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 11/24/2025

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 on 11/19/25 - 11/21/25 and 11/24/25.	{D 000}		
{D 113}	10A NCAC 13F .0311 (d) Other Requirements 10A NCAC 13F .0311 Other Requirements (d) The hot water system shall supply hot water to the kitchen, bathrooms, laundry, housekeeping closets, and soiled utility room. The hot water temperature at all fixtures used by residents shall be maintained at a minimum of 100 degrees F and shall not exceed 116 degrees F. Notwithstanding the requirements of Rule .0301 of this Section, the requirements of this Paragraph shall apply to new and existing facilities. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the hot water temperatures at 4 of 4 sampled fixtures accessible to residents in the special care unit (SCU), were maintained at a minimum of 100 degrees Fahrenheit (F) to a maximum of 116 degrees F with hot water temperatures ranging from 94 degrees F to 131 degrees F. The findings are: Review of the facility Environmental Health Inspection report dated 05/19/25 revealed there were 1.5 demerits listed for hot water temperature ranges of 95-103 degrees Fahrenheit (F) throughout the facility.	{D 113}		

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{D 113}	Continued From page 1 Review of the North Carolina Division of Health Service Regulation Construction Section Hot Water Safety Guide revealed: -A water temperature of 118.4 degrees F could result in a first degree in 15 minutes and a second degree burn in 20 minutes. -A water temperature of 127.4 degrees could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. Observations during the initial tour of the Special Care Unit (SCU) of the facility on 11/19/25 between 9:10am and 10:20am revealed: -At 9:35am, the hot water temperature was 96 degrees F at the sink in the day room. -At 10:02am, the hot water temperature was 116 degrees F at the bathroom sink in room 601. Observation of a personal care aide (PCA) on 11/19/25 at 9:35am revealed she placed her hand under the running water at the sink in the dayroom. Interview with the PCA in the SCU dayroom on 11/19/25 at 9:35am revealed: -She used the day room sink to wash her hands. -The temperature of the hot water felt as "hot as it gets". Observations of the sink fixture in the bathroom in room 601 of the facility SCU on 11/19/25 at 2:20pm revealed the hot water temperature was 123 degrees F. Interview with the Special Care Coordinator (SCC) on 11/19/25 at 2:26pm revealed: -She had not checked any hot water temperatures in the SCU. -The facility Maintenance Director performed	{D 113}		

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{D 113}	Continued From page 2	{D 113}		

water temperature checks.
-She was not sure how often water temperature checks were done.

Observations of the sink fixture in the bathroom in room 612 of the facility SCU on 11/19/25 between 2:30pm and 2:38pm revealed:
-At 2:30pm, the hot water temperature was 131 degrees F.
-At 2:38pm, the hot water temperature was 125 degrees F.

Interview with the resident in room 612 on 11/19/25 at 2:30pm revealed:
-She used the water fixture at the bathroom sink in room 612.
-Sometimes the water temperature was kind of hot when it was turned on for a while (no specific timeframe provided).

Observations of the sink fixture in the bathroom sink in room 501 of the facility SCU on 11/19/25 at 2:44pm revealed the hot water temperature was 120 degrees F.

Interview with the Administrator on 11/19/25 at 2:52pm revealed:
-He requested the facility Maintenance Director to perform hot water temperature checks in every room of the facility the morning of 11/19/25 and room 612 hot water temperature was reported at 107 degrees F.
-The Regional Maintenance Director (RMD) flushed the hot water tanks in the morning of 11/19/25 because there were low hot water temperature readings at some of the hot water temperature fixtures.
-The hot water temperature thermostats had not been adjusted.
-He did not know why there were some

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{D 113}	Continued From page 3 "super-hot" water temperatures now. Recheck of hot water temperatures, after calibration of thermometers, with the RMD and facility Maintenance Director on 11/19/25 from 3:17pm to 3:44pm revealed: -The hot water temperature at the bathroom sink in room 501 of the SCU was 95 degrees F with the surveyor thermometer, 96 degrees F with the facility Maintenance Director thermometer, and 96 degrees F with the RMD thermometer at 3:29pm. -The hot water temperature at the bathroom sink in room 601 of the SCU was 106 degrees F with the surveyor thermometer, 107 degrees F with the facility Maintenance Director thermometer, and 107 degrees F with the RMD thermometer at 3:29pm. -The hot water temperature at the bathroom sink in room 612 of the SCU was 94 degrees F with the surveyor thermometer, 94 degrees F with the facility Maintenance Director thermometer, and 94 degrees F with the RMD thermometer at 3:29pm. -The hot water temperature at the dayroom sink of the SCU was 97.8 degrees F with the surveyor thermometer, 98 degrees F with the facility Maintenance Director thermometer, and 98 degrees F with the RMD thermometer at 3:44pm. Review of the facility's weekly water temperature check log sheets revealed: -On 11/13/25, there were 14 documented water temperature check readings for fixtures accessible to residents, ranging from 100 degrees F to 116 degrees F. There were no specific fixtures identified. -On 11/15/25, there were 14 documented water temperature check readings for fixtures accessible to residents, ranging from 98 degrees	{D 113}		

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{D 113}	Continued From page 4 F to 120 degrees F, including room 612 at 120 degrees F and a second reading of 102 degrees F. There were no specific fixtures identified. Recheck of hot water temperatures with the RMD and facility Maintenance Director on 11/20/25 from 10:04am to 10:26am revealed: -The hot water temperature at the bathroom sink in room 501 of the SCU was 106 degrees F with the surveyor thermometer, 106 degrees F with the facility Maintenance Director thermometer, and 107 degrees F with the RMD thermometer at 10:07am. -The hot water temperature at the bathroom sink in room 601 of the SCU was 107 degrees F with the surveyor thermometer, 107 degrees F with the facility Maintenance Director thermometer, and 107 degrees F with the RMD thermometer at 10:25am. -The hot water temperature at the bathroom sink in room 612 of the SCU was 108.3 degrees F with the surveyor thermometer, 108 degrees F with the facility Maintenance Director thermometer, and 109 degrees F with the RMD thermometer at 10:29am. -The hot water temperature at the dayroom sink of the SCU was 105 degrees F with the surveyor thermometer, 105 degrees F with the facility Maintenance Director thermometer, and 106.0 degrees F with the RMD thermometer at 3:44pm. Interview with the Divisional Vice President of Operations (DVPO) on 11/19/25 at 2:35pm revealed: -The RMD reported to her that he had flushed the hot water temperature system on 11/19/25. -She did not think the RMD had adjusted the hot water temperature earlier on 11/19/25. Second interview with the DVPO on 11/19/25 at	{D 113}		

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{D 113}	Continued From page 5 2:44pm revealed: -She contacted the RMD who informed her that the eight hot water tanks at the facility had been flushed. -Caution signs would be posted at water fixtures alerting staff and residents of the fluctuating hot water temperatures, as requested. Interview with the RMD on 11/19/25 at 3:09pm revealed: -There was sediment in the hot water fixtures. -He flushed the hot water tanks on the morning of 11/19/25. -He had just lowered the hot water temperature thermostats to 125 degrees F from 130 degrees F. -He was not sure when the hot water temperature thermostats had last been adjusted. -There were nine tankless hot water heaters at the facility, and he needed to figure out which tank supplied hot water to what section of the facility. Interview with the facility Maintenance Director on 11/19/25 at 3:41pm revealed: -He checked hot water temperatures in two facility rooms of each hall every week. -He kept a water temperature logbook in the office. Second interview with the facility Maintenance Director on 11/20/25 at 10:28am revealed: -There had not been a plumber at the facility since he was employed. -He was not sure when the plumber had last been to the facility. Interview with the Administrator on 11/24/25 at 6:09pm revealed: -The plumber came to the facility on 11/21/24 at	{D 113}		

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{D 113}	Continued From page 6 12:00pm. -The hot water system was purged, and ditch switches were reset. -The facility was told that a power outage may cause difficulty with the hot water heaters and pump. -Since then, the hot water temperatures had been pretty stable. _____ The facility failed to ensure hot water temperatures were maintained between 100 degrees Fahrenheit (F) and 116 degrees F at the sinks in the SCU, with hot water temperatures ranging from 120 degrees F to 131 degrees F. A water temperature of 118.8 degrees F could result in a first degree burn in 15 minutes and a second degree burn in 20 minutes. A water temperature of 127.4 degrees F could result in a first degree burn in 30 seconds and a second degree burn in 60 seconds. A water temperature of 131 degrees F could result in a first degree burn in 17 seconds which placed the residents at a potential risk for burns, and was detrimental to the health, safety, and welfare of the residents. This constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/19/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 8, 2026.	{D 113}		
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff	D 125		

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D 125	Continued From page 7 (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, interviews, and record reviews, the facility failed to ensure 2 of 6 sampled staff (B, C) who administered medications had completed the state approved 5-hour, 10-hour and/or 15-hour medication aide training courses as required. The findings are: 1. Review of Staff C's personnel record revealed: -Staff C was hired as a medication aide (MA) / supervisor on 12/02/24. -Staff C completed the medication administration clinical skills validation checklist on 12/14/24. -Staff C passed the state written MA examination on 08/10/04. -There was no documentation of Staff C completing the state approved 5-hour, 10-hour, and/or 15-hour MA training courses. -There was no MA verification of employment form for Staff C. Review of October 2025 electronic medication administration records (eMARs) revealed there was documentation Staff C administered medications on 10/01/25 - 10/03/25, 10/06/25 - 10/08/25, 10/11/25, 10/12/25, 10/16/25, 10/17/25, 10/20/25 - 10/22/25, 10/25/25, 10/26/25, 10/29/25	D 125		

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D 125	Continued From page 8	D 125		

and 10/30/25.

Review of November 2025 eMARs revealed there was documentation Staff C administered medications on 11/03/25, 11/04/25, 11/07/25 - 11/10/25, 11/11/25 - 11/14/25, and 11/17/25.

Telephone interview with Staff C on 11/24/25 at 6:34pm revealed:
-He started working at the facility about a year ago and he had been administering medications since he started working at the facility.
-He completed the 5-hour and 10-hour MA training courses at this facility with a facility RN.
-He had also completed MA training at other sister facilities in the past.
-He did not know why the facility did not have his certificates on file.
-He would try to locate a copy of the certificates.

Interviews with the Administrator on 11/24/25 at 2:45pm and 6:20pm revealed:
-The Registered Nurse (RN) who completed the state approved 5-hour, 10-hour, and/or 15-hour medication aide (MA) training courses for Staff C no longer worked with their company.
-He did not have a current phone number for the previous RN, so he was unable to contact the RN to see if she had a copy of Staff C's certificates for the state approved 5-hour, 10-hour, and/or 15-hour MA training courses.

Refer to interviews with the Administrator on 11/24/25 at 2:45pm and 6:20pm.

Refer to interview with the Business Office Manager (BOM) on 11/24/25 at 6:07pm.

2. Review of Staff B's personnel record revealed:
-Staff B was hired as a medication aide (MA) /

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D 125	Continued From page 9	D 125		

supervisor on 06/13/25.
-Staff B completed the medication administration clinical skills validation checklist on 08/08/25.
-Staff B passed the state written MA examination on 11/16/15.
-Staff B completed the state approved 5-hour MA training course on 08/08/25.
-There was no documentation of Staff B completing the state approved 10-hour or 15-hour MA training course.
-There was no MA verification of employment form for Staff B.

Review of October 2025 electronic medication administration records (eMARs) revealed there was documentation Staff B administered medications on 10/01/25 - 10/05/25, 10/08/25, 10/11/25, 10/15/25, 10/16/25, 10/18/25, 10/19/25, 10/21/25 - 10/23/25, 10/27/25 - 10/29/25, and 10/31/25.

Review of November 2025 eMARs revealed there was documentation Staff B administered medications on 11/01/25 - 11/05/25, 11/07/25, 11/08/25, 11/10/25, 11/13/25 - 11/16/25 and 11/19/25.

Observation of Staff B on 11/24/25 at 12:00pm revealed she was administering medications to residents on the assisted living (AL) side of the facility.

Interviews with the Administrator on 11/24/25 at 2:45pm and 6:20pm revealed:
-The Registered Nurse (RN) who completed the state approved 5-hour and 10-hour medication aide (MA) training courses for Staff B no longer worked with their company.
-He did not have a current phone number for the previous RN, so he was unable to contact the RN

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D 125	Continued From page 10 to see if she had a copy of Staff B's certificate for the state approved 10-hour MA training course. Refer to interviews with the Administrator on 11/24/25 at 2:45pm and 6:20pm. Refer to interview with the Business Office Manager (BOM) on 11/24/25 at 6:07pm. _____ Interviews with the Administrator on 11/24/25 at 2:45pm and 6:20pm revealed: -The Business Office Manager (BOM) was responsible for the personnel files. -The BOM, Resident Care Coordinator (RCC), and Special Care Coordinator (SCC) were responsible for making sure the MAs had completed MA training requirements. -He usually completed random checks of a couple of personnel files per week. -He and the BOM used a spreadsheet to track the personnel files. -He had not noticed any issues with the personnel files. -He did not realize a medication training certificate currently in the personnel files was not the certificate for the state-approved MA training courses. Interview with the BOM on 11/24/25 at 6:07pm revealed: -The facility's contracted RN was responsible for doing MA training. -The facility's contracted RN usually gave any training paperwork to her, and she filed it in each individual employee's personnel file. -It was her responsibility to make sure documentation of required training was in the personnel files. -She and the Administrator were responsible for auditing personnel files, but she was not sure	D 125		

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D 125	Continued From page 11 how often the audits were supposed to be done because she had only worked at the facility for about 6 weeks. -She audited the personnel files about 2 weeks ago but did not realize a medication training certificate currently in the MAs' personnel files was not the correct certificate for the state-approved MA training courses.	D 125		
{D 310}	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets were served as ordered for 2 of 4 residents sampled (#1, #3) with physician orders for a texture modified diet. The findings are: 1. Review of Resident #3's current FL-2 dated 06/16/25 revealed diagnoses including Huntington's disease, iron deficiency anemia, hypothyroidism, and hyperlipidemia. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 09/23/22.	{D 310}		

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{D 310}	Continued From page 12 Review of Resident #3's care plan dated 09/02/25 revealed the resident required limited assistance with feeding. Review of Resident #3's physician's order dated 10/03/25 revealed: -There was a physician's order for Resident #3's entire meal to be chopped. -Allergies listed for Resident #3 were seafood and shellfish. Review of the diet order list posted on the bulletin board in the kitchen revealed: -The diet order list was reviewed in November 2025 (no specific date documented). -Resident #3's diet was listed as regular chopped entire meal. -There were no allergies listed for Resident #3 on the diet order list. Observations of the breakfast meal delivery on 11/20/25 from 8:00am to 9:10am revealed: -Resident #3 was served a plate of scrambled eggs, pancakes cut up in bite-sized pieces with pancake syrup topping, and two bacon strips cut up in small pieces. -Resident #3 fed herself. -Resident #3 took sips of coffee between bites of food. -Resident #3 did not eat the cut-up bacon served. Review of the menu extensions spread sheet for a chopped diet revealed bacon was to be omitted and replaced with ground sausage patty or links that were 1/2 -inch diced and tender cooked. Observations of the lunch meal delivery on 11/21/25 from 12:11pm to 12:58pm revealed: -The cook served the meal from a serving table	{D 310}		

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located in the dining room outside the kitchen.
-The meal served to Resident #3 included a whole dinner roll.
-Resident #3 pierced the whole dinner roll with her fork and bit a small corner of the whole dinner roll.

Interview with the cook on 11/21/25 at 12:39pm revealed:
-He did not know Resident #3's entire meal was supposed to be served chopped.
-He had not reviewed the diet roster posted in the kitchen.
-He had only been employed for three weeks.
-He should have known Resident #3's entire meal was supposed to be chopped.

Review of the menu extensions spread sheet for a chopped diet revealed a dinner roll was to be pureed or pre-gelled/soaked until gelled through entire thickness or if allowed, the bread should be well-moistened and cut in bite sized pieces.

Observation of the cook on 11/21/25 at 12:40pm revealed the cook removed the whole dinner roll and replaced it with a dinner roll cut up in bite sized pieces.

Interview with Resident #3's Power of Attorney (POA) on 11/20/25 at 9:07am revealed:
-Resident #3 had dysphagia (difficulty swallowing).
-Resident #3 could not chew or swallow certain textures of foods.
-She had to intervene by removing a plate of seafood when Resident #3 was served the plate of seafood at the dinner meal on 11/01/25.
-She had provided the new dietary manager with a list of foods to which Resident #3 had allergies.

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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 310}	Continued From page 14 Interview with Resident #3 on 11/20/25 at 1:17pm revealed: -She was served catfish at dinner on 11/19/25. -After her family member and the chef talked, the catfish was replaced with meatballs. -She was allergic to fish and all seafood. -When she ate fish, it caused her to have stomach cramps. Second interview with Resident #3 on 11/20/25 at 3:45pm revealed the last time she had a reaction to fish was "years ago". Interview with a dietary aide on 11/24/25 at 8:30am revealed: -She was the server and had only been employed about one week. -The cook plated the food, and the server took the food to the residents. -The cook was responsible for informing the server of which resident the plated food was to be served, especially when there were food allergies. -She thought catfish nuggets were served on the dinner menu one night. -Resident #3's family member was present when the catfish nuggets were served and mentioned to the server about Resident #3's food allergy. -Resident #3 did not eat any of the food. -Resident #3's family member intervened immediately, and the plate with catfish nuggets was removed. Interview with Resident #3's primary care provider (PCP) on 11/20/25 at 1:32pm revealed: -Resident #3's diet order was for her entire meal to be chopped. -The resident could process foods easier if the foods were chopped. -Choking was a hazard and great concern for Resident #3 if the resident was served a whole	{D 310}		

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{D 310}	Continued From page 15	{D 310}		

dinner roll.
-She had great concerns for anaphylaxis shock or breathing problems if the resident was given foods to which she was allergic.

Refer to the interview with the Dietary Manager on 11/19/25 at 10:20am.

Refer to the second interview with the Dietary Manager on 11/24/25 at 8:03am.

Refer to the interview with the Administrator on 11/24/25 at 11:13am.

2. Review of Resident #1's current FL-2 dated 03/13/25 revealed:
-Diagnoses included dementia, major depressive disorder, kidney failure, hypertension, vitamin D deficiency, muscle weakness, gastro-esophageal reflux, and cellulitis.
-There was documentation for a chopped no added table salt diet order.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 10/01/21.

Review of Resident #1's care plan dated 08/06/25 revealed the resident required limited assistance with feeding.

Review of Resident #1's physician's order dated 10/28/25 revealed a physician's order for a chopped meat no added table salt diet.

Review of the diet order list posted on the bulletin board in the kitchen revealed:
-The diet order list was reviewed in November 2025 (no specific date documented).
-Resident #1's diet was listed as chopped no

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{D 310}	Continued From page 16 added table salt. Observations of the breakfast meal delivery on 11/20/25 from 8:00am to 9:10am revealed: -Resident #1 was served a plate of scrambled eggs, pancakes with pancake syrup cut up in bite-sized pieces, and bacon cut up in small pieces. -Resident #1 fed himself. -Resident #1 took sips of juice between bites of food. -Resident #1 ate approximately 25% of the cut-up bacon served to him. Review of the menu extensions spread sheet for a chopped diet revealed bacon was to be omitted and replaced with ground sausage patty or links that are 1/2 -inch diced and tender cooked. Interview with the cook on 11/24/25 at 4:25pm revealed: -He did not know a resident prescribed a chopped diet could not be served bacon. -There was a recipe book in the kitchen, but he had not looked at the extension spreadsheet menu for preparing bacon. -He understood and agreed that a resident prescribed a chopped diet should not be served bacon. Refer to the interview with the Dietary Manager on 11/19/25 at 10:20am. Refer to the second interview with the Dietary Manager on 11/24/25 at 8:03am. Refer to the interview with the Administrator on 11/24/25 at 11:13am. Interview with the Dietary Manager on 11/19/25 at	{D 310}		

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{D 310}	Continued From page 17 10:20am revealed: -He had been employed at the facility for one month. -The spreadsheet menus and diet rosters were posted on the bulletin board in the kitchen for guidance in preparing meals. Second interview with the Dietary Manager on 11/24/25 at 8:03am revealed: -He received copies of diet orders from the Resident Care Coordinator (RCC) and Special Care Coordinator (SCC). -The cooks were responsible for plating the resident's food. -The cooks were usually notified of new diet orders and were requested to check the bulletin board in the kitchen. -The cooks were supposed to reconfirm what was on the resident diet order. -Resident allergies were also posted on the kitchen bulletin board diet spread sheet. Interview with the Administrator on 11/24/25 at 11:13am revealed: -He expected the resident diet orders to be posted so dietary staff could determine which diet and food items were to be served to each resident. -Resident diet orders should be posted on the kitchen bulletin board or in a notebook in the kitchen. -He expected the RCC and SCC to communicate with the dietary manager any changes to resident diet orders and to provide a copy of the diet order to make sure of dietary staff awareness. -There might be a situation because dietary staff were fairly new, including the dietary manager, that dietary staff did not know resident diet orders. -He expected each resident's diet order to be	{D 310}		

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{D 310}	Continued From page 18 verified before the resident was served a meal. -The RCC, MCC, and dietary manager were responsible to ensure the diet roster posted in the kitchen was accurate. _____ The facility failed to ensure residents with orders for chopped meals (#1, #3) were served a therapeutic diet as ordered. The two residents were served bacon, a food item that was not supposed to be served to a resident with chopped meats according to the facility's menu. Resident #3 was served catfish nuggets for which there were documented food allergies of seafood and shellfish, and Resident #3 was served a whole roll instead of chopped. This failure placed the residents (#1, #3) at a potential risk for choking and an allergic reaction (#3), and was detrimental to the health, safety, and welfare of the residents and constitutes a Type B Violation. _____ The facility provided a plan of correction in accordance with G. S. 131D-34 on 11/24/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 8, 2026.	{D 310}		
{D 344}	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or	{D 344}		

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{D 344}	Continued From page 19 (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#5) for an eye drop used for glaucoma. The findings are: Review of the facility's undated Medication Orders Policies and Procedures revealed: -The facility should ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments using a clarification form if orders are not clear or complete. -Clarification of orders would be sent to the pharmacy and filed in the resident's record. Review of Resident #5's current FL-2 dated 04/24/25 revealed diagnoses included type 2 diabetes, hyperlipidemia, hypertensive heart disease with heart failure, paroxysmal atrial fibrillation, and congestive heart failure. Review of Resident #5's quarterly medication review dated 06/25/25 revealed: -The pharmacist noted Resident #5 had an order for Latanoprost 0.005% eye drops to be administered prn (as needed) but Latanoprost was commonly used as scheduled eye drops not on a prn basis. (Latanoprost eye drops are used to treat glaucoma. Glaucoma is chronic condition that causes high pressure inside the eye.	{D 344}		

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{D 344}	Continued From page 20 Latanoprost works by lowering pressure in the eyes.) -The pharmacist's recommendation included clarifying whether the primary care provider (PCP) wanted to continue Latanoprost as prn and if so, a diagnosis for prn use of Latanoprost was to be provided. -The PCP agreed with the recommendation on 07/01/25 and ordered Latanoprost 0.005% eye drops, instill 1 drop into both eyes every night at bedtime (scheduled). Review of Resident #5's PCP order dated 07/30/25 revealed an order for Latanoprost 0.005% eye drops, instill 1 drop into both eyes every night at bedtime. Review of Resident #5's signed 6-months physician's order sheet dated 10/24/25 revealed: -The list of orders included Latanoprost 0.005% eye drops instill 1 drop in both eyes at bedtime. -There was an entry underneath the scheduled instructions for "at bedtime as needed". -The order sheet was signed by the resident's PCP. Review of Resident #5's progress notes, provider orders, and provider visit notes revealed no documentation the conflicting instructions for Latanoprost 0.005% eye drops on the physician's order sheet dated 10/24/25 had been clarified. Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Latanoprost 0.005% with special instructions to instill 1 drop in both eyes at bedtime. -The section for frequency noted "at bedtime as needed".	{D 344}		

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{D 344}	Continued From page 21 -There was no scheduled time entered on the eMAR system. -There was a row to document the time, prn reason, and prn result. -No Latanoprost was documented as administered from 10/01/25 - 10/31/25. Review of Resident #5's November 2025 eMAR revealed: -There was an entry for Latanoprost 0.005% with special instructions to instill 1 drop in both eyes at bedtime. -The section for frequency noted "at bedtime as needed". -There was no scheduled time entered on the eMAR system. -There was a row to document the time, prn reason, and prn result. -No Latanoprost was documented as administered in November 2025. Observation of Resident #5's medications on hand on 11/24/25 at 12:33pm revealed: -There was a 2.5ml bottle of Latanoprost 0.005% eye drops dispensed on 06/13/25 for Resident #5. -The instructions on the label were to instill 1 drop in both eyes as needed. -The bottle was over half full of eye drops. -There was a second 2.5ml unopened bottle of Latanoprost 0.005% eye drops stored in the refrigerator and dispensed on 09/13/25 for Resident #5. -The instructions on the label were to instill 1 drop in both eyes at bedtime. Interview with a medication aide (MA) on 11/24/25 at 10:22 am revealed: -She did not administer medications to Resident #5 frequently so she could not recall any	{D 344}		

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{D 344}	Continued From page 22 concerns about the Latanoprost eye drops. -If a medication was scheduled, it would "pop up" on the eMAR to be administered. -If a medication was prn, it would not usually "pop up" on the eMAR to be administered. -She did not recall Resident #5's Latanoprost eye drops "popping up" to be administered so she had not administered any. -If something did not match, either the MAs, Resident Care Coordinator (RCC), or Special Care Coordinator (SCC) should call the pharmacy to clarify. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy entered orders into the eMAR system but someone at the facility would have to approve an order for it to become active. -The facility staff could also change the order in the eMAR system if something was not entered correctly. -Latanoprost showed as being scheduled in the eMAR system used by the pharmacy. -She did not know why the facility's eMAR system showed scheduled but also noted prn on the same entry. -There was no documentation of the facility contacting the pharmacy to clarify the discrepancy. Telephone interview with the RCC on 11/24/25 at 5:37pm revealed: -She had just started as the RCC on 10/09/25. -She was not aware of any discrepancy with Resident #5's Latanoprost order. -The MAs should notify her if information on the eMAR and a medication label did not match. -Either she, the SCC, or the MAs were responsible for clarifying medication orders.	{D 344}		

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 344}	Continued From page 23 -She did not know why Resident #5's Latanoprost order had not been clarified. Interview with the Administrator on 11/21/25 at 2:02pm revealed: -He was not aware of a discrepancy with Resident #5's Latanoprost eye drops. -The RCC and SCC were responsible for weekly cart audits, and they should notify the PCP and him of any discrepancies. Second interview with the Administrator on 11/24/25 at 6:21pm revealed: -The RCC or SCC were responsible for clarifying any unclear medication orders. -If the MAs noticed a discrepancy, the MAs should report it to the RCC or SCC so they could get clarification from the pharmacy and/or provider. Interview with Resident #5's PCP on 11/21/25 at 12:59pm revealed: -Latanoprost was not usually prescribed as a prn medication because it was used to treat glaucoma. -She sent an order at the end of July 2025 to stop prn Latanoprost and start scheduled Latanoprost eye drops. -No one at the facility had contacted her to clarify the discrepancy on Resident #5's October 2025 physician's order sheet. -Not receiving Latanoprost on a scheduled basis could lead to loss of vision. -Resident #5 had not complained of any vision problems to her. Based on observations, interviews, and record review, it was determined that Resident #5 was not interviewable.	{D 344}		

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{D 358}	Continued From page 24	{D 358}		
{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: FOLLOW-UP TO TYPE A2 VIOLATION The Type A2 Violation is abated. Non-compliance continues. THIS IS A TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 3 of 5 sampled residents (#3, #4, #5) including errors with two antibiotics (#4), a diuretic (#4), a potassium supplement (#4), insulin (#5), an eye drop for glaucoma (#5), and an iron supplement (#3). The findings are: 1. Review of Resident #4's most current FL-2 dated 11/20/25 revealed diagnoses included essential hypertension, urinary tract infection (UTI), unspecified urinary incontinence, and unspecified infectious disease. Review of Resident #4's Resident Register revealed she was admitted on 11/18/24.	{D 358}		

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{D 358}	Continued From page 25 a. Review of a physician order sheet for Resident #4 dated 10/31/25 revealed there was an order for Azithromycin 250mg take 2 on day 1, then take 1 on days 2-5 (Azithromycin is an antibiotic used to treat infections). Review of Resident #4's October 2025 electronic medication administration record (eMAR) revealed there was not an entry for Azithromycin. Review of Resident #4's November 2025 eMAR revealed: -There was an entry for Azithromycin 250mg take 2 tablets once daily for 1 day. -There was an entry for Azithromycin 250mg take 1 tablet once daily on days 2-5. -Azithromycin 250mg 2 tablets was documented as administered on 11/04/25. -Azithromycin 250mg 1 tablet was documented as administered daily on 11/05/25-11/08/25. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy had an order dated 10/31/25 for Resident #4's Azithromycin 250mg tablets, take two on the first day and take one for the next four days. -The pharmacy received Resident #4's Azithromycin order from the facility on 11/03/25 at 9:41am. -Resident #4's Azithromycin was delivered to the facility on 11/03/25 at 1:27pm, so the medicine should have started 11/03/25. -The facility asked for a back-up pharmacy to be used immediately for Resident #4's Azithromycin, and it was sent to the back-up pharmacy. Interview with Resident #4 on 11/19/25 at 10:57am revealed:	{D 358}		

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{D 358}	Continued From page 26 -When she got medication through her pharmacy benefit management company it was always delayed, and took about a week to get to the facility. -She took about 4 pills in the morning and 5 at night. -She had stents and heart problems. Second interview with Resident #4 on 11/20/25 at 10:20am revealed: -She started with Amoxicillin due to symptoms of hoarse throat and bronchitis which was given for 10 days, and she still could not shake it so she was given Azithromycin (Amoxicillin is an antibiotic used to treat infections). -She no longer had bronchitis. -She did not refuse her antibiotics, but they came late and she did not know why. Interview with a medication aide (MA) on 11/20/25 at 4:47pm revealed: -Resident #4 had reported symptoms of ear ache and sinus infection. -The facility did have Azithromycin orders for Resident #4 from 10/31/25 and there was not a delay receiving orders from the doctor. -She thought there was a problem with the pharmacy because she never received Resident #4's Azithromycin. Interview with the Administrator on 11/21/25 at 2:03pm revealed: -Antibiotics should be administered on the date it was scheduled to start or the date that it was received by the facility. -Medications from the pharmacy were delivered Tuesday through Friday. -The Resident Care Coordinator (RCC) and Special Care Coordinator (SCC) would have to check with the pharmacy and ask for a back-up	{D 358}		

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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	{D 358}		

pharmacy with new orders on the weekend.
-In the absence of the RCC or SCC, the MAs were responsible for making sure medication was sent.

Second interview with the Administrator on 11/21/25 at 3:55pm revealed:
-Resident #4's prescription for Azithromycin was not sent to the pharmacy until 11/03/25 and the medication arrived through the back-up pharmacy.
-Staff should have sent Resident #4's order for Azithromycin to the pharmacy on Friday (10/31/25) and should not have waited until Monday (11/03/25).
-To use a back-up pharmacy, the facility staff had to go through the facility's contracted pharmacy and the contracted pharmacy made a decision on who the back-up pharmacy was.

Third interview with the Administrator on 11/24/25 at 6:09pm revealed:
-Only the RCC and SCC sent orders to the pharmacy.
-The pharmacy did not accept orders on the weekend.
-If the back-up pharmacy was requested sooner, Resident #4's Azithromycin may have come through.

Interview with Resident #4's primary care provider (PCP) on 11/21/25 at 1:10pm revealed:
-Azithromycin was ordered for Resident #4's sinus infection and ear infection.
-Resident #4 was complaining of ear pain and sinus pressure when she prescribed the Azithromycin.
-She spoke with Resident #4 weekly and Resident #4 was feeling better the next week (the week of 11/02/25-11/08/25).

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{D 358}	Continued From page 28 -Anytime orders were not followed there was concern. -If a resident was given antibiotics, it was given to prevent or treat an infection. -If medication was delayed the infection could get worse and cause other issues. -The facility should start antibiotics as soon as possible and if medication was ordered she usually gave the facility a 24-hour window. -When she first started working at the facility, she was concerned that the pharmacy was not getting orders that she wrote. -The new RCC was doing better about processing orders. -She left her orders with the RCC. -Orders should be sent on the same day they were written. -The Azithromycin order written on 10/31/25 should have been sent to the pharmacy on 10/31/25. b. Review of urology office visit documentation for Resident #4 dated 11/18/25 revealed: -The documentation included the provider's assessment and signed orders. -Resident #4 was diagnosed with a urinary tract infection (UTI). -There was an order for Doxycycline 100mg take one capsule twice daily for ten days (Doxycycline is an antibiotic used to treat infections). -The order for Doxycycline 100mg was associated with the diagnosis of UTI. -The provider noted bladder leakage, burning on urination, frequent urination, night time urination, nocturia, urinary frequency, urinary incontinence and urinary urgency in their review of systems. Review of Resident #4's November 2025 electronic medication administration record (eMAR) revealed:	{D 358}		

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{D 358}	Continued From page 29 -There was an entry for Doxycycline 100mg capsule take one twice daily for 10 days scheduled at 8:00am and 8:00pm. -Doxycycline 100mg was documented as administered on 11/20/25 at 8:00am and 8:00pm. -Doxycycline 100mg was documented as administered once on 11/21/25 at 8:00am. -Resident #4's Doxycycline was documented as not administered by exception from 11/21/25 at 8:00pm to 11/24/25 due to Resident #4's scheduled absence. Observation of Resident #4's medications on hand on 11/20/25 at 4:47pm revealed: -There was a package containing 18 Doxycycline 100mg capsules on the cart for Resident #4. -The label indicated 20 Doxycycline 100mg capsules were originally dispensed for Resident #4 on 11/18/25. -The directions on the label were for Resident #4 to take one capsule twice daily for 10 days. -Two capsules had been removed from the package. Review of a packing slip signed and received by facility staff on 11/19/25 revealed 20 Doxycycline 100mg capsules were delivered to the facility for Resident #4. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy had an order dated 11/18/25 for Resident #4's Doxycycline 100mg capsule take one twice daily for 10 days. -The pharmacy received Resident #4's Doxycycline order from her urology provider on 11/18/25 at 11:55am. Telephone interview with a pharmacist at the	{D 358}		

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{D 358}	Continued From page 30 facility's contracted pharmacy on 11/24/25 at 8:48am revealed on 11/19/25, the pharmacy restarted the eMAR entry for Resident #4's Doxycycline. Interview with Resident #4 on 11/19/25 at 10:57am revealed: -A resident passed last night (11/18/25) and she missed her medication. -She had never missed her medication before. -She was not able to get medication for her current UTI, and she had not started the medication yet. -She was at the doctor's office yesterday (11/18/25) for the UTI, and they ordered the medication yesterday. -When she got medication through her pharmacy benefit management company, it was always delayed, and took about a week to get to the facility. -She took about 4 pills in the morning and 5 at night. -She had stents and heart problems. Second interview with Resident #4 on 11/20/25 at 10:20am revealed: -She got Doxycycline yesterday afternoon (11/19/25). -She had kidney trouble since she was a child and she had every antibiotic. -She had burning with urination and back pain with her UTIs. -Her blood pressure went up when she had pain related to the UTI and she had to get up four or five times to go to the bathroom at night. Interview with a medication aide (MA) on 11/20/25 at 4:47pm revealed: -Resident #4's Doxycycline started 11/19/25 and should end on 11/29/25.	{D 358}		

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{D 358}	Continued From page 31 -Resident #4's first dose of Doxycycline was documented as administered on 11/20/25. -She did not know why only one dose was documented on the eMAR when two capsules were missing from the package. -She had seen problems where the entry showed as discontinued on the eMAR but the medication was not discontinued. -Resident #4 had reported symptoms of ear ache and sinus infection, but had not complained to her about back ache or urinary symptoms. -She did not administer Doxycycline to Resident #4 yesterday. -She scanned every medication that she gave and that would put the medication on the eMAR. -She did not recall Doxycycline being on the eMAR yesterday. Interview with a second MA on 11/21/25 at 3:55pm revealed: -She gave Doxycycline to Resident #4 at noon on 11/19/25 but did not document it. -Resident #4 was complaining that she needed the Doxycycline. -The eMAR was showing that the Doxycycline was discontinued on 11/19/25 and that was why it was not administered twice on that day. -She was concerned that the eMAR was showing the Doxycycline was discontinued, but did not discuss the concern with the pharmacy or the primary care provider (PCP). -She told the next MA that Resident #4 would let her know to administer the Doxycycline. Second interview with the second MA on 11/24/25 at 10:12am revealed: -She could not click the Doxycycline was administered to Resident #4 on 11/19/25. -The eMAR showed that the medication was discontinued.	{D 358}		

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{D 358}	Continued From page 32 -When she spoke to the Resident Care Coordinator (RCC) on 11/19/25 about Resident #4's Doxycycline, the RCC advised her to continue to administer the medication because it was important, and the RCC would call the pharmacy. -Both the MAs and the RCC could call the pharmacy for any concerns. -She checked orders against the eMARs daily to see if everything was correct, including discontinuations. -If orders did not match the eMAR, she would call the supervisor and pharmacy. -If the eMAR showed medication was discontinued but a new entry needed to be started, she would have to call the pharmacy and physician so that new script could be sent to the pharmacy if needed. Interview with the RCC on 11/21/25 at 3:55pm revealed: -When Resident #4's Doxycycline capsule was scanned, it showed as a discontinued medication. -There was not a back-up or paper MAR to document on when the eMAR was not working. -Some MAs would not give a medication if it showed as discontinued on the eMAR. -Resident #4's evening dose of Doxycycline was not given on 11/19/25. -Resident #4's Doxycycline came from the facility's contracted pharmacy. Interview with the Administrator on 11/21/25 at 3:55pm revealed: -It should be documented on shift to shift communication that there was a problem with Resident #4's eMAR and the Doxycycline. -To use a back-up pharmacy, the facility staff had to go through the facility's contracted pharmacy and the contracted pharmacy made a decision on	{D 358}		

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{D 358}	Continued From page 33 who the back-up pharmacy was. Second interview with the Administrator on 11/21/25 at 2:03pm revealed: -He found out today (11/21/25) that when family took Resident #4 to the Urologist, the facility did not get information, and the prescription for Doxycycline was sent directly to the pharmacy. -The facility would need to meet with family to make sure they received information about medical appointments or recommendations. -Antibiotics should be administered on the date it was scheduled to start or the date that it was received by the facility. -The RCC, Special Care Coordinator (SCC), and MAs should be looking at the eMARs daily and report any discrepancies between orders and eMAR entries to the provider and family. -Staff discussed discrepancies between orders and eMAR entries at their daily stand-up meetings. -The RCC and SCC approved orders on the eMAR which were entered by the pharmacy into the eMAR system, and staff should be looking daily for new entries. -MAs who saw that an eMAR entry was discontinued were supposed to check the orders and call the pharmacy. -The facility had been having meetings with the pharmacy to address concerns. -The RCC, SCC, and staff should be doing cart audits, checking the eMAR, orders and medications on hand. Third interview with the Administrator on 11/24/25 at 6:09pm revealed: -When there was a question about medication, MAs should contact the RCC or SCC or contact the pharmacy. -The expectation was that if the medication and	{D 358}		

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{D 358}	Continued From page 34	{D 358}		

the orders were in the facility, staff should administer the medication and use a paper MAR to document.

Interview with Resident #4's PCP on 11/21/25 at 1:10pm revealed:
-Anytime orders were not followed there was concern.
-If a resident was given antibiotics, it was given to prevent or treat an infection.
-If medication was delayed, the infection could get worse and cause other issues.
-In case of a UTI, patients could become septic and it could lead to hospitalizations.
-Resident #4 had issues with her kidneys at some point in time.
-Her BUN was slightly elevated, which could indicate potential kidney issues.
-Resident #4's creatinine was normal.
-The BUN and creatinine indicated how waste was moved throughout the body.
-Dehydration played into BUN elevation.
-The facility should start antibiotics as soon as possible and if medication was ordered she usually gave the facility a 24-hour window.
-Frequency of urination, back pain and burning were all symptoms of UTI which the Doxycycline would be treating.

Attempted telephone interview with Resident #4's urology provider on 11/24/25 at 9:27am was unsuccessful.

c. Review of Resident #4's physician order sheet dated 10/31/25 revealed there was an order for Furosemide 20mg take one tablet once daily (Furosemide is a diuretic medication which can be used to treat volume overload, or an excess of fluid in the body).

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{D 358}	Continued From page 35 Review of Resident #4's November 2025 electronic medication administration record (eMAR) revealed: -There were two entries for Furosemide 20mg take one tablet once daily. -The first entry for Furosemide 20mg had a start date of 06/14/25 and an end date of 11/04/25. -The second entry for Furosemide 20mg had a start date of 11/04/25 and was listed as "Open Ended". -Furosemide 20mg was documented as administered 11/01/25-11/03/25 on the first entry -Furosemide 20mg was documented as not administered "Discontinued" on 11/04/25 on the first eMAR entry. -Furosemide 20mg was documented as administered daily on 11/05/25-11/21/25 in the second entry. Observation of Resident #4's medications on hand on 11/20/25 at 4:47pm revealed there were six remaining doses of Furosemide 20mg tablets out of seven that had been dispensed in the multi-dose pack (MDP) for the week of 11/20/25-11/26/25. Review of a packing slip dated 11/03/25 revealed: -The packing slip was signed by the facility 11/04/25. -There were 7 Furosemide 20mg tablets received by the facility for Resident #4. Interview with Resident #4 on 11/19/25 at 10:57am revealed: -A resident passed last night (11/18/25) and she missed her medication. -She had never missed her medication before. -She took about 4 pills in the morning and 5 at night. -She had stents and heart problems.	{D 358}		

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{D 358}	Continued From page 36 Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy received a prescription renewal on 11/03/25 which was dated 10/31/25 for Resident #4's Furosemide 20mg. -When the pharmacy received prescription renewals, the pharmacy re-entered the eMAR entry and the previous eMAR entry was discontinued. -For renewals the provider did not discontinue the medication, but the pharmacy discontinued what was on the eMAR and the new order was shown. -eMAR entries had to be approved by the facility. -The facility may not allow all staff to approve the eMAR entries, so there could be a delay. -The pharmacy received the renewed order for Resident #4's Furosemide. Interview with Resident #4's primary care provider (PCP) on 11/21/25 at 1:10pm revealed: -Resident #4's missed dose of Furosemide on 11/04/25 was not a concern because the resident was stable, but she was on the medication for a reason. -One missed dose of Furosemide was not a significant concern. Interview with a medication aide (MA) on 11/24/25 at 10:12am revealed: -Both the MAs and the Resident Care Coordinator (RCC) could call the pharmacy for any concerns. -She checked orders against the eMARs daily to see if everything was correct, including discontinuations. -If orders did not match the eMAR she would call the supervisor and pharmacy. -If the eMAR showed that medication was	{D 358}		

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{D 358}	Continued From page 37 discontinued but a new entry needed to be started, she would have to call the pharmacy and physician so that new script could be sent to the pharmacy if needed. -If there were orders but no eMAR entry or medications on hand she had to call the pharmacy and physician to send a copy of the order if needed to send to the pharmacy. Telephone interview with the RCC on 11/24/25 at 5:35pm revealed: -The pharmacy put entries on the eMAR. -The RCC or their designated person could approve entries on the eMAR. -She did not know whether MAs could approve entries on the eMAR. -The Administrator was the Special Care Coordinator (SCC) before, so he had access to approve entries on the eMAR. -The only person she designated to do something was the Administrator and he already had access to the eMAR. -When the Administrator was the SCC he had administrative capabilities and gave her access to approve entries on the eMAR. -The only thing the facility could see about Resident #4's Furosemide on 11/04/25 was that the entry was discontinued. -The RCC could not see the new entry for Furosemide until the next day (11/05/25). Interview with the Administrator on 11/24/25 at 6:09pm revealed: -When there was a question about medication, MAs should contact the RCC or SCC or contact the pharmacy. -The expectation was that if the medication and the orders were in the facility, staff should give the medication and use a paper MAR to document.	{D 358}		

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{D 358}	Continued From page 38 -The RCC and SCC were responsible for making sure medications were administered or verified. Interview with Resident #4's primary care provider (PCP) on 11/21/25 at 1:10pm revealed: -Resident #4's missed dose of Furosemide on 11/04/25 was not a concern because the resident was stable, but she was on the medication for a reason. -One missed dose of Furosemide was not a significant concern. d. Review of Resident #4's physician order sheet dated 10/31/25 revealed there was an order for Potassium Chloride tablet, ER particles/crystals 10mEq take one tablet once daily (Potassium Chloride tablets can be prescribed to treat a deficiency of potassium). Review of Resident #4's November 2025 electronic medication administration record (eMAR) revealed: -There were two entries for Potassium Chloride tablet, ER particles/crystals 10 mEq, take one tablet once daily. -The first entry for Potassium Chloride tablet had a start date of 06/14/25 and an end date of 11/04/25. -The second entry for Potassium Chloride tablet had a start date of 11/04/25 and was listed as "Open Ended". -Potassium Chloride tablet was documented as administered 11/01/25-11/03/25 on the first entry -Potassium Chloride tablet was documented as not administered "Discontinued" on 11/04/25 on the first eMAR entry. -Potassium Chloride tablet was documented as administered daily on 11/05/25-11/21/25 in the second entry.	{D 358}		

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{D 358}	Continued From page 39 Observation of Resident #4's medications on hand on 11/20/25 at 4:47pm revealed there were six remaining Potassium Chloride micro tablets 10mEq out of seven that had been dispensed in the multi-dose pack for the week of 11/20/25-11/26/25. Review of a packing slip dated 11/03/25 revealed: -The packing slip was signed by the facility 11/04/25. -There were 7 extended release Potassium Chloride micro tablets 10mEq received by the facility for Resident #4. Interview with Resident #4 on 11/19/25 at 10:57am revealed: -A resident passed last night (11/18/25) and she missed her medication. -She had never missed her medication before. -She took about 4 pills in the morning and 5 at night. -She had stents and heart problems. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy received a prescription renewal on 11/03/25 which was dated 10/31/25 for Resident #4's Potassium Chloride. -When the pharmacy received prescription renewals, the pharmacy re-entered the eMAR entry and the previous eMAR entry was discontinued. -For renewals the provider did not discontinue the medication, but the pharmacy discontinued what was on the eMAR and the new order was shown. -eMAR entries had to be approved by the facility. -The facility may not allow all staff to approve the eMAR entries, so there could be a delay. -The pharmacy received the renewed order for	{D 358}		

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(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 the for Resident #4's Potassium Chloride on the same communication as the Furosemide (a diuretic for swelling). Interview with Resident #4's primary care provider (PCP) on 11/21/25 at 1:10pm revealed: -Resident #4's missed dose of Potassium Chloride on 11/04/25 was not a concern because the resident was stable, but she was on the medication for a reason. -One missed dose of Potassium was not a significant concern. -With Furosemide (diuretic for swelling) and Potassium, the Potassium is prescribed because of the Furosemide, so if she was not getting the Furosemide she would not need the Potassium. Interview with a MA on 11/24/25 at 10:12am revealed: -Both the MAs and the RCC could call the pharmacy for any concerns. -She checked orders against the eMARs daily to see if everything was correct, including discontinuations. -If orders did not match the eMAR she would call the supervisor and pharmacy. -If the eMAR showed that medication was discontinued but a new entry needed to be started, she would have to call the pharmacy and physician so that new script could be sent to the pharmacy if needed. -If there were orders but no eMAR entry or medications on hand she had to call the pharmacy and physician to send a copy of the order if needed to send to the pharmacy. Telephone interview with the RCC on 11/24/25 at 5:35pm revealed: -The pharmacy put entries on the eMAR. -The RCC or their designated person could	{D 358}		

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{D 358}	Continued From page 41	{D 358}		

approve entries on the eMAR.
-She did not know whether MAs could approve entries on the eMAR.
-The Administrator was the Special Care Coordinator (SCC) before, so he had access to approve entries on the eMAR.
-The only person she designated to do something was the Administrator and he already had access to the eMAR.
-When the Administrator was the SCC he had administrative capabilities and gave her access to approve entries on the eMAR.
-The only thing the facility could see about Resident #4's Potassium on 11/04/25 was that the entry was discontinued.
-The RCC could not see the new entry for Resident #4's Potassium until the next day (11/05/25).

Interview with the Administrator on 11/24/25 at 6:09pm revealed:
-When there was a question about medication, MAs should contact the RCC or SCC or contact the pharmacy.
-The expectation was that if the medication and the orders were in the facility, staff should administer the medication and use a paper MAR to document.
-The RCC and SCC were responsible for making sure medications were administered or verified.

2. Review of Resident #5's current FL-2 dated 04/24/25 revealed diagnoses included type 2 diabetes, hyperlipidemia, hypertensive heart disease with heart failure, paroxysmal atrial fibrillation, and congestive heart failure.

a. Review of Resident #5's current FL-2 dated 04/24/25 revealed an order for Humalog insulin 5 units before meals. (Humalog is rapid-acting

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{D 358}	Continued From page 42 insulin used to lower blood sugar in diabetics.) Review of Resident #5's primary care provider (PCP) order dated 09/12/25 revealed an order to decrease Humalog insulin to 4 units subcutaneously before meals; hold if blood sugar is less than 100; and notify PCP if blood sugar is less than 60 or greater than 400. Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Humalog insulin inject 4 units before meals; hold if blood sugar is less than 100; notify PCP if blood sugar is less than 60 or greater than 400. -Humalog was scheduled at 7:30am, 11:30am, and 4:30pm. -The resident's Humalog was documented as administered on 7 occasions when the blood sugar was less than 100 and should have been held. -The resident's blood sugar was 96 on 10/03/25 at 11:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 83 on 10/07/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 76 on 10/09/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 84 on 10/13/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 97 on 10/14/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 89 on 10/19/25 at 4:30pm and Humalog was documented as administered but should have been held.	{D 358}		

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{D 358}	Continued From page 43 -The resident's blood sugar was 85 on 10/26/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar ranged from 76 - 394 from 10/01/25 - 10/31/25. Review of Resident #5's November 2025 eMAR revealed: -There was an entry for Humalog insulin inject 4 units before meals; hold if blood sugar is less than 100; notify PCP if blood sugar is less than 60 or greater than 400. -Humalog was scheduled at 7:30am, 11:30am, and 4:30pm. -The resident's Humalog was documented as administered on 2 occasions when the blood sugar was less than 100 and should have been held. -The resident's blood sugar was 93 on 11/13/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar was 75 on 11/18/25 at 7:30am and Humalog was documented as administered but should have been held. -The resident's blood sugar ranged from 75 - 363 from 11/01/25 - 11/19/25. Observation of Resident #5's medications on hand on 11/24/25 at 12:16pm revealed: -There was a Humalog insulin pen dispensed on 11/13/25 for Resident #5. -The instructions were to inject 4 units 3 times daily subcutaneously 1 hour before meals; hold if blood sugar is less than 100; notify PCP if blood sugar is less than 60 or greater than 400. Interview with a medication aide (MA) on 11/24/25 at 10:22 am revealed: -The MAs should hold Resident #5's Humalog if the resident's blood sugar was less than 100 and	{D 358}		

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document it as being held on the eMAR.
-She did not recall having to hold Resident #5's Humalog insulin because the resident's blood sugar was not usually less than 100 when she worked.
-She did not know why Resident #5's Humalog was documented as being administered when her blood sugar was less than 100 and should have been held.

Interview with a second MA on 11/24/25 at 12:14pm revealed:
-She usually held and documented Resident #5's Humalog insulin as being held when the resident's blood sugar was less than 100.
-She was not sure why there were some entries on the eMAR that did not show she documented Resident #5's insulin as being held when the blood sugar was less than 100.

Telephone interview with the Resident Care Coordinator (RCC) on 11/24/25 at 5:37pm revealed:
-Resident #5's Humalog insulin should be held if the resident's blood sugar was less than 100.
-When she worked as a MA, if she held Resident #5's Humalog, she would document it was not administered and noted on the eMAR that it was held due to the blood sugar level.
-The MAs should hold Resident #5's Humalog insulin when the resident's blood sugar was <100 and document it as held.
-She just started working as the RCC on 10/09/25.
-She did not know the facility's protocols for checking the eMARs to make sure medications were being administered as ordered.
-She usually checked the exceptions report for the eMAR every morning for refusals and unavailable medications.

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{D 358}	Continued From page 45 -She had not reviewed the eMARs to ensure the MAs were holding Resident #5's Humalog insulin as ordered. -She was not aware Resident #5's Humalog had not been held as ordered. Interview with the Administrator on 11/21/25 at 2:02pm revealed: -The MAs should follow the order to hold Resident #5's Humalog insulin if the resident's blood sugar was less than 100. -The RCC and Special Care Coordinator (SCC) were responsible for checking the eMARs daily to make sure medications were being administered or held as ordered. Interview with Resident #5's PCP on 11/21/25 at 12:59pm revealed: -There was an order to hold Resident #5's Humalog if the blood sugar was less than 100 to prevent the resident's blood sugar from dropping too low. -Not holding Resident #5's Humalog insulin when the blood sugar was less than 100 could cause the resident's blood sugar to drop too low which could cause the resident to pass out and require a call to emergency medical services (EMS). Based on observations, interviews, and record review, it was determined that Resident #5 was not interviewable. Attempted telephone interview with a third MA on 11/24/25 at 4:33pm was unsuccessful. Attempted telephone interview with a fourth MA on 11/24/25 at 4:36pm was unsuccessful. b. Review of Resident #5's quarterly medication review dated 06/25/25 revealed:	{D 358}		

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{D 358}	Continued From page 46 -The pharmacist noted Resident #5 had an order for Latanoprost 0.005% eye drops to be administered prn (as needed) but Latanoprost was commonly used as scheduled eye drops not on a prn basis. (Latanoprost eye drops are used to treat glaucoma. Glaucoma is chronic condition that causes high pressure inside the eye. Latanoprost works by lowering pressure in the eyes.) -The pharmacist's recommendation included clarifying whether the primary care provider (PCP) wanted to continue Latanoprost as prn and if so, a diagnosis for prn use of Latanoprost was to be provided. -The PCP agreed with the recommendation on 07/01/25 and ordered Latanoprost 0.005% eye drops, instill 1 drop into both eyes every night at bedtime. Review of Resident #5's PCP order dated 07/30/25 revealed an order for Latanoprost 0.005% eye drops, instill 1 drop into both eyes every night at bedtime. Review of Resident #5's October 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Latanoprost 0.005% with special instructions to instill 1 drop in both eyes at bedtime. -The section for frequency noted "at bedtime as needed". -There was no scheduled time entered on the eMAR system. -There was a row to document the time, prn reason, and prn result. -No Latanoprost was documented as administered from 10/01/25 - 10/31/25. Review of Resident #5's November 2025 eMAR	{D 358}		

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{D 358}	Continued From page 47 revealed: -There was an entry for Latanoprost 0.005% with special instructions to instill 1 drop in both eyes at bedtime. -The section for frequency noted "at bedtime as needed". -There was no scheduled time entered on the eMAR system. -There was a row to document the time, prn reason, and prn result. -No Latanoprost was documented as administered in November 2025.Observation of Resident #5's medications on hand on 11/24/25 at 12:33pm revealed: -There was a 2.5ml bottle of Latanoprost 0.005% eye drops dispensed on 06/13/25 for Resident #5. -The instructions on the label were to instill 1 drop in both eyes as needed. -The bottle was over half full of eye drops. -There was a second 2.5ml unopened bottle of Latanoprost 0.005% eye drops stored in the refrigerator and dispensed on 09/13/25 for Resident #5. -The instructions on the label were to instill 1 drop in both eyes at bedtime. Interview with a medication aide (MA) on 11/24/25 at 10:22 am revealed: -She did not administer medications to Resident #5 frequently so she could not recall any concerns about the Latanoprost eye drops. -If a medication was scheduled, it would "pop up" on the eMAR to be administered. -If a medication was prn, it would not usually "pop up" on the eMAR to be administered. -If something did not match, either the MAs, Resident Care Coordinator (RCC), or Special Care Coordinator (SCC) should call the pharmacy to clarify.	{D 358}		

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{D 358}	Continued From page 48 Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/21/25 at 12:09pm revealed: -The pharmacy did not receive an order dated 07/01/25 for Resident #5's Latanoprost 0.005% eye drops to be scheduled. -The pharmacy received an order from Resident #5's PCP on 07/30/25 for Latanoprost 0.005% eye drops, 1 drop in each eye daily at bedtime. -The pharmacy entered orders into the eMAR system but someone at the facility had to approve an order for it to become active. -The facility staff could also change orders in the eMAR system if something was not entered correctly. -Latanoprost showed as being scheduled in the eMAR system used by the pharmacy. -She did not know why the facility's eMAR system showed scheduled but also noted prn on the same entry. Telephone interview with the RCC on 11/24/25 at 5:37pm revealed: -She had just started as the RCC on 10/09/25. -She was not aware of any discrepancy with Resident #5's Latanoprost order. -She did not know the facility's protocols for checking the eMARs to make sure medications were being administered as ordered. -She usually checked the exceptions report for the eMAR every morning for refusals and unavailable medications. -She had not reviewed the eMARs and compared them with medication orders to ensure medications were being administered as ordered. -The MAs should notify her if information on the eMAR and a medication label did not match. -Either she or the MAs sent orders to the pharmacy, and the pharmacy staff usually	{D 358}		

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entered orders into the eMAR system.
-She or the SCC had to approve orders in the eMAR system for the orders to become active.
-Since she was not working at the facility in July 2025, she did not know why the scheduled order for Resident #5's Latanoprost was not in the eMAR system.

Interview with the Administrator on 11/21/25 at 2:02pm revealed:
-He was not aware of a discrepancy with Resident #5's Latanoprost eye drops.
-The RCC and SCC were responsible for checking and approving orders after the pharmacy entered the orders into the eMAR system.
-The RCC and SCC should approve orders daily as soon as the notification appeared in the eMAR system.
-The RCC and SCC were responsible for weekly cart audits and they should notify the PCP and him of any discrepancies.

Interview with Resident #5's PCP on 11/21/25 at 12:59pm revealed:
-Latanoprost was not usually prescribed as a prn medication because it was used to treat glaucoma.
-She sent an order at the end of July 2025 to stop prn Latanoprost and start scheduled Latanoprost eye drops.
-Not receiving Latanoprost on a scheduled basis could lead to loss of vision.
-Resident #5 had not complained of any vision problems to her.

Based on observations, interviews, and record review, it was determined that Resident #5 was not interviewable.

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{D 358}	Continued From page 50 3. Review of Resident #3's current FL-2 dated 06/16/25 revealed diagnoses included Huntington's disease, iron deficiency anemia, hypothyroidism, and hyperlipidemia. Review of Resident #3's Resident Register revealed the resident was admitted to the facility on 09/23/22. Review of Resident #3's physician's order dated 09/02/25 and 10/03/25 revealed there was a physician's order for Ferrous Gluconate (a dietary iron supplement) 324mg tablet take one twice daily. Review of Resident #3's October 2025 electronic medication administration record (eMAR) revealed: -There was a printed entry for Ferrous Gluconate 324mg tablet twice daily scheduled at 9:00am and 9:00pm with documentation for administration from 10/01/25 through 10/30/25. -Ferrous Gluconate 324mg tablet was documented as "not administered: discontinued" at 9:00am on 10/28/25 and 10/29/25. -Ferrous Gluconate 324mg tablet was documented as "not administered: discontinued" at 9:00pm on 10/03/25, 10/06/25, 10/07/25, 10/08/25, 10/11/25, 10/12/25, 10/17/25, 10/21/25, 10/29/25, and 10/30/25. Review of Resident #3's November 2025 eMARs revealed: -There was a printed entry for Ferrous Gluconate 324mg tablet twice daily scheduled at 9:00am and 9:00pm with documentation for administration from 11/01/25 through 11/23/25. -Ferrous Gluconate 324mg tablet was documented as "not administered: discontinued" at 9:00am on 11/15/25.	{D 358}		

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{D 358}	Continued From page 51 -Ferrous Gluconate 324mg tablet was documented as "not administered: discontinued" at 9:00pm on 11/03/25, 11/09/25, 11/11/25, 11/13/25, and 11/15/25. -There was no documentation for administration or reason for no administration of the Ferrous Gluconate 324mg tablet for 11/16/25 through 11/23/25 at 9:00am and 9:00pm. Observation of Resident #3's medications on hand on 11/24/25 at 12:54pm revealed Ferrous Gluconate 325mg tablet was on hand and packaged in a pharmacy multi-dose package (MDP). Interview with a medication aide (MA) on 11/24/25 at 12:59pm revealed: -The Ferrous Gluconate entry on Resident #3's eMAR populated as discontinued when she scanned the medication package. -If the medication populated as discontinued, she did not administer the medication. -She removed Resident #3's Ferrous Gluconate from the MDP and destroyed it according to facility protocol. -She was not able to access signed physician orders, nor did she ever look at signed physician order copies. -She contacted the Resident Care Coordinator (RCC) when she documented the Ferrous Gluconate as discontinued on the eMAR. -The RCC told her that she would reach out to the pharmacy. Telephone interview with a second MA on 11/24/25 at 6:38pm revealed: -He did not administer Resident #3's Ferrous Gluconate when he scanned the MDP and the medication populated on the eMAR as discontinued.	{D 358}		

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{D 358}	Continued From page 52 -He thought Ferrous Gluconate was discontinued for Resident #3. Interview with the RCC on 11/20/25 at 4:06pm revealed: -She was not aware that medication instructions on the eMAR were populating as discontinued when there was no physician order to discontinue the medication. -There was no system in place to document the administration of a medication when the instructions on the eMARs for the medication populated as discontinued. -The MAs did not document medication administration on a paper MAR if the eMAR was not working properly. Second interview with the RCC on 11/24/25 at 5:37pm revealed: -Some of the MAs followed the eMAR and would not administer Resident #3's Ferrous Gluconate when the Ferrous Gluconate populated on the eMAR as discontinued. -She thought a MA informed her on 11/21/25 about the Ferrous Gluconate populating on Resident #3's eMAR as discontinued. -She had not seen a physician's order to discontinue Resident #3's Ferrous Gluconate. -She had planned to contact the primary care provider (PCP) on 11/21/25 about Resident #3's Ferrous Gluconate but had not been able to do so for personal reasons. Telephone interview with a pharmacist at the facility's contracted pharmacy on 11/24/25 at 9:06am revealed: -There was a current order in the pharmacy profile for Ferrous Gluconate 324mg tablet twice daily for Resident #3. -The pharmacy had not received a physician	{D 358}		

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 11/24/2025

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 53	{D 358}		

order to discontinue the Ferrous Gluconate 324mg tablet twice daily for Resident #3.
-Ferrous Gluconate 324mg tablets were dispensed to the facility weekly, including on 09/01/25, 09/08/25, 09/15/25, 09/22/25, 09/29/25, 10/06/25, 10/13/25, 10/20/25, 10/27/25, 11/03/25, 11/10/25, and 11/17/25 for a quantity of 14 tablets, in MDPs.
-She did not know why the facility MAs documented the Ferrous Gluconate as discontinued/not administered with the medication in the MDPs.

Interview with the Administrator on 11/20/25 at 2:07pm revealed:
-He expected medications to be administered as ordered.
-The RCC and Special Care Coordinator (SCC) should be looking at the eMARs daily and performing weekly medication cart audits.
-The facility's contracted pharmacy provider entered new orders into the eMAR system.
-The RCC and SCC were responsible for approving medication entries in the eMAR system.
-He expected new orders entered on the EMARs to be approved by the RCC and SCC as soon as the entry populated in the eMAR system for approval.
-The RCC and SCC were responsible for checking the eMARs for accuracy.
-If a discrepancy was found on the eMAR, the RCC and SCC should report the discrepancy to the provider, family, and him.

Second interview with the Administrator on 11/24/25 at 6:35pm revealed:
-He expected residents' medications to be administered as ordered at all times.
-If there was an issue with a resident's

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	HAL051065	A. BUILDING: _____ B. WING _____	R-C 11/24/2025

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 54 medication, the RCC and SCC were to be notified to ensure the resident received the right medication. Attempted telephone interview with Resident #3's PCP on 11/24/25 at 6:24pm was unsuccessful. _____ The facility failed to administer medications as ordered to 3 of 5 sampled residents (#3, #4, #5). Resident #4 did not receive an antibiotic prescribed on 10/31/25 until 11/04/25, and received only one of two ordered doses of antibiotic on 11/19/25, placing her at risk for worsening infections. Resident #5's rapid-acting insulin was not held as ordered on 9 occasions in October 2025 and November 2025 putting the resident at risk of her blood sugar dropping which could lead to the resident passing out and requiring a call to emergency medical services. Resident #5's eye drops for glaucoma were not administered daily as ordered since July 2025 putting the resident at risk of vision loss. The failure of the facility to administer medications as ordered was detrimental to the health and safety of the residents and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 11/21/25 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED JANUARY 8, 2026.	{D 358}		