STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010013	A. BUILDING: _____ B. WING _____	R 04/02/2025

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THE LANDINGS OF OAK ISLAND	2910 PINE PLANTATION PARKWAY OAK ISLAND, NC 28461

(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 completed an annual and follow-up survey from 04/01/25 to 04/03/25.	D 000		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature	D 248		

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D 248	Continued From page 1	D 248		

confirming the review and receipt of information contained in the form.
The Resident Register is available on the internet website, https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record.

This Rule is not met as evidenced by:
Based on interviews and record reviews, the facility failed to ensure a Resident Register was completed within 72 hours of admission to the facility for 4 of 4 sampled residents (#2, #5, #6, and #7).

The findings are:

1. Review of Resident #2's current FL2 dated 8/20/24 revealed diagnoses included Dementia, hypothyroidism, prostate cancer, and osteoarthritis.

Review of Resident #2's Resident Register revealed he did not have an admission date.

Interview with the Administrator on 04/02/25 at 8:28am revealed he did not know that Resident #2's Resident Register did not have an admission date.

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D 248	Continued From page 2 Refer to interview with the Business Office Manager (BOM) on 04/02/25 at 8:17am. Refer to interview with the Administrator on 04/02/25 at 8:28am. 2. Review of Resident #5's current FL2 dated 03/25/25 revealed diagnosis included benign prostatic hyperplasia. Review of Resident #5's Resident Register revealed: -He did not have an admission date. -Resident #5's Resident Register had not been signed and dated by the responsible person. -Resident #5's Resident register had not been signed and dated by the Administrator or designee. Interview with the Administrator on 04/02/25 at 8:28am revealed: -He did not know that Resident #5's Resident Register did not have an admission date. -He did not know that Resident #5's Resident Register had not been signed and dated by the responsible person. -He did not know that Resident #5's Resident Register had not signed and dated by the Administrator or designee. Refer to interview with the Business Office Manager (BOM) on 04/02/25 at 8:17am. Refer to interview with the Administrator on 04/02/25 at 8:28am. 3. Review of Resident #6's current FL2 dated 10/18/24 revealed diagnoses included hypothyroidism, dementia, atrial fibrillation, and osteoarthritis.	D 248		

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D 248	Continued From page 3 Review of Resident #6's Resident Register revealed: -Resident #6's Resident Register had not been signed and dated by the responsible person. -Resident #6's Resident Register had not been signed and dated by the Administrator or designee. Interview with the Administrator on 04/02/25 at 8:28am revealed: -He did not know that Resident #6's Resident Register had not been signed and dated by the responsible person. -He did not know that Resident #6's Resident Register had not signed and dated by the Administrator or designee. Refer to interview with the Business Office Manager (BOM) on 04/02/25 at 8:17am. Refer to interview with the Administrator on 04/02/25 at 8:28am. 4. Review of Resident #7's current FL2 dated 08/06/24 revealed diagnoses included hypothyroidism, diabetes, gastroesophageal reflux disease, Alzheimer's, hypertensive retinopathy, arthritis, and epiretinal membranes of right eye. Review of Resident #7's Resident Register revealed: -She did not have an admission date. -Resident #7's Resident Register had not been signed and dated by the responsible person. -Resident #7's Resident Register had not been signed and dated by the Administrator or designee.	D 248		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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D 248	Continued From page 4 Interview with the Administrator on 04/02/25 at 8:28am revealed: -He did not know that Resident #7's Resident Register did not have an admission date. -He did not know that Resident #7's Resident Register had not been signed and dated by the responsible person. -He did not know that Resident #7's Resident Register had not signed and dated by the Administrator or designee. Refer to interview with the Business Office Manager (BOM) on 04/02/25 at 8:17am. Refer to interview with the Administrator on 04/02/25 at 8:28am. _____ Interview with the Business Office Manager (BOM) on 04/02/25 at 8:17am revealed: -She started working at the facility on 07/08/24. -The Administrator provided the Resident Register to the resident or Power of Attorney (POA) to complete. -The Administrator was responsible for ensuring that the Resident Register was completed. -She performed monthly resident chart audits to ensure that the records were complete. Interview with the Administrator on 04/02/25 at 8:28am revealed: -He started working at the facility on 04/29/24. -He was responsible for ensuring that the Resident Register was completed. -He was the only staff member that could sign the Resident Register. -He attended every contract and Resident Register signing. -When he was unable to attend the signing, he gave the BOM permission to sign the documents. -He reviewed the Resident Register before they	D 248		

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D 248	Continued From page 5 were submitted to the home office. -The BOM sometimes reviewed the Resident Register once they were signed. -He did not know that the Resident Register needed the admission date. -The facility did not have a process for ensuring that the Resident Register was complete.	D 248		
D 306	10A NCAC 13F .0904(d)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (d) Food Requirements in Adult Care Homes: (4) Water shall be served to each resident at each meal, in addition to other beverages. This Rule is not met as evidenced by: Based on observations and interviews, the facility failed to serve water to each resident in the Special Care Unit. The findings are: Observation of the breakfast meal in the Special Care Unit (SCU) on 04/02/25 between 8:15am and 9:00am revealed: -There were 17 residents in the dining room. -Seventeen residents were served orange juice only. -Staff did not offer the residents water. -There was no water served to the residents. Observation of a resident who left the dining room	D 306		

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D 306	Continued From page 6 after eating breakfast on 04/02/25 at 8:28am revealed the resident went to the medication cart, picked up a cup and attempted to pour water from the water pitcher located on top of the medication cart. Observation of the lunch meal in the SCU on 04/02/25 at 12:09pm revealed: -There were 18 residents in the dining room. -Eighteen residents were served a flavored beverage. -There was one resident with a ½ cup of water in the dining room that was obtained due to the resident taking medications before his meal. -Staff did not offer the other residents water. -There was no water served to the residents. Interview with the dietary aide on 04/02/25 at 1:34pm revealed she would normally put out a pitcher of water in the SCU during meals but forgot to do it today. Interview with the Administrator on 04/02/25 at 1:37pm revealed: -He was aware residents were to be served water at each meal. -He did not know why water was not served to the residents in the SCU during breakfast and lunch.	D 306		
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		

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D 338	Continued From page 7 Based on observations, interviews and record reviews, the facility failed to ensure 1 of 5 sampled residents (#3) was treated with consideration. Review of Resident #3's current FL-2 dated 02/27/25 revealed: -Diagnoses included hyperlipidemia, Alzheimer's, and hypervitaminosis. -She was intermittently disoriented. -She was ambulatory. Observation of the facility during the initial tour on 04/01/25 at 9:00am revealed resident #3 was exiting an empty room after using the bathroom in that room. Interview with Resident #3 on 04/01/25 at 9:00am revealed: -She had to use the bathroom in another room because her suite mate had "blew up their bathroom" and she couldn't use it because the suite mate was in there. -She wanted to move from her room or have her suite mate moved. -Her suite mate constantly left feces on the toilet or on the floor in the bathroom. -Her suite mate left dirty underwear containing feces in the bathroom on the grab rail. -She complained to the Administrator about her suite mate, and he said he would take care of it. Observation of Resident #3's room on 04/02/25 at 2:01pm revealed all of Resident #3's belongings were in her room. Second interview with Resident #3 on 04/02/25 at 2:01pm revealed she had not been moved to another room but she still wanted to move or have her suite mate moved.	D 338		

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D 338	Continued From page 8 Interview with the Administrator on 04/02/25 at 2:02pm revealed: -Resident #3 was moved from her room to another room last night. -He had not been to see Resident #3 today to follow up with her regarding the move. Interview with a medication aide (MA) on 04/02/25 at 2:11pm revealed: -He asked the Administrator yesterday, 04/01/25 if Resident #3 could be moved to another room because she complained about her suite mate. -He was told to check a specific room and determine if the air conditioning unit worked and to see if there was a bed in the room. -He found the AC unit worked and there was a bed in the room. -He gave the Administrator the update regarding the room and the Administrator said okay. Second interview with the Administrator on 04/02/25 at 2:03pm revealed: -There was no facility protocol regarding residents relocating from room to another. -Resident #3 mentioned to him last week about an incident with her suite mate leaving the bathroom nasty with feces and the smell. -Resident #3 asked him last week if she could be moved to another room. -Last week, he told Resident #3 there was a process, and the incident needed to happen again before the facility would move her. -He made the decision to move Resident #3 yesterday, 04/01/25 to another room and asked the MA on duty to move the resident.	D 338		
D 364	10A NCAC 13F .1004 (g) Medication Administration	D 364		

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D 364	Continued From page 9 10A NCAC 13F .1004 Medication Administration (g) The facility shall ensure that medications are administered to residents within one hour before or one hour after the prescribed or scheduled time unless precluded by emergency situations. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered within one hour before or after the scheduled times for 3 of 5 residents observed (#5, #6, and #7) including medications used to treat constipation and for urinary health (#5), used to treat high blood pressure (#6), and used to treat pain, diabetes, and Alzheimer's disease. (#7). The findings are: Review of the Medication Services/Pharmaceutical Care Services policy dated 09/24 revealed that medications may be given up to one hour before or one hour after the prescribed time unless the physician orders an exact time. 1. Review of Resident #5's current FL2 dated 03/25/25 revealed diagnosis included benign prostatic hyperplasia. Review of Resident #5's current physician order sheet dated 03/25/25 revealed: -There was an order for Azo Cranberry Plus Probiotics to be administered twice daily (Azo Cranberry with Probiotics is used for urinary tract health). -There was an order for Docusate Sodium 100mg to be administered twice daily (Docusate Sodium is used for treating constipation).	D 364		

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D 364	Continued From page 10 Observation of the medication aide (MA) on 04/01/25 at 9:25am revealed the MA walked into Resident #5's room and administered his morning medications. Review of Resident #5's April eMAR revealed: -There was an entry for Azo Cranberry with Probiotics scheduled at 8:00am and 8:00pm. -There was an entry for Docusate Sodium 100mg scheduled at 8:00am and 8:00pm. Refer to interview with the MA on 04/01/25 at 1:35pm. Refer to interview with the Memory Care Coordinator (MCC) on 04/01/25 at 2:18pm. Refer to interview with the Clinical Nurse Consultant (CNC) on 04/01/25 at 2:00pm. Refer to interview with the Administrator on 04/01/25 at 2:30pm. Attempted telephone interview with the primary care provider (PCP) on 04/02/25 at 11:30am was unsuccessful. 2. Review of Resident #6's current FL2 dated 10/18/24 revealed diagnoses included hypothyroidism, dementia, atrial fibrillation, and osteoarthritis. Review of Resident #5's current physician order sheet dated 10/18/25 revealed there was an order for Metoprolol Tartrate 25mg administer ½ tablet twice daily (Metoprolol Tartrate is used to treat high blood pressure). Observation of the MA on 04/01/25 at 9:43am	D 364		

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revealed the MA walked into Resident #6's room and administered her morning medications.

Review of Resident #6's April eMAR revealed there was an entry for Metoprolol Tartrate 25mg administer ½ tablet scheduled at 8:00am and 8:00pm.

Observation of the MA on 04/01/25 at 9:43am revealed the MA walked into Resident #6's room and administered her morning medications.

Refer to interview with the MA on 04/01/25 at 1:35pm.

Refer to interview with the Memory Care Coordinator (MCC) on 04/01/25 at 2:18pm.

Refer to interview with the Clinical Nurse Consultant (CNC) on 04/01/25 at 2:00pm.

Refer to interview with the Administrator on 04/01/25 at 2:30pm.

Attempted telephone interview with the primary care provider (PCP) on 04/02/25 at 11:30am was unsuccessful.

3. Review of Resident #7's current FL2 dated 08/06/24 revealed diagnoses included anxiety, diabetes, Alzheimer's, hypothyroidism, hypertensive retinopathy, arthritis, gastroesophageal reflux disease, and epiretinal membrane of right eye.

Review of Resident #7's current physician order sheet dated 04/01/25 revealed:
-There was an order for Lisinopril-hydrochlorothiazide 20-25mg to be administered twice daily

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(Lisinopril-hydrochlorothiazide is used to treat hypertension).
-There was an order for Memantine 10mg to be administered twice daily (Memantine is used to treat Alzheimer's disease).
-There was an order for Metformin 500mg to be administered twice daily (Metformin is used to treat diabetes).
-There was an order for Humulin 70/30 inject 30 units every morning and 10 units every evening (Humulin 70/30 is used to treat diabetes).
-There was an order for Diclofenac Sodium gel apply 2 grams to be administered four times daily (diclofenac gel is used to treat pain).

Observation of the MA on 04/01/25 at 9:55am revealed:
-The MA walked into Resident #7's room and administered Resident #7's morning medications, the oral medication was administered at 9:55am.
-She performed a fingerstick at 9:57am to obtain blood sugar level which was 147.
-She administered the Humulin 70/30 30 units SQ at 10:00am.

Review of Resident #7's April eMAR revealed:
-There was an entry for Lisinopril-hydrochlorothiazide 20-25mg scheduled at 8:30am and 8:30pm.
-There was an entry for Memantine 10mg scheduled at 8:30am and 8:30pm.
-There was an entry for Metformin 500mg scheduled at 8:30am and 8:00pm.
-There was an entry for Humulin 70/30 scheduled at 7:30am and 4:30pm.
-There was an entry for Diclofenac Sodium gel apply 2 grams scheduled at 8:30am, 12:30pm, 4:30pm, and 8:30pm.

Observation of the MA on 04/01/25 at 9:55am

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D 364	Continued From page 13 revealed: -The MA walked into Resident #7's room to administer Resident #7's morning medications, the oral medication was administered at 9:55am. -She performed a fingerstick at 9:57am to obtain blood sugar level which was 147. -She administered the Humulin 70/30 30 units SQ at 10:00am. Refer to interview with the MA on 04/01/25 at 1:35pm. Refer to interview with the Memory Care Coordinator (MCC) on 04/01/25 at 2:18pm. Refer to interview with the Clinical Nurse Consultant (CNC) on 04/01/25 at 2:00pm. Refer to interview with the Administrator on 04/01/25 at 2:30pm. Attempted telephone interview with the primary care provider (PCP) on 04/02/25 at 11:30am was unsuccessful. _____ Interview with the MA on 04/01/25 at 1:35pm revealed: -She had worked as an MA at the facility for three months. -She knew that she was late administering medications. -She had notified the Memory Care Coordinator (MCC) that she was late administering medications. -There was only one MA on the Assisted Living side of the facility. -She passed the morning medications and then went back and administered the gels. -She documented in their eMAR system that she had administered medications late.	D 364		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL010013	A. BUILDING: _____ B. WING _____	R 04/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LANDINGS OF OAK ISLAND	2910 PINE PLANTATION PARKWAY OAK ISLAND, NC 28461

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D 364	Continued From page 14 Interview with the MCC on 04/01/25 at 2:18pm revealed: -She had been in her role as MCC for six months. -She did not know that the morning medications were administered late. -It was concerning that the medications were passed late. -She was supposed to notify the PCP when medications were administered late. Interview with the Clinical Nurse Consultant (CNC) on 04/01/25 at 2:00pm revealed: -She did not know that the morning medications were administered late. -The PCP should be notified when medications were administered late. -The PCP should determine if the next dose of medication should be held or administered based on the time the medications were administered. -When medications were administered late it could affect the continuity of the medication. Interview with the Administrator on 04/01/25 at 2:30pm revealed: -He had been the Administrator at the facility for one year. -He did not know that the morning medications were administered late. -The MA or the MCC should notify the PCP that the morning medications were administered late. -He was concerned about the effect on the resident for medications administered late.	D 364		
D 406	10A NCAC 13F .1009 (b) Pharmaceutical Care 10A NCAC 13F .1009 Pharmaceutical Care (b) The facility shall assure action is taken as needed in response to the medication review and	D 406		

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D 406	Continued From page 15 documented, including that the physician or appropriate health professional has been informed of the findings when necessary. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure quarterly pharmacy review recommendations were reviewed by a resident's primary care provider (PCP) for 1 of 5 sampled residents (#1). The findings are: Review of Resident #1's current FL-2 dated 06/10/24 revealed: -Diagnoses included dementia with agitation and hypokalemia. -There were other diagnoses listed but they were not legible. Review of Resident #1's Resident Register revealed an admission date of 01/12/24. Review of Resident #1's quarterly pharmacy review on 12/10/24 revealed: -There was a repeated recommendation dated 09/2024 with no response. -There was a recommendation to evaluate the resident's current dose of Quetiapine tab 25mg, take ½ tablet twice daily and determine if the medication needed to be discontinued due to no valid diagnoses on file to support antipsychotic and provide a rationale if the medication was continued. (Quetiapine is an antipsychotic medication used to treat bipolar disorder, depression, and schizophrenia). -There was no documentation the primary care	D 406		

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D 406	Continued From page 16	D 406		

provider (PCP) had reviewed the pharmacy review.

Review of Resident #1's quarterly pharmacy review on 03/17/25 revealed:
-There were repeated recommendations dated 09/2024 and 12/2024 with no response.
-There was a recommendation to evaluate the resident's current dose of Quetiapine tab 25mg, take ½ tablet twice daily and determine if the medication needed to be discontinued due to no valid diagnoses on file to support antipsychotic and provide a rationale if the medication was continued.
-There was no documentation the PCP had reviewed the pharmacy review.

Review of Resident #1's printed record on 04/02/25 revealed:
-There was a request to the Memory Care Coordinator (MCC) on 04/02/25 at 8:00am to review documentation where Resident #3's PCP had been notified of pharmacy recommendations.
-The documentation to verify the pharmacy recommendations were sent for Resident #1 was never provided.

Interview with the MCC on 04/02/25 at 8:00am revealed:
-Resident #3 had an outside PCP.
-She was responsible to ensure the recommendations for the quarterly pharmacy reviews were reviewed by the PCP.
-She faxed Resident #3's pharmacy recommendations to his PCP but had not received a response.

Interview with the Administrator on 04/02/25 at 11:22am revealed:
-The pharmacy recommendations were emailed

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D 406	Continued From page 17 to him, the Director of Resident Care, and the MCC from the contracted pharmacy. -He was not aware Resident #3's pharmacy recommendations were not reviewed by his provider. -He had not been able to conduct chart audits. -He did not have any expectations for Resident #3's pharmacy recommendations to be completed because he used an outside PCP. -He needed to create a process to ensure pharmacy recommendations were reviewed when residents had an outside PCP. Based on observations, interviews, and record reviews it was determined Resident #1 was not interviewable. Attempted telephone interview with the facility's contracted pharmacy on 04/02/25 at 10:37am was unsuccessful. Attempted telephone interviews with Resident #1's PCP on 04/02/25 at 9:56 am and 11:38am were unsuccessful.	D 406		