STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 a follow-up survey and complaint investigation on 09/25/24-09/26/24. The complaint investigations were initiated by the Johnston County Department of Social Services on 09/17/2024.	D 000		
D 117	0A NCAC 13F .0311 (h) Other Requirements 0A NCAC 13F .0311 Other Requirements (h) In facilities licensed for 7-12 residents, an electrically operated call system shall be provided connecting each resident bedroom to the live-in staff bedroom. The resident call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of the resident lying on the bed. This Rule is not met as evidenced by: Based on observations and interviews the facility failed to ensure that a resident's electrically operated call bell in their room could be activated with a single action and remain on until deactivated by staff at the point of origin and be within reach of the resident's bed (#7). The findings are: Review of Resident # 7's FL-2 dated 08/22/24 revealed: -Diagnoses included generalized weakness, urinary tract infections, risk of falls, hypertension, right hip replacement, insomnia, high cholesterol, hyperthyroidism, diabetes, and gastroesophageal reflux disease. -She was semi-ambulatory and orientation was	D 117		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 117	Continued From page 1	D 117		

not documented.

Observation of Resident #7's room on 09/25/24 at 4:50pm revealed:
-There were multiple strings tied together from her bathroom call bell to her recliner.
-The call light outside of her room was hanging sideways and not attached to the wall.
-The call bell in her room was pushed by the surveyor and the call light outside of her room did not light up.
-Staff did not responded to her call bell located in her room.
-Resident #7 had to sit her recliner up, locate the call bell string and pulled the string 4 times before she was able to activate the call bell at 5:09pm.
-Staff responded to the call bell at 5:10pm.
-The call bell located on the wall outside of her room was blinking red.

Interview with Resident #7 on 09/25/24 at 4:45pm revealed:
-Her call bell in her room had been broken for over a month.
-Her family member tied several strings together from the call bell in her bathroom.
-She was not strong enough to pull the string to activate the call bell each time she needed help.
-She had to wait until someone came into her room or yell for help.

Interview with s personal care aide (PCA) on 09/25/24 at 5:15pm revealed:
-Resident # 7's call bell had been broken for a couple of months.
-The call light blinked red when it was activated from the bathroom.

Interview with a medication aide (MA) on 09/25/24 at 5:20pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 117	Continued From page 2	D 117		

-Resident #7's call bell had been broken for several months.
-There were strings tied to her bathroom call bell for Resident #7 to use to call for help.

Interview with the Resident Care Coordinator (RCC) on 09/25/24 at 10:00am revealed:
-Resident #7's call bell had been broken since sometime in August.
-The facility tied strings together to attach to the call bell in the resident's bathroom.
-The resident did not have any issue with being able to pull the call bell string.

Interview with the Administrator on 09/26/24 at 10:15am revealed:
-Resident #7's call bell had not worked since sometime in July.
-The Regional Director of Maintenance (RDM) was at the facility the day she was notified that the call bell was not working and they both went to the resident's room to check the call bell.
-The RDM was responsible for submitting the work order to have the contracted vendor fix the call bell.
-The vendor came to the facility and said they had to order a part but she was unsure of the date.
-She tied strings together to reach from the resident's bathroom to her recliner then the resident's family member added a string with a wooden piece on the end.
-Resident #7 did not have any difficulty using the string to call for help.
-The vendor came out yesterday (09/25/24) and repaired the call bell.

Interview with the RDM on 09/26/24 at 10:43am revealed:
-He was notified about Resident #7's call bell not working on 09/06/24.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 117	Continued From page 3 -He was onsite on 09/06/24 and evaluated the call bell, called the contracted vendor, and placed a work order. -He had called the vendor multiple times but could not remember the dates. -The contracted vendor had informed him that their work schedule was backed up. -He had placed 3 work orders for the call bell repair, 08/29/24, 09/06/24, and 09/25/24. -The Administrator would notify him when the repair had been completed or if it was not completed. -The Administrator called him yesterday (09/25/24) and notified him that the call bell had not been repaired and he submitted another work order. Telephone interview with Resident# 7's family member on 09/25/24 at 4:20pm revealed: -Resident #7's call bell had been broken since early August, was not sure of the date. -She had tied strings to her call bell in the bathroom so that she was able to call for help. -She had also contacted the RDM and the contracted vendor on 09/06/24 and 09/12/24 and the call bell had not been fixed.	D 117		
D 253	10A NCAC 13F .0801(a) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) An adult care home shall assure that an initial assessment of each resident is completed within 72 hours of admission using the Resident Register.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 253	Continued From page 4	D 253		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure an initial assessment was completed within 72 hours of admission using the Resident Register for 2 of 7 sampled residents (#1 and #2).

The findings are:

1. Review of Resident #1's current FL2 dated 06/24/24 revealed:
-Diagnoses included cellulitis of left lower limb, history of falls, hypothyroidism and congestive heart failure.
-She was ambulatory and no information on her orientation.

Review of Resident #1's Resident Register revealed:
-There was a resident face sheet with an admission date of 04/25/24.
-There were no signatures on the last page of the Resident Register.

Refer to the interview with the Special Care Coordinator (SCC) on 09/26/24 at 2:00pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/26/24 at 1:51pm.

Refer to the interview with the Administrator on 09/26/24 at 1:45pm.

2. Review of Resident #2's current FL2 dated 02/09/24 revealed:
-Diagnoses included lymphocytic colitis, senile dementia, hypothyroidism, hypokalemia,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 253	Continued From page 5	D 253		

hypomagnesemia, and osteoporosis.
-She was ambulatory and intermittently disoriented.

Review of Resident #2's Resident Register revealed:
-There was a resident face sheet with an admission date of 02/09/24.
-There were no signatures on the last page of the Resident Register.

Refer to the interview with the Special Care Coordinator (SCC) on 09/26/24 at 2:00pm.

Refer to the interview with the Resident Care Coordinator (RCC) on 09/26/24 at 1:51pm.

Refer to the interview with the Administrator on 09/26/24 at 1:45pm.

_____

Interview with the Special Care Coordinator (SCC) on 09/26/24 at 2:00pm revealed:
-She had only been in this facility as the SCC for about 2 weeks.
-She and the Resident Care Coordinator (RCC) and the administrator all completed the admission paperwork for the residents.
-The facility was working towards having only electronic records for the residents.
-There were times when documents were scanned that were not totally completed (without all required signatures and dates).

Interview with the Resident Care Coordinator (RCC) on 09/26/24 at 1:51pm revealed:
-She had worked as the SCC prior to becoming the RCC.
-She was currently helping to train the SCC in her role as she had only been in the SCC role for a couple of weeks now.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 253	Continued From page 6 -The facility was short on medication aides (MAs) so she and the SCC and the Administrator were all MAs, so they had been filling in to make sure the staffing was covered for MAs. -She knew there were times documents were electronically scanned into the computer system without being complete of all required information. Interview with the Administrator on 09/26/24 at 1:45pm revealed: -The SCC, RCC, and she were all responsible for completing admission paperwork for residents. -There had been a lot of staff changeover in the facility with promotions from within. -The SCC had only been in her role at the facility for 2 weeks and was being trained in her role by the RCC. -The RCC had been the SCC prior to moving in the role of the RCC. -All of them, (the administrator, RCC and SCC) had been filling in as MAs working on the floor administering medications to the residents, which had caused some of the residents' admission paperwork to have been overlooked and not completed. -The admission paperwork was normally completed and then scanned into the computer system. -The facility was going "paperless" and relying on electronic records. -Some of the documents were scanned into the system prior to making sure all the documents were completed with all required signatures and dates. -She was working, along side of the RCC and SCC, in order to audit the records to make sure everything was completed.	D 253		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 7	D 254		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure an initial assessment of each resident was completed within 30 days following admission and at least annually thereafter using an assessment instrument	D 254		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 8	D 254		

established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument for 2 of 5 sampled residents (#2, #4).

The findings are:

1. Review of Resident #2's current FL2 dated 02/09/24 revealed:
-Diagnoses included lymphocytic colitis, senile dementia, hypothyroidism, hypokalemia, hypomagnesemia, and osteoporosis.
-She was ambulatory and intermittently disoriented.

Review of Resident #2's Resident Register revealed:
-There was a resident face sheet with an admission date of 02/09/24.
-There were no signatures on the last page of the Resident Register.

Review of Resident #2's care plan dated as completed on 03/15/24 revealed:
-The document had been recorded by a previous staff member who was no longer at the facility.
-The resident's activities of daily living (ADLs) were bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating and were assessed as independent, supervision or set up, limited, extensive and total dependent.
-Her eating ADL was documented as independent.
-Her bathing ADL was documented as supervision or set up.
-Her dressing ADL was documented as supervision or set up.
-Her personal hygiene (grooming) ADL was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 9	D 254		

documented as supervision or set up.
-Her ambulation or locomotion ADL was not documented as to the level of care she required.
-Her transferring ADL was documented as supervision or set up.
-Her toileting ADL was documented as independent.
-There were no signatures by the facility representative nor the primary care provider.
-There were no dates indicated at the bottom of the document where the signatures would have been located.

Interview with the Special Care Coordinator (SCC) on 09/26/24 at 2:00pm revealed:
-She had only been in this facility as the SCC for about 2 weeks.
-She and the Resident Care Coordinator (RCC) and the administrator all completed the initial care plans for the residents and the primary care provider (PCP) would sign the document upon the next visit to the facility.
-Newly admitted residents would be placed on the PCPs list to be seen at the next weekly visit.
-The facility was working towards having only electronic records for the residents.
-There were times when documents were scanned that were not totally completed (without all required signatures and dates).

Interview with the Resident Care Coordinator (RCC) on 09/26/24 at 1:51pm revealed:
-She had worked as the SCC prior to becoming the RCC.
-She was currently helping to train the SCC in her role as she had only been in the SCC role for a couple of weeks now.
-Resident #2's care plan had been completed by a former staff member and should have been completed before being scanned into the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 10	D 254		

computer system.
-She knew there were times documents were electronically scanned into the computer system without being complete of all required information but she could not be sure what happened to Resident #2's care plan.

Interview with the Administrator on 09/26/24 at 1:45pm revealed:
-The SCC, RCC, and she were all responsible for completing care plans for residents.
-There had been a lot of staff changeover in the facility with promotions from within.
-The SCC had only been in her role at the facility for 2 weeks and was being trained in her role by the RCC.
-The RCC had been the SCC prior to moving in the role of the RCC.
-All of them, (the administrator, RCC and SCC) had been filling in as MAs working on the floor administering medications to the residents, which had caused some of the residents' admission paperwork to have been overlooked and not completed.
-The care plans were normally completed by one of them (Administrator, RCC or SCC) and then the resident would be scheduled to see the PCP.
-Once the PCP saw the resident and completed the care plan, it was scanned into the computer system.
-The facility was going "paperless" and relying on electronic records.
-Some of the documents were scanned into the system prior to making sure all the documents were completed with all required signatures and dates.
-She was working, along side of the RCC and SCC, in order to audit the records to make sure everything was completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 11	D 254		

2. Review of Resident #4's current FL-2 dated 01/16/24 revealed diagnoses included dementia, chronic obstructive pulmonary disease, gout, oxygen dependency, hypertension, fibromyalgia, systemic lupus erythematous, and anxiety.

Review of Resident #4's Resident Register revealed she was admitted to the Special Care Unit (SCU) on 01/16/24.

Review of Resident #4's record revealed there was no resident care plan.

Interview with the Resident Care Coordinator (RCC) on 09/26/24 at 1:51pm revealed:
-She had worked as the Special Care Coordinator (SCC) prior to becoming the RCC.
-She was currently helping to train the SCC in her role as she had only been in the SCC role for a couple of weeks now.
-Resident #4's resident care plan had been overlooked in the staff's transitioning from SCC to RCC.
-She knew there were times documents were electronically scanned into the computer system without being complete of all required information, but she could not be sure what happened to Resident #4's care plan.

Interview with the Administrator on 09/26/24 at 1:45pm revealed:
-The SCC, RCC, and she were all responsible for completing admission documents for residents.
-Residents admitted to the SCU would have their profile completed by the SCC or the Administrator within 30 days from their admission and a care plan completed accordingly.
-There had been a lot of staff changeover in the facility with promotions from within.
-The SCC had only been in her role at the facility

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 254	Continued From page 12 for 2 weeks and was being trained in her role by the RCC. -The RCC had been the SCC prior to moving in the role of the RCC. -All of them, (the administrator, RCC and SCC) had been filling in as MAs working on the floor administering medications to the residents, which had caused some of the residents' admission paperwork to have been overlooked and not completed. -The resident care plans were normally completed by one of them (Administrator or SCC) and then the resident would be scheduled to see the PCP to have their care plan completed and signed by the PCP. -The facility was going "paperless" and relying on electronic records. -Some of the documents were scanned into the system prior to making sure all the documents were completed with all required signatures and dates. -She was working, alongside the RCC and SCC, in order to audit the records to make sure everything was completed. Based on observations, interviews, and record reviews, it was determined Resident #4 was not interviewable.	D 254		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by:	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 338	Continued From page 13	D 338		

Based on interviews and record reviews, the facility failed to ensure residents were free from theft of personal property (#6, #7, and #8).

The findings are:

1. Review of Resident #6's FL-2 dated 09/25/24 revealed:
-Diagnoses included dementia, hypertension, depression, skin cancer, fibromyalgia, bladder cancer, and high cholesterol.
-She was intermittently disoriented.

Interview with Resident #6's family member on 09/25/24 at 9:30am revealed:
-She wanted to report that her mother was missing her cell phone, $35 in cash, and her driver's license.
-She was on her way to discuss the missing items with the Administrator.

Second interview with Resident #6's family member on 09/25/24 at 2:32pm revealed:
-Her family member had her cell phone on Monday evening because she talked with another family member every evening but that family member could not reach the resident on Tuesday evening.
-Resident #6 was also missing $35 dollars in cash and her driver's license.
-She did not have a place to lock up any valuables.
-She kept her purse between the bed and the nightstand.
-She reported the missing items first to a staff member and then to the Administrator on 09/25/24.

Interview with Resident #6 on 09/25/24 at 3:30pm revealed:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 338	Continued From page 14	D 338		

-She was missing her cell phone, $35 cash and her driver's license since yesterday (09/24/24).
-She kept her cell phone on the nightstand and her purse beside her bed.
-She reported it to a staff member but was unsure of their name.

Interview with the Administrator on 09/26/24 at 2:00pm revealed:
-Resident #6's family member reported on 09/25/24 that Resident #6 was missing her cell phone and $35 in cash.
-The Resident Care Coordinator (RCC) and herself searched Resident #6's room and was unable to locate the items.

2. Review of Resident #7's FL-2 dated 08/22/24 revealed:
-Diagnoses included generalized weakness, urinary tract infections, risk of falls, hypertension, right hip replacement, insomnia, high cholesterol, hyperthyroidism, diabetes, and gastroesophageal reflux disease.
-There was no documentation in regard to orientation.

Interview with Resident #7 on 09/25/24 at 2:55pm revealed she was missing $200 in cash since August 2024 and she reported it to the Administrator around the first of September 2024.

Interview with Resident #7's family member on 0925/24 at 4:20pm revealed:
-She had given Resident #7 $200 cash for her hair appointments.
-Resident #7 found the money missing on 09/03/24 when she went to get her hair permed.
-She spoke with the Administrator mid-September 2024 and was informed she did not know that this had happened.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 338	Continued From page 15	D 338		

-She did not have anywhere to lock her valuables or a way to lock her room.

Interview with the Administrator on 09/26/24 at 2:00pm revealed:
-She had been notified that Resident #7 was missing $200 in cash around the end of August by a family member but it had been a week since the money went missing that she was notified.
-The Resident Care Coordinator (RCC) and herself searched Resident #6's room and was unable to locate the items.

3. Review of Resident #8's FL-2 dated 05/13/24 revealed:
-Diagnoses included dementia, asthma, peripheral vascular disease, chronic pain, chronic kidney disease, chronic obstructive pulmonary disease, and coronary artery disease.
-She was intermittently disoriented.

Interview with Resident #8 on 09/26/24 at 8:45am revealed:
-She had two $50 bills that was in her closet that were missing.
-She had a cell phone that was missing.
-She told her family member and facility staff but she was unsure of their name.

Interview with Resident #8's family member on 09/26/24 at 9:00am revealed:
-Resident #8's cell phone went missing around 08/16/24.
-A family member reported that the cell phone was missing to someone in the Administrator's office around 08/16/24.
-The facility staff told the family member they would let them know if the cell phone was found.
-Resident #8 was missing two $50 bills that she had received but family was unsure of the date

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 338	Continued From page 16 but she had reported it to the previous Administrator. Interview with the Administrator on 09/2/24 at 2:00pm revealed: -Resident # 8's money went missing before she was the Administrator. -She was not informed that Resident #8's cell phone was missing.	D 338		
D 378	10A NCAC 13F .1006 (b) Medication Storage 10A NCAC 13F .1006 Medication Storage (b) All prescription and non-prescription medications stored by the facility, including those requiring refrigeration, shall be maintained under locked security except when under the direct physical supervision of staff in charge of medication administration. This Rule is not met as evidenced by: Based on observation and interviews the facility failed to ensure medications were stored securely as evidenced by 2 medications carts that were left unlocked and unattended. The findings are: Observation of medications carts on the assisted living (AL) side on 09/25/24 at 1:30pm revealed: -There were two unlocked medication carts sitting outside of resident rooms. -There was not a medication aide within site of the unlocked medication carts. -There was 3 visitors and 2 residents that walked by the 2 medication carts. -They were observed unlocked for 10 minutes	D 378		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 378	Continued From page 17 from 1:30pm-1:40pm. Interview with the Medication Aide (MA) on 09/25/24 at 1:45pm revealed: -He had forgot to lock the medication cart when he walked away. -He had been educated to lock the medication cart when not in attendance. Interview with a second MA on 09/25/24 at 2:15pm revealed: -She had forgot to lock her medication cart when she went to lunch. -She had been trained to lock the medication cart when unattended. Interview with the RCC on 09/25/24 revealed staff had been trained to lock the medication carts when they were not in attendance. Interview with the Administrator on 09/26/24 at 10:15am revealed: -The medication carts were to be kept locked when unattended. -The staff had been educated to keep the medication carts locked when unattended. -She was concerned that someone could remove medications from the medication carts.	D 378		
D 438	10A NCAC 13F .1205 Health Care Personnel Registry 10A NCAC 13F .1205 Health Care Personnel Registry The facility shall comply with G.S. 131E-256 and supporting Rules 10A NCAC 13O .0101 and .0102.	D 438		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 438	Continued From page 18	D 438		

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to complete a Health Care Personnel Registry (HCPR) 24- Hour Initial Report and a Five Working Day Investigative Report after the Administrator became aware that a resident's family member reported allegations of theft (#7).

The findings are:

Review of Resident #7's FL-2 dated 08/22/24 revealed:
-Diagnoses included generalized weakness, urinary tract infections, risk of falls, hypertension, right hip replacement, insomnia, high cholesterol, hyperthyroidism, diabetes, and gastroesophageal reflux disease.
-There was no documentation in regard to orientation.
Interview with Resident #7 on 09/25/24 revealed she was missing $200.00 in cash since August 2024 and she did report it to the Administrator around the first of September 2024.

Interview with Resident #7's family member on 0925/24 at 4:20pm revealed:
-She had given Resident #7 $200.00 cash for her hair appointments.
-Resident #7 found the money missing on 09/03/24 when she went to get her hair permed.
-She spoke with the Administrator mid-September 2024 and was informed she did not know that this had happened.
-She did not have any where to lock her valuables or a way to lock her room.

Interview with the Administrator on 09/26/24 at 2:00pm revealed:
-The Resident Care Coordinator (RCC) and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL051065	A. BUILDING: _____ B. WING _____	R-C 09/26/2024

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 438	Continued From page 19 herself searched Resident #7's room and was unable to locate the items. -She did not complete a 24-hour report or a 5-day report to Health Care Personnel Registry (HCPR). -She did not know that she was required to report missing personal property to HCPR.	D 438		