to interview with the Regional Supervisor on 07/12/24 at 2:25pm. Refer to interview with the Registered Nurse on 07/12/24 at 2:05pm. Refer to interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm. Refer to interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm. Refer to interview with the Administrator on 07/12/24 at 6:03pm. 4. Review of the personnel record for Staff D, medication aide (MA) on 07/11/24 revealed: -Staff D was hired on 12/02/22 as a personal care aide. -There was a medication aide clinical skills checklist competency evaluation dated 10/12/23. -There was a certificate for completion of a 15-hour C.E.U. medication aide training course dated 09/28/23. -There was a statement on the 09/28/23 certificate documenting "completion of this course fulfilled 15.00 hours of continuing education". -There was a signature with licensing credentials for a "Ph.D. - Program Director." -There was a signature with licensing credentials for the facility's registered nurse (RN) dated	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 8 09/28/23. -There was no documentation for Staff D's written medication administration examination status. -There was no documentation Staff D had completed the 5-hour and 10-hour or 15-hour North Carolina State approved medication administration training program. Interview with the Administrator on 07/12/24 at 11:50am revealed she performed a search on 07/12/24 for Staff D's medication administration written examination status and found Staff D passed the medication administration written examination on 12/08/83 (document presented for review). Second review of Staff D's personnel records on 07/12/24 revealed there was no certificate of completion for the 15-hour North Carolina state approved medication administration training. Review of May 2024, June 2024, and July 2024 MARs revealed there was documentation of medication administration by Staff D on 05/11/24, 05/25/24, 06/02/24 through 06/12/24, 06/14/24, 06/17/24, 06/18/24, 06/19/24, 06/24/24, 06/25/24, 06/26/24, and fingerstick blood sugar checks and insulin administration on 07/01/24, 07/02/24, 07/03/24, 07/06/24, and 07/07/24. Refer to interview with the Administrator on 07/11/24 at 5:10pm. Refer to interview with the Regional Supervisor on 07/12/24 at 9:00am. Refer to interview with the Regional Supervisor on 07/12/24 at 2:25pm. Refer to interview with the Registered Nurse on	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 9 07/12/24 at 2:05pm. Refer to interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm. Refer to interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm. Refer to interview with the Administrator on 07/12/24 at 6:03pm. 5. Review of the personnel record for Staff E, medication aide (MA) on 07/11/24 revealed: -Staff E was hired on 06/07/22 as a medication aide. -There was documentation Staff E passed the medication aide written examination on 08/29/19. -There was a medication aide clinical skills checklist competency evaluation dated 06/19/24. -There were infection control skills check-off lists dated 06/19/24 for handwashing, alcohol-based hand rub, putting on and removing gloves, putting on and removing gowns, and putting on and removing masks. -There was a certificate for completion of a 15-hour C.E.U. medication aide training course dated 06/03/24. -There was a statement on the 06/03/24 certificate documenting "completion of this course fulfilled 15.00 hours of continuing education". -There was a signature with licensing credentials for a "Ph.D. - Program Director" on the 06/03/24 certificate. -There was a signature with licensing credentials for the facility registered nurse (RN) dated 06/03/24 on the certificate. -There was no documentation Staff E had completed the 5-hour and 10-hour or 15-hour North Carolina State approved medication administration training program.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 10 Second review of Staff E's personnel records on 07/12/24 revealed there was a certificate of completion for the 15-hour North Carolina state approved medication administration training program dated 06/03/24 with a RN signature of trainer. Review of June 2024 and July 2024 MARs revealed Staff E documented administering medications 07/03/24, 07/04/24, 07/05/24, 07/08/24, 07/09/24, and 07/10/24, including controlled substances. Refer to interview with the Administrator on 07/11/24 at 5:10pm. Refer to interview with the Regional Supervisor on 07/12/24 at 9:00am. Refer to interview with the Regional Supervisor on 07/12/24 at 2:25pm. Refer to interview with the Registered Nurse on 07/12/24 at 2:05pm. Refer to interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm. Refer to interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm. Refer to interview with the Administrator on 07/12/24 at 6:03pm. Interview with the Administrator on 07/11/24 at 5:10pm revealed: -The BOM was responsible to ensure appropriate documents, including medication aide training documents such as the certification for the	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 11 medication aide written examination and medication aide clinical skills checklist, were in the MAs personnel file. -The facility nurse was supposed to review 5/10-hour or 15-hour state approved medication aide training certificates before performing the medication administration clinical skills checklist competency evaluation. Interview with the Regional Supervisor on 07/11/24 at 9:00am revealed: -The course content in the 15-hour medication aide training conducted at the facility was the same as the North Carolina state approved medication administration training. -There had been approval for use of the training material used by the facility, and she would research and try to provide a copy of the approval. -The medication administration training program used by the facility included an online video viewed by the employee. -There was an RN, and whoever was approved by the facility, that reviewed the facility used medication administration training course with the employee. -The RN reviewed the facility's used medication aide training information with the medication aide trainees when she conducted the MAs clinical skills competency evaluation. -Upon hire the medication aide was assigned the online medication aide training course. Interview with the Regional Supervisor on 07/12/24 at 2:25pm revealed: -She did not have any information regarding approval of the 15-hour medication administration training used by the facility. -She could not speak on how training activities were conducted in the region for this facility	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 12 because she recently assumed her position in the region. -She could not say for sure what the facility had done previously with regards to the skills/activities that were supposed to occur during the medication aide training course. -She did not know "factual" that the training presenter reviewed the medication aide student training manual nor how long it took the trainees to complete the online course because she had not gone through the 15-hour medication aide training course used by the facility. Interview with the RN on 07/12/24 at 2:05pm revealed: -It had probably been two years since in-person medication administration trainings were conducted. -The facility used an online medication administration training course. -She reviewed the online medication administration training information with medication aide employees when she completed medication administration clinical skills checklist competency evaluations. -She signed the online medication administration training certificates. -She was not the person teaching the online medication administration course used at the facility. -There was a physician on the screen teaching the medication administration online course. -She was not sure how long it took the trainees to watch the online medication administration training course. -She had never viewed the online facility used medication administration training course. -She did not know if the state approved medication administration course content was reviewed with trainees by the instructor	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 125	Continued From page 13 conducting the online video medication administration training used by the facility. Interview with the Business Office Manager (BOM) on 07/12/24 at 4:12pm revealed: -She was responsible for employee personnel records. -She started a checklist upon hire for employees to ensure required documents were in the personnel records. -She had not reviewed personnel records to ensure appropriate documentation of training for employees hired prior to her hire date of 11/27/23 because she assumed those personnel records were complete. Interview with the current Special Care Unit (SCU) Director on 07/12/24 at 4:40pm revealed: -The 15-hour medication aide training she took at the facility was "basically a video" and she was not able to communicate with the presenter. -About two weeks after she was hired, she completed the online video course which took her about two hours, including a pretest, the video, and a post test. -The facility RN completed her medication administration clinical skills competency evaluation about three weeks after. Interview with the Administrator on 07/12/24 at 6:03pm revealed: -She had concerns for medication errors. -There were complaints from family members about medications. -She expected the BOM and herself to know about staff qualifications, including medication aide certification classes. -She expected management staff to communicate with each other and work as a team.	D 125		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure 1 of 4 reviewed residents from the medication pass observation (#7) had a current FL-2 completed annually. The findings are: Review of Resident #7's FL-2 dated 06/05/23 revealed: -Diagnoses included cervical spinal stenosis, sacroilitis, unsteadiness, uncontrolled type 2	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 235	Continued From page 15 diabetes, and osteoporosis. -She was intermittently disoriented. Review of Resident #7's record revealed Resident #7 did not have an updated FL-2 completed since 06/05/23. An updated FL2 since 06/05/23 was requested for Resident #7 on 07/10/24 at 11:35am and was not provided. Interview with the Resident Care Coordinator on 07/12/24 at 4:15pm revealed: -She knew the residents were to have a completed FL2 signed by the primary care provider upon admission and at least annually. -It was her responsibility to ensure there was an updated, completed and signed FL2 on the residents' chart. -She thought she only had to place the FL2 form for the provider to complete and sign, she was not aware until just recently that she was responsible for completing the FL2 for the provider to review and sign. -She had just started in the RCC role a little over a month ago and was still learning the position. -She had not completed chart audits for all the residents. Interview with the Administrator on 07/12/24 at 5:38pm revealed: -She had just started in the Administrator role this week. -The RCC was to perform chart audits for each resident, which included review of the residents' FL2, physicians order sheet, care plan, two step tuberculosis testing, vaccines, and healthcare referrals. -The RCC was responsible for ensuring the FL2s were complete and up to date for each resident.	D 235		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 235	Continued From page 16 -She expected each resident to have a current signed FL2.	D 235		
D 349	10A NCAC 13F .1002 (f) Medication Orders 10A NCAC 13F .1002 Medication Orders (f) The facility shall assure that all current orders for medications or treatments, including standing orders and orders for self-administration are reviewed and signed by the resident's physician or prescribing practitioner at least every six months. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure all current orders for medications and treatments were reviewed and signed by the resident's physician or prescribing practitioner at least every six months for 1 of 5 sampled residents (Resident #2) and 2 of 4 residents observed (Resident #8, and #10) during the medication pass. The findings are: 1. Review of Resident #2's current FL2 dated 08/24/23 revealed: -Diagnoses included hypertension, hyperlipidemia, atrial fibrillation, coronary artery disease, history of breast cancer, recurrent urinary tract infections and squamous cell skin cancer. -Under the medications, name and strength, dosage and route section, there was an entry "See attached".	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 17 Review of Resident #2's signed physician's order sheet dated 08/24/23 revealed: -There was an order for fluconazole (fluconazole is used to treat fungal and yeast infections)150mg, take 1 tablet daily as needed for vaginal itching. -There was an order for cephalexin (cephalexin is an anti-biotic) 250mg, take once daily. -There was an order to weigh the resident monthly. -There was an order to obtain monthly vital signs on the 14th day of the month. -There was an order for loratadine (loratadine is used to treat allergy symptoms) 10mg, take one daily at bedtime. -There was an order for melatonin (melatonin is a supplement used to aid sleep) 3mg, take one daily at bedtime. -There was an order for mupirocin ointment, 2% (mupirocin is used to treat skin infections), apply topically to affected areas twice daily for neoplasm of uncertain behavior of the skin. -There was an order for vitamin D2 (vitamin D2 is supplement used to treat low vitamin D levels),take one capsule by mouth every Saturday. -There was an order for guaifenesin (guaifenesin is used to thin mucous) extended release 12 hour, 600mg ,take one tablet twice daily as needed for congestion. -There was an order for amlodipine (amlodipine is used to treat high blood pressure and chest pain) 5mg, take one tablet daily. -There was an order for apixaban (apixaban is a blood-thinner) 2.5mg, take one tablet twice daily. -There was an order for acetaminophen (acetaminophen is used to treat mild to moderate pain), take two tablets every 8 hours as needed for headache or pain, may self-administer and keep at bedside.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 18 -There was an order for Cepacol sore-throat lozenges (Cepacol is used to treat sore throat) 15-2.6mg, take one lozenge every 4 hours as needed for sore throat. -There was an order for sodium chloride aerosol spray (sodium chloride aerosol spray is used to treat dry nasal passages), use 2 sprays in each nostril every 4 hours as needed for nasal congestion. -There was an order for fenofibrate (fenofibrate is used to treat high cholesterol and triglycerides) 54mg, take one tablet at bedtime. -There was an order for pravastatin (pravastatin is used to treat high cholesterol) 20mg, take one tablet at bedtime. -There was an order for trazadone (trazadone is used to treat depression and can be used as a sedative) 50mg, take one tablet at bedtime for sleep. -There was an order for albuterol sulfate (albuterol is a bronchodilator) HFA aerosol inhaler 90mcg/actuation, inhale one puff every 6 hours as needed for shortness of breath or cough. May keep at bedside. -There was an order for tramadol (tramadol is used to treat moderate to moderately severe pain) 50mg, take one tablet every six hours as needed for pain. -There was an order metoprolol succinate (metoprolol is used to treat high blood pressure) extended release 24 hour, 25mg, take one tablet daily. -There was an order for lorazepam (lorazepam is used to treat anxiety) 0.5mg, take one tablet twice daily. -There was an order for loperamide (loperamide is used to treat diarrhea), take one tablet as needed with each loose stool for diarrhea, do not exceed 8 doses in 24 hours. -There was an order for milk of magnesia (milk of	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 19 magnesia is used to treat constipation) suspension 400mg/5ml, give 30ml at bedtime as needed for constipation. -There was an order for antacid-antigas suspension, 200-200-20mg/5ml, give 30 ml as needed for heartburn and indigestion, do not exceed 4 doses in 24 hours. A signed physician's sheet for Resident #2 since 08/24/23 was requested on 07/10/24 at 11:25am and was not provided. Review of Resident #2's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #2 since 08/24/23. Refer to interview with the Resident Care Coordinator (RCC) on 07/12/24 at 4:15pm. Refer to interview with the Administrator on 07/12/24 at 5:33pm. 2. Review of Resident #8's current FL2 dated 11/21/23 revealed: -Diagnoses included dementia, hypothyroidism, major depressive disorder, type 2 diabetes and chronic kidney disease. -Under the medications, name and strength, dosage and route section, there was an entry "See attached". Review of Resident #8's signed physician's order sheet dated 11/21/23 revealed: -There was an order for aspirin 81mg (low dose aspirin can be useful in the prevention of heart attack and stroke), take one tablet daily. -There was an order for escitalopram oxalate (escitalopram is used to treat depression and anxiety) 10mg, take one tablet daily.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 20 -There was an order for levothyroxine (levothyroxine is used to treat under active thyroid disorder) 25mcg, take one tablet daily. -There was an order for loperamide (loperamide is used to treat diarrhea) 2mg capsule, take one capsule as needed with each loose stool, not to exceed 8 doses in 24 hours. -There was an order for ramipril (ramipril is used to treat high blood pressure) 10mg, take one capsule daily. -There was an order for calcium carbonate (calcium carbonate is a dietary calcium supplement and can be used as an antacid to relieve heartburn, acid indigestion and upset stomach) 600mg (1500mg), take one tablet by mouth daily. -There was an entry for CentraVite Senior (a multi-vitamin), take one tablet daily. -There was an entry for amlodipine (amlodipine is used to treat high blood pressure and chest pain) 5mg, take one tablet daily. -There was an order for donepezil (donepezil is used to treat dementia and memory loss) 10mg, take one tablet daily at bedtime. -There was an order for rosuvastatin (rosuvastatin is used to treat high cholesterol) 20mg, take one tablet by mouth daily at bedtime. -There was an order for quetiapine (quetiapine is used to treat schizophrenia and major depression) 100mg, take one tablet at bedtime. -There was an order for nystatin cream (nystatin cream is used to treat fungal or yeast infections of the skin) apply topically to skin folds twice daily. -There was an order for nitrofurantoin monohydrate 100mg (nitrofurantoin is an antibiotic used to treat bladder infections), take one capsule by mouth every day. -There was an order to check blood glucose before meals.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 21 -There was an order for Lantus Solostar (Lantus is a long-acting insulin used to control high blood sugar), inject 34units daily before breakfast. -There was an order to obtain vital signs monthly on the 2nd day of the month. Review of Resident #8's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #8 since 11/21/23. A signed physician's order sheet for Resident #8 since 11/21/23 was requested on 07/10/24 at 11:25am and was not provided. Refer to interview with the Resident Care Coordinator (RCC) on 07/12/24 at 4:15pm. Refer to interview with the Administrator on 07/12/24 at 5:33pm. 3. Review of Resident #10's current FL2 dated 10/02/23 revealed: -Diagnoses included moderate late onset Alzheimer's disease, paroxysmal atrial fibrillation, sick sinus syndrome with cardiac pacemaker, hypertension. Overactive bladder, osteoporosis, allergic rhinitis, hyperlipidemia and vitamin B12 deficiency. -There was an order for aspirin 81mg (low dose aspirin can be useful in the prevention of heart attack and stroke) take one daily, donepezil 10mg (donepezil is used to treat high blood pressure) take one nightly, enalapril (enalapril is used to treat high blood pressure) 20mg, take one daily, fluticasone 50mcg (fluticasone is used to treat sneezing, itching or runny nose) one spray each nostril each morning, furosemide 20mg (furosemide is used to treat high blood pressure, heart failure and fluid buildup in the body), take	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 22 one daily, ibandronate (ibandronate is used to treat osteoporosis) take one tablet monthly, loratadine (loratadine is used to treat allergy symptoms) 10mg take one daily, memantine (memantine is used to treat dementia related to Alzheimer's Disease) 10mg, take one daily, metoprolol extended release (metoprolol is used to treat high blood pressure) 50mg , take one and a half tablets daily, oxybutynin (oxybutynin is used to treat overactive bladder) 5mg take one twice per day, potassium chloride (potassium chloride is used to treat low potassium) 10mEq, take one tablet daily and pravastatin (pravastatin is used to treat high cholesterol) 20mg, take one tablet daily. Review of Resident #10's signed physician's orders dated 10/26/23 revealed: -There was an order for ibandronate 150mg, take one tablet once per month. -There was an order for fluticasone propionate nasal spray 50mcg/actuation, give 1 spray in each nostril every morning. -There was an order for loratadine 10mg, take one tablet once daily. -There was an order for aspirin 81mg chewable, take one tablet once daily. -There was an order for loperamide (loperamide is used to treat diarrhea) 2mg, take one capsule as needed after each loose stool, not to exceed 4 doses in 24 hours. -There was an order for pravastatin 20mg, take one tablet once daily. -There was an order for furosemide 20mg, take one tablet once daily. -There was an order for potassium chloride extended release 10mEq, take one tablet once daily. -There was an order for donepezil 10mg, take one tablet at bedtime.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 23 -There was an order for memantine 10mg, take one tablet twice daily. -There was an order for oxybutynin chloride 5mg, take one tablet twice daily. -There was an order for enalapril maleate 20mg, take one tablet once daily. -There was an order for metoprolol succinate extended release 50mg, take one and a half tablets (75mg) once daily. -There was an order for acetaminophen (acetaminophen is used to treat mild to moderate pain or fever) 500mg, one tablet every 6 hours for fever 99.5 -101, minor headache or minor discomfort. If fever is greater than 101, severe headache or severe discomfort, call the provider. If symptoms persist for 24 hours, please call the provider. -There was an order for Mi-Acid Suspension (used to treat heartburn) 200-200-20mg/5ml, give 30ml as needed for heartburn/indigestion. -There was an order for guaifenesin (guaifenesin is used to thin mucous) extended release, 12 hour, 600mg, take one tablet every 12 hours as needed for congestion. -There was an order for milk of magnesia (milk of magnesia is used to treat constipation) suspension 400mg/5ml, take 30ml as needed for constipation. -There was an order for triple antibiotic ointment, 3.5mg-400unit-5,000units, topical, use for minor abrasions or skin tears, clean area with normal saline-apply triple antibiotic ointment or equivalent, cover with a band-aid or gauze and tape, change daily up to 7 days as needed-if swelling or redness, any drainage, notify provider. Review of Resident #10's physician's orders revealed there was no six-month medical provider renewal of all medications and treatments for Resident #8 since 10/26/23.	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 24 A signed physician's order sheet for Resident #10 since 10/26/23 was requested on 07/10/24 at 11:25am and was not provided. Refer to interview with the Resident Care Coordinator (RCC) on 07/12/24 at 4:15pm. Refer to interview with the Administrator on 07/12/24 at 5:33pm. --- Interview with the RCC on 07/12/24 at 4:15pm revealed: -The residents were to have a reviewed and signed physicians medication and treatment order sheet every 6 months. -There was a spread sheet and a tickler system to alert her when a resident's orders were to be reviewed and updated by the primary care provider (PCP). -The spread sheet was flagged 3 ways, white meant the orders were up to date, yellow meant the orders were due soon to be reviewed, updated and signed and red meant the orders were past due for the 6-month review. -She started as the RCC just over a month ago and was trying to catch up on all the 6-month provider order reviews. -She knew there were provider order reviews that were past due for the 6-month review. -She was responsible for ensuring the residents had current medication and treatment orders which were to be updated and signed by the primary care provider (PCP) every 6 months. Interview with the Administrator on 07/12/24 at 5:33pm revealed: -The RCC was responsible for obtaining the 6-month updated and signed physician	D 349		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 349	Continued From page 25 medication and treatment orders. -She did not know why the 6-month physician orders had not been updated and signed by the physician. -She expected the RCC perform chart audits to include review of the physician orders to ensure the medication and treatment orders were updated and signed every 6-months.	D 349		
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 observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 2 of 4 residents (#8 and #10) observed during the medication pass including errors with an antibiotic (#8), a topical medication used to relieve pain (#10) and for 2 of 5 sampled residents (#1 and #2) pertaining to a nasal spray (#1), a medication for anxiety and a medication to treat gastro-esophageal reflux (#2). The findings are: The facility's Medication Administration policy was requested on 07/10/24 at 8:29am and was not provided.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 1. The medication error rate was 5% as evidenced by 2 errors out of 38 opportunities during the 8:00am and 9:00am medication pass on 07/10/24. a. Review of Resident #8's current FL2 dated 11/21/23 revealed: -Diagnoses included dementia, hypothyroidism, major depressive disorder, type 2 diabetes and chronic kidney disease. -Under the medications, name and strength, dosage and route section, there was an entry "See attached". Review of Resident #8's signed physician's order sheet dated 11/21/23 revealed there was an order for nitrofurantoin monohydrate 100mg (nitrofurantoin is an antibiotic used to treat bladder infections), take one capsule every day. Observation of the 8:00am medication pass on 07/10/24 revealed: -The medication aide (MA) prepared and administered seven oral medications scheduled for 8:00am to Resident #8 at 7:33am. -No nitrofurantoin monohydrate 100mg, was prepared and administered to Resident #8 when she received her other 8:00am medications at 7:33am. Review of Resident #8's July 2024 electronic medication administration record (eMAR) revealed: -There was an entry for nitrofurantoin monohydrate 100mg, take 1 tablet once a day at 8:00am. -Nitrofurantoin monohydrate 100mg was documented as administered at 8:00am from 07/01/24 to 07/05/24.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 -Nitrofurantoin monohydrate 100mg was documented as not administered at 8:00am on 07/06/24 through 07/10/24 due to the medication "unavailable". Interview with Resident #8 on 07/11/24 at 9:02am revealed: -Staff administered her medications daily. -She was not exactly sure what medications she took. -She was not sure if the facility ever ran out of her medications. Interview with the MA on 07/10/24 at 12:23pm revealed: -The MAs were responsible for re-ordering the residents' medications. -She re-ordered medications when there were 10-15 doses remaining. -Medications were re-ordered by selecting the "re-supply" option on the eMAR system. -She had requested a refill of nitrofurantoin monohydrate for Resident #8 yesterday. -She was not sure why Resident #8's nitrofurantoin monohydrate had not been requested sooner. -Resident #8 took nitrofurantoin monohydrate to help prevent urinary tract infections. Telephone interview with a representative from the facility's contracted pharmacy on 07/11/24 at 8:16am revealed they did not provide Resident #8's medications. Telephone interview with a representative from Resident #8's preferred pharmacy provider on 07/11/24 at 9:02am revealed: -Nitrofurantoin monohydrate 100mg was last dispensed on 01/12/24 for a quantity of 28 tablets, with a note that the resident needed an	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 appointment. -She was unable to locate record of nitrofurantoin monohydrate being dispensed since 01/12/24. -A refill request for nitrofurantoin monohydrate had been received on 07/10/24 from the facility for Resident #8. Second interview with the MA on 07/11/24 at 9:24am revealed: -She had originally sent the nitrofurantoin refill request to the facility's contracted pharmacy by mistake on 07/09/24. -She had requested the nitrofurantoin from Resident #8's preferred pharmacy yesterday afternoon. -Resident #8 received nitrofurantoin daily until this week when she ran out. -She did not know why Resident #8's preferred pharmacy did not have documentation of a refill for nitrofurantoin since 01/12/24. Telephone interview with a representative from Resident #8's primary care provider (PCP) office on 07/11/24 at 8:36am revealed: -Nitrofurantoin monohydrate was prescribed for Resident #8 for chronic urinary tract infections. -Resident #8 was last seen at their office on 07/09/24. -Resident #8 was to continue taking nitrofurantoin monohydrate daily. -She was unable to tell if a new prescription for nitrofurantoin had been issued for Resident #8 at the 07/09/24 office visit. -She was unable to tell if there had been a nitrofurantoin refill request from the facility for Resident #8. Interview with the Resident Care Coordinator (RCC) on 07/10/24 at 12:56pm revealed: -The MAs were responsible for ordering refills for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 the residents. -Refills were re-ordered when the resident had a one-week supply of medication remaining. -Resident #8 did not use the facility's contracted pharmacy provider. -The MA could see the resident's preferred pharmacy on the resident face sheet in the eMAR system. -Resident #8's nitrofurantoin should have been re-ordered from her preferred pharmacy when she had 1 week remaining. -If a medication does not come in for a resident, the facility did have a backup pharmacy. -She did not know why Resident #8's nitrofurantoin monohydrate had not been requested prior to running out. Interview with the Administrator on 07/10/24 at 1:18pm revealed: -The MAs were responsible for requesting refills for the residents. -Refills were requested when a resident had 7 days remaining of medication. -Resident #8 had an appointment with her PCP yesterday and she thought Resident #8's daughter obtained her prescription for nitrofurantoin. -She expected the residents to receive their medication as ordered. b. Review of Resident #10's current FL2 dated 10/02/23 revealed diagnoses included moderate late onset Alzheimer's disease, paroxysmal atrial fibrillation, sick sinus syndrome with cardiac pacemaker, hypertension. overactive bladder, osteoporosis, allergic rhinitis, hyperlipidemia and vitamin B12 deficiency. Review of Resident #10's primary care provider (PCP) progress note dated 06/07/24 revealed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 there was an order for diclofenac Sodium External Gel 1%, apply 2 grams to skin three times per day, apply to left neck and left shoulder (diclofenac is topical medication used to treat pain.). Observation of the 9:00am medication pass in the Special Care Unit (SCU) on 07/10/24 at 8:05am revealed: -The medication aide (MA) donned gloves and squeezed a pea sized amount of diclofenac gel directly onto her gloved finger and rubbed the gel onto Resident #10's left shoulder and left neck area. -The MA did not use the dosing card to dispense the diclofenac gel to Resident #10. Review of Resident #10's electronic medication administration record (eMAR) for July 2024 revealed: -There was an entry for diclofenac Sodium 1% gel, apply to 2 grams topically to affected areas on left neck and shoulder three times daily at 8:00am, 3:00pm and 9:00pm. -There was documentation diclofenac Sodium 1% gel was applied at 9:00am 07/01/24 through 07/10/24 and at 3:00pm 07/01/24 through 07/09/24 and at 9:00pm on 07/01/24 through 07/09/24. Observation of Resident #10's medications on hand on 07/10/24 at 12:08pm revealed: -There was a box containing a 100gram tube of diclofenac Sodium 1% gel. -The box containing the diclofenac Sodium 1% gel was labeled with the resident's name and to apply 2 grams topically to affected areas on left neck and shoulder three times daily. -The box containing the diclofenac Sodium 1% gel had instructions to use the enclosed dosing	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 card to measure a dose and the box contained a dosing card. -2.25 inches long was 2 grams. -4.5 inches long was 4 grams. Interview with Resident #10 on 07/10/24 at 12:15pm revealed: -She used diclofenac for neck and shoulder pain. -She felt the diclofenac gel was helpful for her pain. Interview with the MA on 07/10/24 at 12:10pm revealed: -She was taught to measure diclofenac gel, using a graduated medication cup. -The facility had been out of graduated medication cups for about one week. -She applied enough of the diclofenac 1% gel that she thought would cover Resident #10's left shoulder and neck area. -She was never taught how much diclofenac gel to administer using the dosing card. -She did not know there was a dosing card with the diclofenac gel. Telephone interview with a pharmacist from the facility's contracted pharmacy on 0711/24 at 8:16am revealed: -Diclofenac should be measured by using the clear plastic measuring tool that came with the medication. -A ribbon of gel was to be squeeze down the measuring tool to the ordered dose. -There was little risk of a resident receiving too much medication but too little could cause pain to not be as well controlled. Interview with the Special Care Unit Coordinator (SCUC) on 07/10/24 at 12:40pm revealed: -She thought a graduated medicine cup was used	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 to measure diclofenac gel. -The facility was currently out of graduated measuring cups -She was not aware that diclofenac gel should be administered using the dosing card provided. -Receiving too little of the diclofenac gel could cause Resident #10 to have inadequate pain relief. Interview with the Administrator on 07/10/24 at 1:10pm revealed: -The MA should use the dosing card provided with the diclofenac gel to ensure Resident #10. received the accurate dose. -She was not aware that the MA did not know to use the dosing card for the diclofenac gel. Telephone Interview with Resident #10's PCP on 07/11/24 at 11:34am revealed: -She prescribed diclofenac gel to Resident for neck and shoulder pain. -Staff should use the dosing card that came with the diclofenac gel. -Not using the dosing card could result in Resident #10 getting too much or too little diclofenac. -She was not really concerned that the resident received too much diclofenac gel, her main concern was receiving too little diclofenac could result in inadequate pain relief. 2. Review of Resident #2's current FL-2 dated 08/24/23 revealed diagnoses included hypertension, hyperlipidemia, atrial fibrillation, coronary artery disease, history of breast cancer, recurrent urinary tract infections and history of squamous cell skin cancer. a. Review of Resident #2's Primary Care Provider (PCP) progress note dated 05/10/24 revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 -Resident #2 was on anti-coagulant therapy with Eliquis and the use of a proton pump inhibitor may be beneficial. -There was an order to start pantoprazole (pantoprazole is used to treat gastroesophageal reflux) 20mg, delayed release, take one tablet once per day. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -Resident #2 was documented as being out of the facility on leave on 05/12/24 through 05/17/24. -There was an entry for pantoprazole 20mg delayed release, take one daily scheduled at 6:00am with a start date of 05/17/24. -There was documentation that pantoprazole was administered at 6:00am on 05/18/24, 05/19/24 and 05/20/24. -There was documentation that pantoprazole was not administered at 6:00am on 05/21/24 with the exception documented as "on hold". -There was documentation that pantoprazole was not administered at 6:00am on 05/22/24 through 05/25/24 with the exception documented as medication has not come in yet. -There was documentation that pantoprazole was not administered at 6:00am on 05/26/24 with the exception documented as "on hold". -There was documentation that pantoprazole was not administered at 6:00am on 05/27/24 with the exception documented as medication has not come in yet. -There was documentation that pantoprazole was administered at 6:00am on 05/28/24 through 05/31/24. Observation of Resident #2's medication on hand on 07/12/24 at 12:47 revealed: -There was bubble card of pantoprazole 20mg,	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 take one tablet daily, dispensed on 07/02/24 for quantity of 28 tablets. -There were 23 pantoprazole 20mg tablets remaining in the bubble card. Interview with Resident #2 on 07/11/24 at 11:02am revealed: -She used the facility's contracted pharmacy for some of her medications. -Her responsible party (RP) ordered the majority of her medications through a mail order pharmacy. -She thought about a year ago there was an issue with getting all her medications but that had been straightened out. Telephone interview with a representative with the facility's contracted pharmacy on 07/12/24 at 9:17am revealed: -An order for pantoprazole 20mg for Resident #2 was received on 05/17/24 from the provider. -The pantoprazole 20mg for Resident #2 required a prior authorization. -Pantoprazole 20mg was dispensed to the facility for Resident #2 on 05/25/24 for quantity of 28 tablets for a 28-day supply. Interview with a medication aide (MA) on 07/12/24 at 12:50pm revealed: -If a resident had a new order, the PCP sent the prescription to the pharmacy and the Resident Care Coordinator reviewed and approved the order when the medication arrived. -Medications could take 2-3 days to come from the facility's contracted pharmacy. -Resident #2 received some of her medications from the facility's contracted pharmacy but the majority of her medications were provided by her responsible party via a mail order pharmacy. -She was not sure what caused the delay for	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 Resident #2's pantoprazole in May 2024. -If medications were not received from the pharmacy in a few days, management was notified, and they would contact the pharmacy. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 4:15pm revealed: -She started in the RCC position for the Assisted Living (AL) just over a month ago. -If a resident had a new medication order, the order was sent to the pharmacy by the provider. -When the new medication came in, she reviewed the medication and order on the eMAR. -The majority of Resident #2's medications were provided by her RP via a mail order pharmacy. -She did not know why there was a delay in Resident #2 receiving the pantoprazole. Interview with the Administrator on 07/12/24 at 5:33pm revealed: -If the facility had a delay or difficulty receiving a resident's medication, they should contact the pharmacy. -The facility did have a back up pharmacy. -She had just started in the Administrator position at the facility this week and did not know why there was a delay with Resident #2 receiving pantoprazole in May 2024. -She expected medications to be available for administration to the residents. Attempted telephone interviews with Resident #2's responsible party on 07/09/24 at 4:27pm, on 07/10/24 at 2:53pm and 4:27pm and on 07/11/24 at 9:34am and at 10:39am were unsuccessful. Interview with Resident #2's PCP on 07/12/24 at 12:37pm revealed: -She prescribed pantoprazole for Resident #2 as a precaution since she was on a blood thinner.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 -She was not too concerned that Resident #2 did not receive the pantoprazole for 10 days, but 10 days was an excessive amount of time for a new order to be initiated. b. Review of Resident #2's signed physicians order sheet dated 08/24/23 revealed there was an order for lorazepam (lorazepam is used to treat anxiety) 0.5mg, take one tablet twice daily. Review of the May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for lorazepam 0.5mg, take one tablet twice per day at 8:00am and 8:00pm. -Lorazepam 0.5mg was documented as administered at 8:00am 05/01/24 through 05/11/24 and at 8:00pm 05/01/24 through 05/10/24. -Resident #2 was documented as being out of the facility on leave on 05/11/24 through 05/17/24. -Lorazepam 0.5mg was documented as administered at 8:00pm on 05/17/24 and at 8:00am on 05/18/24. -Lorazepam 0.5mg was documented as not administered at 8:00pm on 05/18/24 through 05/25/24 with the exception documented as on hold. -Lorazepam 0.5mg was documented as not administered at 8:00am on 05/19/24 through 05/24/24 with the exception noted as "on hold". -Lorazepam 0.5mg was documented as not administered at 8:00am on 05/25/24 with the exception documented as "meds has not come in". -Lorazepam 0.5mg was documented as not administered at 8:00pm on 05/25/24 at 8:00pm and 05/26/24 at 8:00am with the exception documented as "on hold". -Lorazepam 0.5mg was documented as administered at 8:00am on 05/27/24 through	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 05/31/24. -Lorazepam 0.5mg was documented as administered at 8:00pm on 05/26/24 through 05/31/24. Review of Resident #2's May 2024 electronic controlled substance record (CSR) revealed: -One tablet of lorazepam 0.5mg was administered at 8:00pm on 05/18/24 and the remaining balance was zero. -60 tablets of lorazepam 0.5mg were documented as received on 05/26/24 at 9:55am. Interview with Resident #2 on 07/11/24 at 11:02am revealed: -She used the facility's contracted pharmacy for some of her medications. -Her responsible party ordered the majority of her medications through a mail order pharmacy. -She thought about a year ago there was an issue with getting all her medications but that had been straightened out. -In the past, the facility had run out of some of her medications, but she thought it had been awhile. Observation of Resident #2's medication on hand on 07/11/24 at 12:56pm revealed there was a bottle of lorazepam 0.5mg dispensed from a mail order pharmacy for a quantity of 60 tablets with a dispense date of 04/02/24 with 27 tablets remaining. Review of Resident #2's July 2024 electronic CSR revealed there were 27 lorazepam 0.5mg tablets remaining after her 07/11/24 dose was administered at 9:03am. Telephone interview with a representative from the facility's contracted pharmacy on 07/12/24 at 9:27am revealed lorazepam 0.5mg was last	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 dispensed for Resident #2 on 05/25/24 for a quantity of 60 tablets for a 30-day supply. Attempted telephone interview with Resident #2's preferred mail order pharmacy on 07/12/24 at 9:55am was unsuccessful. Interview with the medication aide (MA) on 07/11/24 at 12:50pm revealed: -The MAs were responsible for requesting medication refills for the residents. -Resident #2 received some of her medications from the facility's contracted pharmacy. -Resident #2's responsible party (RP) provided the majority of Resident #2's medication via a mail order pharmacy. -Medication refills were to be requested when there was a seven-day supply remaining. -She was not sure why Resident #2 ran out of her lorazepam in May 2024. -She was not sure why the current bottle of lorazepam 0.5mg dated 04/02/24 was not used previously unless her RP did not provide it to the facility until later. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 4:15pm revealed: -She started in the RCC potion for the Assisted Living (AL) just over a month ago. -The MAs were responsible for ordering medication refills for the residents. -Medication refills were requested when there were 7 days of medication remaining to avoid being without. -She thought all of Resident #2's medications except for the lorazepam were provided by her RP from a mail order pharmacy but she wasn't certain. -She was not sure why Resident #2 was out of lorazepam for 7 days in May 2024.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 Interview with the Administrator on 07/12/24 at 5:33pm revealed: -If the facility had a delay or difficulty receiving a resident's medication, they should contact the pharmacy. -The MAs were responsible for conducting cart audits. -Cart audits should be conducted every night on 3rd shift. -Carts audits were conducted to make sure all eMAR medications were on the cart, to check expiration dates, to make sure medications were labeled correctly and easy to read, and to check the cleanliness and organization of the cart. -The RCC was responsible for conducting a cart audit 2 times a week. -She was unsure if cart audits were being performed as she had just started at the facility. -She had just started in the Administrator position at the facility this week and did not know why there was a delay with Resident #2 receiving her lorazepam refill in May 2024. -She expected medications to be available for administration to the residents. Interview with Resident #2's primary care provider (PCP) on 07/12/24 at 12:37pm revealed: -Resident #2 received lorazepam for anxiety. -Being without the lorazepam for more than a day or two could cause increased anxiety in the resident. -She expected the residents' medications to be available and administered as ordered. Attempted telephone interviews with Resident #2's responsible party on 07/09/24 at 4:27pm, on 07/10/24 at 2:53pm and 4:27pm and on 07/11/24 at 9:34am and at 10:39am were unsuccessful	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 3. Review of Resident #1's current FL-2 dated 04/0624 revealed diagnoses included dementia, memory loss, history of falls and multiple joint pain. Telephone interview with the facility's contracted Pharmacist on 07/12/24 at 9:24am revealed: -Fluticasone propionate was prescribed for nasal allergies. -The current pharmacy location recently took over the prescriptions from another location. -The original prescription date for the fluticasone propionate was 05/12/22. -There were 3 different fluticasone prescriptions that were linked after the transfer and have an original date of 05/12/24. -A refill for fluticasone propionate was filled 07/12/24. -Prior to 07/12/24, fluticasone propionate was last dispensed on 07/12/23. -A bottle of fluticasone propionate should have only lasted 60 days at the most because there were 120 sprays in each bottle. -She would not be concerned with Resident #1 not taking the fluticasone propionate daily because the medication was sometimes prescribed as needed. -The effects of not taking fluticasone propionate daily depended on the type of allergies and time of year. -The primary care physician (PCP) needed to amend the order because Resident #1 was not taking the medication daily. Review of Physician's orders dated 06/28/24 revealed: -Diagnoses included dementia, psychotic disturbance, mood disturbance, anxiety, pain in joint and other amnesia.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 -There was an order for fluticasone propionate nasal spray 50mcg, 1 spray in each nostril once daily. (Fluticasone propionate is used to treat nasal allergies.) Review of Resident #1's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fluticasone propionate scheduled to be administered 1 spray in each nostril once daily at 8:00am. -Fluticasone propionate was documented as administered from 05/01/24 through 05/31/24. Review of Resident #1's June 2024 eMAR revealed: -There was an entry for fluticasone propionate scheduled to be administered 1 spray in each nostril once daily at 8:00am. -Fluticasone propionate was documented as administered from 06/01/24 through 06/30/24. Review of Resident #1's July 2024 eMAR revealed: -There was an entry for fluticasone propionate scheduled to be administered 1 spray in each nostril once daily at 8:00am. -Fluticasone propionate was documented as administered from 07/01/24 through 07/05/24 and 07/08/24 through 07/11/24. -Fluticasone propionate was documented as "refused" on 07/06/24 and 07/07/24. Observation of medications on hand on 07/11/24 at 4:35pm revealed: -There was a bottle of fluticasone propionate 50mcg on the medication cart that was dispensed on 07/12/23. -The bottle on the cart with the dispense date of 07/12/23 still had medication left in it.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 Interview with the medication aide (MA) on 07/10/24 at 11:45am revealed: -MAs were responsible for ordering medications that are not narcotics. -Cart audits were done daily, except on Friday, by the MA that was on the cart. -Three residents' medications were audited per day. -When a cart audit was conducted, the MA checked to see if all medications were there, if any medications were expired and if any medications needed to be reordered. -The results of the cart audits were written out and submitted to the Resident Care Coordinator (RCC). Interview with the RCC on 07/10/24 at 12:15pm revealed: -The MA and RCC were responsible for making sure medications were on the cart. -Cart audits started when she became the RCC for the assisted living (AL) side at the beginning of June 2024. -Cart audits were performed daily by a schedule that was broken down into days, shifts and room numbers. -The purpose of the cart audit was to see how many medications were left, if any medications were expired and if medications needed to be reordered. -Cart audit results were written down by the MA. -The RCC reviewed the cart audit results daily. -After she reviewed the cart audit results, she checked the physician's order sheet and signed off on the cart audit results sheet. -The RCC conducted a cart audit once weekly to check for loose pills and expired medication. -She was not sure when cart audits were conducted prior to her becoming the RCC of AL in	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 43 June 2024. Interview with a MA on 07/11/24 at 4:35pm revealed: -There were no other bottles of fluticasone propionate for Resident #1 on the medication cart or in the medication room. -She was unsure why the bottle of fluticasone propionate on the cart was from 07/12/23. Interview with a MA on 07/12/24 at 1:50pm revealed: -She had been an MA at the facility since January 2024. -She worked on the AL side about 4 times a month. -Resident #1 did refuse the fluticasone propionate sometimes but the medication was administered when it was not refused. -She did not recall the last time Resident #1 refused the fluticasone propionate or how many times the medication was refused. -She was unsure why the bottle of fluticasone propionate on the cart was from 07/12/23. -Cart audits were just implemented 2 weeks ago. -All MAs were responsible for conducting cart audits. -She had not done a cart audit for Resident #1 because Resident #1 was not on her assigned hall. Interview with the PCP on 07/12/24 at 10:47am revealed: -Fluticasone propionate was prescribed to Resident #1 for allergies and scheduled for 1 spray in each nostril daily. -She was not sure how long the bottle of fluticasone propionate from 07/12/23 should have lasted, but the bottle should not have lasted a year.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 44 -The fluticasone propionate was not administered daily if the medication was last dispensed on 07/12/23. -The fluticasone propionate should have been administered as prescribed. -The concern with the medication not being administered daily was that Resident #1's allergies would not be treated appropriately. -If Resident #1 complained of allergy symptoms, she would have been led to believe that the medication was ineffective. -She had seen Resident #1 three times in the last 3 months. -Resident #1 had not complained of any allergy symptoms. -She was not aware the fluticasone propionate was not being administered. -If she had known the fluticasone was not being administered as ordered, she would have talked to the MA about administration of the medication and discussed any issues with administration of the medication. Interview with the RCC on 07/12/24 at 2:24pm revealed: -She transitioned to the AL RCC position in June 2024. -She was not aware that the fluticasone propionate on the medication cart for Resident #1 was dated as dispensed on 07/12/23. -She was not aware the fluticasone propionate had not been filled since 07/12/23. -The fluticasone propionate had not been given daily as ordered if the bottle on the cart was 1 year old. -The MA was responsible for ordering medications when a refill was needed. Interview with the Administrator on 07/12/24 at 5:35pm revealed:	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 45 -She became the Administrator on 07/08/24. -She was not aware that the fluticasone propionate on the medication cart for Resident #1 was dated as dispensed on 07/12/24. -Resident #1 was not administered the fluticasone propionate daily because a bottle from 07/12/23 would not have lasted a year. -The MA was responsible for ordering medication because they knew when medications were running low. -If the MA had difficulty ordering medication, they were to notify the RCC. -The MA was responsible for conducting cart audits. -Cart audits should be conducted every night on 3rd shift. -Carts audits were conducted to make sure all eMAR medications were on the cart, to check expiration dates, to make sure medications were labeled correctly and easy to read, and to check the cleanliness and organization of the cart. -The RCC is responsible for conducting a cart audit 2 times a week. -She was unsure if cart audits were being conducted because she was not employed by the facility prior to 07/08/24. -The fluticasone propionate should have been ordered when it was low and 7 days before the expiration date. Telephone interview with Resident #1's family member on 07/10/24 at 5:00pm revealed Resident #1 was supposed to be administered a nasal spray daily, but she has never seen the resident receive the nasal spray. Based on observations, interviews, and record reviews it was determined that Resident #1 was not interviewable.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 387	Continued From page 46	D 387		
D 387	10A NCAC 13F .1007 (b) Medication Disposition 10A NCAC 13F .1007 Medication Disposition (b) Medications, excluding controlled medications that are expired, discontinued, prescribed for a deceased resident or deteriorated shall be stored separately from actively used medications until disposed of. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure an expired medication was destroyed at the facility or returned to the pharmacy within 90 days of the expiration date for 1 of 5 sampled residents (#2). The findings are: Review of Resident #2's current FL-2 dated 08/24/23 revealed diagnoses included hypertension, hyperlipidemia, atrial fibrillation, coronary artery disease, history of breast cancer, recurrent urinary tract infections and history of squamous cell skin cancer. Review of Resident #2's physician's orders dated 08/24/23 revealed there was an order for fenofibrate (fenofibrate is used to treat elevated cholesterol and triglycerides) 54mg, take one tablet at bedtime. Review of Resident #2's May 2024 electronic medication administration record (eMAR) revealed: -There was an entry for fenofibrate 54mg, take 1 tablet at bedtime, scheduled at 8:00pm.	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 387	Continued From page 47 -There was documentation that fenofibrate was administered at 8:00pm on 05/01/24 through 05/10/24 and at 8:00pm on 05/17/24 through 05/31/24. -There was documentation that fenofibrate 54mg was not administered 05/11/24 through 05/16/24 with the exception documented as out of the facility on leave. Review of Resident #2's June 2024 eMAR revealed: -There was an entry for fenofibrate 54mg, take one tablet at bedtime, scheduled for 8:00pm. -There was documentation that fenofibrate 54mg was administered at 8:00pm on 06/01/24 through 06/30/24. Review of Resident #2's July 2024 eMAR revealed: -There was an entry for fenofibrate 54mg, take one tablet at bedtime, scheduled for 8:00pm. -There was documentation that fenofibrate 54mg was administered at 8:00pm on 07/01/24 through 07/10/24. Observation of Resident #2's medications on hand on 07/11/24 at 12:10pm revealed: -There was a bottle of fenofibrate 54mg dispensed from the resident's mail order pharmacy dated 04/07/23 for a quantity of 90 tablets with a use by date of 03/27/24. -There were 3 additional bottles of fenofibrate 54mg dispensed from Resident #2's mail order pharmacy dated 10/25/23, 01/02/24 and 05/28/24 each for a quantity of 90. Telephone interview with a representative from the facility's contracted pharmacy on 07/12/24 at 9:17am revealed: -There was an active order for Resident #2 for	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 387	Continued From page 48 fenofibrate 54mg, take one tablet at bedtime. -Fenofibrate 54mg had never been dispensed by from the contracted pharmacy for Resident #2. Attempted telephone interview with Resident #2's preferred mail order pharmacy on 07/12/24 at 9:55am was unsuccessful. Interview with the medication aide (MA) on 07/11/24 at 12:15pm revealed: -She did not know why Resident #2 had 4 bottles of fenofibrate 54mg on the medication cart. -Resident #2's responsible party provided the fenofibrate from a mail order pharmacy. -She was not sure which bottle of fenofibrate was used to administer to Resident #2. -The MAs did medication cart audits weekly to make sure medications were available and to check expiration dates. -She was not sure why she or the other MAs had not noticed the expiration date on the bottle of fenofibrate 54mg. -She removed the expired bottle of fenofibrate from the medication cart. Attempted telephone interviews with Resident #2's responsible party on 07/09/24 at 4:27pm, on 07/10/24 at 2:53pm and 4:27pm and on 07/11/24 at 9:34am and at 10:39am were unsuccessful. Interview of the Resident Care Coordinator (RCC) on 07/12/24 at 04:15pm revealed: -The MA and RCC were responsible for making sure medications were on the cart. -Medication cart audits started when she became the RCC for the assisted living (AL) side at the beginning of June 2024. -Medication cart audits were done daily, the MAs performed audits on 3 residents per shift. -Medication cart audits consisted of checking to	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 387	Continued From page 49 make sure medications were available for the residents, requesting refills if needed, checking for expired medications, cleaning and organizing the medication cart. -She reviewed the medication cart audit results daily. -After she reviewed the medication cart audit results, she checked the physician's order sheet and signed off on the medication cart audit results sheet. -She conducted a medication cart audit once weekly to check for loose pills and expired medication. -She was not sure when medication cart audits were conducted prior to her becoming the RCC of AL in June 2024. -Resident #2 should not have expired medications on the medication cart. Interview with the Administrator on 07/12/24 at 5:33pm revealed: -She became the Administrator on 07/08/24. -She was not aware that Resident #2 had expired medication on the medication cart. -The MA was responsible for conducting cart audits. -Cart audits should be conducted every night on the third shift. -Carts audits were conducted to make sure all eMAR medications were on the cart, to check expiration dates, to make sure medications were labeled correctly and easy to read, and to check the cleanliness and organization of the cart. -The RCC was responsible for conducting a cart audit 2 times a week. -She was unsure if cart audits were being conducted because she was not employed by the facility prior to 07/08/24. -There should not be expired medications on the medication cart.	D 387		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	10A NCAC 13F .1008 (g) Controlled Substance 10A NCAC 13F .1008 Controlled Substance (g) A dose of a controlled substance accidentally contaminated or not administered shall be destroyed at the facility. The destruction shall be conducted so that no person can use, administer, sell, or give away the controlled substance. The destruction shall be documented on the medication administration record (MAR) or the controlled substance record showing the time, date, quantity, manner of destruction, and the initials or signature of the person destroying the substance. This Rule is not met as evidenced by: Based on interviews, and record reviews, the facility failed to ensure a controlled substance not administered was destroyed and documented on the medication administration record or controlled substance record reflected the reason for destruction and the manner of destruction for 1 of 6 residents (#6) sampled who had orders for a controlled substance used to treat moderate to severe pain. The findings are: Review of Resident #6's current FL-2 dated 09/07/23 revealed diagnoses included cerebrovascular accident, hypertensive heart disease, thoracic compression fracture, fatigue, vitamin B12 deficiency, and failure to thrive. Review of Resident #6's nursing progress notes revealed she was discharged from the facility on 06/06/24.	D 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	Continued From page 51 All oxycodone orders since 04/01/24 were requested on 07/12/24 at 8:35am were not provided. Interview with the hospice case manager on 07/11/24 at 5:02pm revealed: -Resident #6 was admitted to hospice services on 04/02/24 for a diagnosis of hypertensive heart disease. -Oxycodone solution 5mg/5ml, give 5mls every 4 hours as needed was ordered for Resident #6 on 04/02/24. -Sometimes the hospice nurse ordered oxycodone solution through the hospice mail order pharmacy. -The oxycodone suspension came from the hospice mail order pharmacy in a bottle. -Many facilities would not use the oxycodone solution in multi-dose bottles and wanted pre-filled syringes. -She could not access Resident #6's oxycodone dispensing records since the resident had been discharged from hospice services. Attempted telephone interview with the hospice pharmacy provider for Resident #6 on 07/12/24 at 9:42am was unsuccessful. Telephone interview with a representative from the facility's back up pharmacy on 07/11/24 at 4:48pm revealed: -Oxycodone solution 5mg/5ml was dispensed on 04/30/24 for 90ml for a 4- day supply to take 5mls every 4 hours as needed. -Oxycodone solution 5mg/5ml was dispensed on 05/25/24 for 120ml for an eight-day supply to take 5ml three times per day on a scheduled basis. Telephone interview with a representative with the facility's contracted pharmacy provider on	D 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	Continued From page 52 07/11/24 at 4:03pm revealed: -An order was received on 04/05/24 for Resident #6, for oxycodone solution 5mg/5ml, take 5ml every four hours as needed for shortness of breath. -The order was profiled initially. -Oxycodone solution 5mg/5ml was dispensed for Resident #6 on 04/29/24 for 60ml (12 syringes) for a 2-day supply of oxycodone 5mg/ml every 4 hours as needed. -A new order was received on 05/05/24 for Resident #6 for oxycodone solution 5mg/5ml to take 5ml three times per day on a scheduled basis. -Oxycodone solution 5mg/5ml was dispensed for Resident #6 on 5/26/24 for 30ml (6 syringes) for a 1-day supply of oxycodone 5mg/5ml every 4 hours as needed. -Oxycodone solution 5mg/5ml was dispensed for Resident #6 on 05/30/24 for 75mls (15 syringes) for a 5-day supply of oxycodone 5mg/5ml on a scheduled basis three times per day. -Oxycodone solution 5mg/5ml was dispensed for Resident #6 on 06/01/24 for 60mls (12 syringes) for a 2 supply of oxycodone 5mg/5ml every 4 hours as needed. Review of Resident #6's April 2024 electronic controlled substance record (CSR) revealed: -On 04/27/24 at 11:17pm oxycodone 5mls was documented as wasted. -The reason was listed as "other". -The comment section was blank. -One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of how the medication was wasted. Review of Resident #6's May 2024 electronic CSR revealed:	D 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	Continued From page 53 -On 05/05/24 at 11:29pm oxycodone 19mls was documented as wasted. -The reason was listed as "other". -The comment section was blank. -One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of how the medication was wasted. -On 05/15/24 at 1:00pm oxycodone 420mls was documented as wasted. -The reason was listed as "other". -The comment section was blank. -One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of the medication was wasted. -On 05/26/24 at 7:24pm oxycodone 5mg/5ml 12 syringes were documented as wasted. -The reason was listed as "other". -The comment section was blank. -One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of the medication was wasted. Review of Resident #6's June 2024 electronic CSR revealed: -On 06/02/24 at 10:25pm, oxycodone 5mg/ml 18 syringes were documented as wasted. -The reason was listed as "other". -The comment section was blank. -One MA documented the medication was wasted and a second MA documented as the verifier (witness) but there was no documentation of how the medication was wasted. Interview with a MA on 07/12/24 at 12:50pm revealed: -When a controlled medication was wasted, the CSR had to be completed to include the MA's	D 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	Continued From page 54 name, the name of the verifier or witness, the medication name, the quantity of medication and the reason why the medication was wasted. -She was not aware that the method of destruction was required on the CSR. Interview with the Resident Care Coordinator (RCC) on 07/12/24 at 3:59pm revealed: -The facility received oxycodone solution for Resident #6 in multi-dose bottles from the hospice mail order pharmacy. -Resident #6's responsible party (RP) brought in oxycodone solution in multi-dose bottles a couple times as well when they had trouble getting the pre-filled oxycodone syringes from the pharmacy. -She notified hospice and Resident #6's RP that the facility had to administer oxycodone solution in pre-filled syringes. -The oxycodone solution received in the multi-dose bottles were wasted into the 'pill buster' once the pre-filled syringes were received. -The oxycodone syringes were wasted in the "pill buster" when a new order was received. -When a controlled substance was wasted, the MAs documented the name of the medication, the quantity of medication, there must be a (verifier) witness, there must be a reason documented as to why the medication was wasted. -She was not aware that the method of destruction was required. -The electronic controlled substance log required a reason for the medication waste, that included a check box for resident refused, dropped medication, medication already prepped but was discontinued, prepped for wrong resident or other. -If "other" was selected, a comment box appeared, and a comment was required to be entered.	D 398		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 398	Continued From page 55 -The comment box did not show up on the printed controlled substance record (CSR). -She was not sure why the comment box did not show up on the printed CSR. Interview with the Administrator on 07/12/24 at 5:33pm revealed: -When controlled medications were wasted, the control substance log should include the date, the name of the medication, the quantity of medication, who wasted the medication, a witness or verifier, the reason the medication was wasted and how the medication was wasted. -She was not aware that the printed CSR did not reflect the reason the medication was wasted or how the medication was wasted. -She was not aware of a way to print the CSR that reflected the comment box.	D 398		
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 .0801 and .0802 of this Subchapter, the facility shall: (1) Within 30 days of admission to the special care unit and quarterly thereafter, develop a written resident profile containing assessment data that describes the resident's behavioral patterns, selfhelp abilities, level of daily living skills, special management needs, physical abilities and disabilities, and degree of cognitive impairment. (2) Develop or revise the resident's care plan required in Rule .0802 of this Subchapter based on the resident profile and specify programming that	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 464	Continued From page 56 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 review and interviews, the facility failed to ensure quarterly resident profiles to assess special care residents' needs were conducted for 1 of 1 sampled resident (#5). The findings are: Review of the Resident Register for Resident #5 dated 05/17/21 revealed: -The resident was admitted to the facility on 05/18/21. -The resident was forgetful and needed reminders. Review of Resident #5's FL-2 dated 02/08/23 revealed: -Diagnoses included dementia, senile degeneration of the brain, and cerebral infarction. -The resident was non-ambulatory, incontinent of bowel and bladder, and required total personal care assistance with bathing, feeding, and dressing. -The resident's level of orientation was documented as constantly disoriented. -The current level of care was documented as assisted living facility. -The recommended level of care was documented as special care unit (SCU). Review of Resident #5's record on 07/10/24 for SCU Profiles revealed: -The SCU Profile was dated 02/06/23. -There were no additional SCU Profile	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 464	Continued From page 57 assessments for Resident #5. -The resident required prompting with eating. -The resident required assistance with bathing, dressing, grooming, bowel and bladder, transferring, walking, and orientation. -The resident required the use of a wheelchair. Review of a SCU Profile for Resident #5 presented on 07/11/24 at 9:31am revealed: -There was a SCU Profile was dated 07/10/24 prepared by the previous Special Care Unit Coordinator (RCC). -The resident was assessed to require total care for feeding, toileting, mobility, transferring, bathing, dressing, and grooming and hygiene. -The resident's cognitive impairments were documented as profound loss. -The resident required use of a geri-chair. Review of a care plan for Resident #5 revealed: -The care plan was dated 06/21/23. -The resident had bilateral limited upper extremity strength. -The resident received hospice services. -There were no additional care plans for Resident #5. Observations of Resident #5 on 07/09/24 at 10:40am revealed: -The resident resided on the SCU of the facility. -The resident was asleep in a hospital bed. -There was a fall mattress on the floor next to the resident's bed. -There was a recliner geri-chair positioned next to the wall inside the resident's room. Interview with the Administrator on 07/10/24 at 4:25pm revealed: -There were no additional quarterly reviews. -The quarterly assessment profile document was	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 464	Continued From page 58 not available in the facility computer system. -She did not know why the quarterly profile document had not been loaded to the facility computer system for use. -The Resident Care Coordinator (RCC) was responsible to complete the quarterly assessments for residents in the SCU. Second interview with the Administrator on 07/11/24 at 9:30am revealed: -She looked in the facility computer system on 07/10/24 to find out how to do quarterly reviews and found out the document was not loaded to the facility computer system. -She had not reviewed any other records for SCU residents and did not know whether quarterly profiles had been completed on any of the SCU residents. -A quarterly assessment was completed on Resident #5 on 07/10/24. Interview with the RCC (previous Special Care Unit Coordinator(SCUC)) on 07/11/24 at 11:30am revealed: -She was responsible to complete yearly care plans and quarterly resident profiles. -She kept a tickler file system on her computer to keep up with due dates, including care plans and quarterly reviews. -She disabled her tickler system in error when she cleared a resident information who was no longer at the facility. -She missed completing resident care plans because her tickler was messed up. -She had never conducted a care plan meeting which was supposed to be done before a new care plan was completed. -She knew quarterly assessments were supposed to be completed because she was trained by another SCUC who mentioned to her that the	D 464		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 464	Continued From page 59 quarterly assessments were supposed to be completed. -She thought she remembered seeing the quarterly assessment document on her computer system but could not remember a timeframe for when see saw the quarterly assessment document. -She was responsible to complete the quarterly assessments as the SCUC.	D 464		
D 611	10A NCAC 13F .1801(b) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (b) The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following: (1) Standard and transmission-based precautions, including: (A) respiratory hygiene and cough etiquette; (B) environmental cleaning and disinfection; (C) reprocessing and disinfection of reusable resident medical equipment; (D) hand hygiene; (E) accessibility and proper use of personal protective equipment (PPE); and (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions; (2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 60 Section; (3) Measures for the facility to consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents, and visitors for signs of illness; and use of source control as tolerated by the residents; and (4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides (MA), observed during the 8:00am medication pass on 07/10/24, who did not sanitize or wash her hands between the preparation and administration of multiple oral medications to residents, and did not don gloves to perform a fingerstick blood sugar on a resident, and failed to notify the local health department and to post signage pertaining to a covid outbreak in the Special Care unit, to provide a safe and sanitary environment for residents and	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 61 to prevent the transmission of disease and infection The findings are: 1. Review of the facility's hand hygiene policy dated September 2021 revealed: -Hand hygiene can be obtained by proper handwashing and/or use of alcohol-based hand rub. -Hand hygiene will be used to aid in the prevention and spread/transmission of infections. -Staff were to follow proper hand hygiene procedures. -According to the Centers for Disease Control and Prevention, washing hands with soap and water is the best way to reduce the number of microbes on them in most situations. -Caregivers must always wash their hands when assisting a resident , including, before and after resident contact involving personal care, before assisting with medications, and after any contact with any body fluids. Observation of a medication aide (MA) administering medications in the assisted living (AL) hall during the 8:00am medication pass on 07/10/24 from 7:22am through 7:40am revealed: -There was a bottle of hand sanitizer on the medication cart located on the 100 hall of the AL. -The MA did not sanitize or wash her hands prior to preparing medications for a resident. -The MA prepared and administered oral medications to a resident at 7:26am and performed a fingerstick blood sugar (FSBS) on the same resident at 7:27am without donning gloves or washing her hands before or after performing the FSBS. -The MA returned to the medication cart and used her hands to enter documentation into the	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 62 computer system and unlocked the medication cart and did not sanitize or wash her hands. -The MA did not clean the glucometer before returning it to the resident's labled box on the medication cart. -The MA prepared and administered medications to a second resident and performed a blood sugar check via a hand-held scanning device on the resident's upper right arm at 7:33am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA unlocked the medication cart and prepared and administered oral medications to a third resident at 7:37am. -The MA returned to the medication cart and used her hands to enter documentation into the computer system. -The MA did not sanitize or wash her hands. -The MA began preparing medications for the next resident at 7:40am. Interview with the MA on 07/10/24 at 12:23pm revealed: -She used hand sanitizer or washed her hands before and after she administered medications to each resident. -She used gloves to administer eye drops, ear drops, nasal sprays, topical medications, insulin injections and finger stick blood sugars. -She did not realize she had not sanitized or washed her hands between administration of the residents' medications. -She did not realize she failed to use gloves or wash her hands before and after she performed the FSBS. -She was nervous during the medication pass and forgot to sanitize her hands and use gloves. -Good hand hygiene and the use of gloves were	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 63 important to prevent the spread of germs and infection. Interview with Resident Care Coordinator (RCC) on 07/10/24 at 1:13pm revealed: -MAs should use hand sanitizer or wash their hands after administering medication to each resident. -Gloves should always be used for the application of topical medications, administration of eye drops, ear drops, insulin injections and FSBS. -She had just started in the RCC role a little over a month ago. -She was not sure how the MAs were trained as far as hand hygiene and infection control. -The MAs were expected to use good hand hygiene and gloves to prevent the spread of germs and contamination. Interview with the Administrator on 07/10/24 at 1:18pm revealed: -MAs should wash their hands prior to starting the medication pass. -MAs should perform hand hygiene, using hand sanitizer between each resident when preparing and administering medications. -Gloves were used to administer eye drops, ear drops, topical creams and ointments, insulin injections, and FSBS. -Hand hygiene was reviewed during employee orientation, training and periodic in-services. -Infection control in-services were held during employee orientation, MA training and annually. -MAs were expected to use good hand hygiene and gloves during the medication pass. -Not performing hand hygiene could spread infection or contaminate resident medications. 2. Observations of the facility on 07/09/24 at 8:45am revealed there was no signage on the	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 64 entrance door regarding mask use. Observations inside the facility front door entrance on 07/09/24 at 8:45am revealed a box of face mask on a table. Interview with the Administrator on 07/09/24 at 8:51am revealed: -There were four residents residing in the special care unit (SCU) who had been diagnosed with COVID (an upper respiratory infection). -There were three staff who worked on the SCU that were out of the facility who reported having COVID. Telephone interview with a nurse at the local Health Department on 07/09/24 at 9:20am revealed: -A facility was considered in COVID outbreak status if there were two or more cases of the COVID virus. -She had not received any report from the facility regarding residents or staff with reported COVID virus since January 2024. -The facility could report any COVID virus by calling or emailing the local Health Department. -The facility was supposed to post signage in the front of the facility of the outbreak of the COVID virus. -Usage of KN95 or N95 face mask would be the guidance for face covering to prevent spread of COVID. -It was recommended to try and keep staff isolated to the COVID area once staff worked in the area. -The recommendation for COVID testing of facility staff was once the staff entered a COVID area, the staff should be tested day 1, day 3, and day 5. -The facility would need to be free of positive	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 65 COVID test results for 14 days to be cleared of COVID outbreak status. Second interview with the Administrator on 07/09/24 at 9:45am revealed: -She was informed on 07/08/24 about positive COVID status at the facility. -There was one resident on the SCU who had tested positive for COVID. -There was one resident from the SCU who was currently hospitalized and tested positive for COVID at the hospital. -There were three staff on 07/08/24 and one staff on 07/07/24 who worked on the SCU that did not work due to reported COVID. -There had not been any mass staff or resident testing for COVID in the SCU or in the assisted living section of the facility. -She did not have enough staff to have separate staff for each section of the facility. -She did room to room visits on the SCU on 07/08/24 to make sure the residents were feeling okay. -She conducted room to room checks on the assisted living section residents on 07/09/24 to make sure the residents were feeling okay. -So far there were no residents in the assisted living section showing any symptoms of the COVID virus. The facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 MAs, observed during the 8:00am medication pass on 07/10/24, who did not sanitize or wash her hands between the preparation and administration of multiple oral medications to residents, and did not don gloves to perform a fingerstick blood sugar on a resident, and failed to notify the local health department and to post signage pertaining to a COVID	D 611		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	hal-051065	A. BUILDING: _____ B. WING _____	R-C 07/12/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF SMITHFIELD	200 KELLIE DRIVE SMITHFIELD, NC 27577

(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 611	Continued From page 66 outbreak in the Special Care unit put the residents at risk for transmission of disease and infection. This failure was detrimental to the health, safety and welfare of the residents which constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on July 30, 2024 for this violation. CORRECTION DATE FOR THIS TYBE B VIOLATION SHALL NOT EXCEED AUGUST 26, 2024	D 611		