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| D 000 | Initial Comments<br><br>The Adult Care Licensure Section and the Johnston County Department of Social Services conducted a follow-up survey and a complaint investigation on February 25-26, 2026. | D 000 | | |
| D 079 | 10A NCAC 13F .0306 (a)(5) Housekeeping and Furnishings<br><br>10A NCAC 13F .0306 Housekeeping and Furnishings<br><br>(a) Adult care homes shall:<br>(5) be maintained in an uncluttered, clean and orderly manner, free of all obstructions and hazards;<br>Notwithstanding the requirements of Rule .0301 of this Section, this Rule shall apply to new and existing facilities.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to maintain an environment free of hazards including personal care and cleaning products that were accessible to residents on the Special Care Unit (SCU).<br><br>The findings are:<br><br>Review of the facility policy for safety measures for accidental Ingestion dated September 2021 revealed:<br>-Periodic screening for personal items that could be ingested are maintained by staff (all liquid | D 079 | | |

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| D 079 | Continued From page 1 | D 079 | | |

personal items, aerosols, hearing aids, pins, buttons, clips, etc.) in a secure location until needed for resident use.
-Resident and responsible party are notified of policy at admission.
-Resident rooms and care areas are inspected regularly for unsafe items that could be accidentally ingested or harmful (glass items, pictures with glass covers, vases, etc.).
-Staff routinely monitor residents for possible hoarding of substances that could be ingested.
-All toxic substances remain in the original container and secured in a locked area unless being under direct supervision.

Review of the facility's census report on 02/25/26 revealed there were 20 residents on the Special Care Unit (SCU) of the facility.

Observation of room 504 on 02/25/26 between 8:56am and 9:27am revealed there was a disposable razor in the bathroom.

Observation of room 502 on the SCU on 02/25/26 between 8:56am and 9:27am revealed there was a 1 pound 3.6-ounce container of disinfecting wipes sitting on the bathroom sink with a warning label reading: Caution: causes moderate eye irritation. Call a poison control center for treatment advice.

Interview with the resident in room 502 on 02/25/26 at 9:12am revealed:
-He did not know what the disinfecting wipes were used for.
-He did not know who put them in his bathroom.

Interview with a personal care aide (PCA) on 02/25/26 at 10:00am revealed:
-Residents were not allowed to have personal

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| D 079 | Continued From page 2 | D 079 | | |

care products in their rooms.
-Personal care products were stored in a locked closet.
-Personal care products were removed so that residents did not ingest to product.
-Personal care items were given to the residents in the morning before breakfast and during showers then they were locked up in the closet.
-Residents were not allowed to have cleaning products in their rooms.

Interview with a medication aide (MA) on 02/25/26 at 10:05am revealed:
-Personal care products should not be in the residents' rooms.
-She rounded in the morning and would remove any personal care products found.
-She had not made rounds today, 02/25/26.
-Personal care products and cleaning products were removed for the residents' safety.
-Residents could ingest a product or harm themselves or others.

Interview with the Special Care Coordinator (SCC) on 02/25/26 at 10:10am revealed:
-Personal care products were locked in a closet; each resident had a bin with their name on it.
-Personal care products were locked up for the residents' safety.
-The residents could harm themselves or others if they had access to products or razors.
-Residents were not allowed to have cleaning products in their rooms.
-The staff rounded every 2 hours and looked for personal care products when they performed personal care.
-She rounded every 3-4 hours and would look for personal care products.

Interview with the Regional Director of Operations

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| D 079 | Continued From page 3<br>(RDO) on 02/25/26 at 11:05am revealed:<br>-Personal care products are not to be kept in the residents' room.<br>-The PCAs and MAs should make rounds multiple times a day looking for personal care products.<br>-She was concerned that a resident could ingest a cleaning product or cut themselves or others with a razor. | D 079 | | |
| D 306 | 10A NCAC 13F .0904(d)(4) Nutrition and Food Service<br><br>10A NCAC 13F .0904 Nutrition and Food Service<br>(d) Food Requirements in Adult Care Homes:<br>(4) Water shall be served to each resident at each meal, in addition to other beverages.<br><br>This Rule is not met as evidenced by:<br>Based on observations and interviews, the facility failed to ensure water was served at the breakfast meal on the Special Care Unit (SCU) in addition to other beverages.<br><br>The findings are:<br><br>Observations of the breakfast meal service on 02/26/26 between 7:55am and 8:50am revealed:<br>-There were 19 residents present for the breakfast meal service.<br>-There was apple juice placed in front of the residents. | D 306 | | |

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| D 306 | Continued From page 4<br>-No resident was served water in addition to the apple juice.<br>-Some residents were served coffee in addition to the apple juice.<br>-One resident was served water after the meal.<br><br>Interview with a personal care aide (PCA) on 02/26/26 at 8:50am revealed:<br>-Water was not placed on the tables for the residents to drink.<br>-She did not know why water was not served.<br><br>Interview with a medication aide (MA) on 02/16/26 at 8:55am revealed:<br>-Water was not served to all the residents.<br>-She did not know why water was not served.<br><br>Interview with a second MA on 02/26/26 at 8:55am revealed:<br>-The kitchen only sent 3 water glasses this morning.<br>-She served one resident water after the resident ate breakfast.<br>-Water was not served with meals.<br>-She had never provided water to every resident with meals.<br><br>Interview with the Dietary Manager on 02/26/26 at 9:15am revealed:<br>-The facility did not have enough water glasses to provide water for every resident at meals.<br>-The facility had recently purchased 30 water glasses but still did not have enough water glasses.<br>-The kitchen also provided the water glasses to the MAs to use when they administered medications.<br><br>Interview with the Regional Director of Operations (RDO) on 02/26/26 at 9:48am revealed: | D 306 | | |

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| D 306 | Continued From page 5<br>-She did not know that there were not enough water glasses in the facility to serve water to the residents at each meal.<br>-She did know that the facility had recently purchased water glasses.<br>-There should be enough water glasses in the facility for each resident to be served water, milk, and juice (or beverage of choice) at each meal and for the MAs to have enough water glasses for the medication pass. | D 306 | | |
| D 344 | 10A NCAC 13F .1002(a) Medication Orders<br><br>10A NCAC 13F .1002 Medication Orders<br>(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:<br>(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;<br>(2) if orders are not clear or complete; or<br>(3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same.<br>The facility shall ensure that this verification or clarification is documented in the resident's record.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to clarify medication orders for 1 of 5 sampled residents (#5) including a medication used to treat involuntary movements.<br><br>The findings are: | D 344 | | |

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Review of Resident #5's current FL-2 dated 06/16/25 revealed: -Diagnoses included Huntington's disease, hypothyroidism, hyperlipidemia, generalized anxiety disorder, hypertension, iron deficiency.
-There was an order for Austedo 12mg, 1 tablet to be administered twice daily (used to treat involuntary movements).

Review of Resident #5's Resident Register revealed an admission date of 09/23/22.

Review of Resident #5's physician order dated 07/29/25 revealed there was an order for Austedo XR 9mg, 2 tablet to be administered twice daily.

Review of Resident #5's physician order dated 12/12/25 revealed there was an order for Austedo XR 9mg, 2 tablet to be discontinued on 12/12/25.

Review of Resident #5's physician order dated 12/12/25 revealed there was an order for Austedo 12mg, 1 tablet to be administered twice daily.

Review of Resident #5's physician order dated 12/29/25 revealed there was an order for Austedo 12mg, 1 tablet to be discontinued on 12/29/25.

Review of Resident #5's physician order dated 02/16/26 revealed there was an order for Austedo 9mg, 2 tablets to be administered twice daily.

Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed:
-There was an entry for Austedo 12mg, 1 tablet to be administered twice daily scheduled at 8:00am and 8:00pm.
-There was documentation Austedo 12mg 1

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tablet twice daily was administered at 8:00am and 8:00pm from 01/01/26 to 01/06/26.
-There was documentation from 01/07/26 to 01/31/26 Austedo 12mg was discontinued at 8:00am and 8:00pm.
-There was an entry for Austedo 12mg, 2 tablets twice daily to be administered twice daily scheduled at 8:00am and 5:00pm.
-There was documentation Austedo 12mg, 2 tablets twice daily was administered at 8:00am and 5:00pm from 01/07/26 to 01/15/26.
-There was documentation Austedo 12mg, 2 tablets twice daily was administered on 01/16/26 at 5:00pm.
-There was documentation Austedo 12mg, 2 tablets twice daily was discontinued on 01/16/26 at 8:00am.
-There was documentation from 01/17/26 to 01/31/26 Austedo 12mg, 2 tablets twice daily was discontinued at 8:00am and 5:00pm.
-There was an entry for Austedo 9mg, 2 tablets twice daily to be administered twice daily scheduled at 8:00am and 5:00pm.
-There was documentation Austedo 9mg, 2 tablets twice daily was administered on 01/17/26 at 5:00pm.
-There was documentation Austedo 9mg was administered at 8:00am and 5:00pm from 01/18/26 to 01/31/26.

Telephone interview with Resident #5's family member on 02/25/26 at 2:00pm revealed:
-Resident #5 Austedo was filled by a specialty pharmacy.
-When she received Resident #5's Austedo from the pharmacy, she took it to the facility.
-She was told by the Administrator that the order had to be sent for profile to the facility's pharmacy.
-She contacted Resident #5's neurologist who

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sent in an order for Austedo to the facility's pharmacy.

Telephone interview with a pharmacy representative at Resident #5's previous specialty pharmacy on 02/26/26 at 10:03am revealed:
-The pharmacy was a specialty pharmacy and dispensed Austedo for Resident #5.
-Austedo 9mg was dispensed for Resident #5 on 12/08/25 for a quantity of 120 tablets which was a 30-day supply.
-Austedo 9mg was dispensed for Resident #5 on 01/07/26 for a quantity of 120 tablets which was a 30-day supply.
-The medication was delivered to Resident #5's family member.
-The medication was used to manage Resident #5's Huntington's Disease.

Telephone interview with a pharmacy technician at Resident #5's current specialty pharmacy on 02/26/26 at 10:22am revealed:
-Austedo 9mg was dispensed for Resident #5 on 02/12/26 for a quantity of 120 tablets which was a 30-day supply.
-Austedo 9mg was dispensed for Resident #5 on 01/16/26 for a quantity of 120 tablets which was a 30-day supply.

Telephone interview with a pharmacist at the facility's contracted pharmacy on 02/26/26 at 10:30am revealed:
-The pharmacy had not been filling the Austedo prescription because Resident #5's family member had the medication filled at another pharmacy.
-The pharmacy filled Austedo 9mg tablets, a 30-day supply in error on 01/20/26 but no other time had they filled the prescription.
-The pharmacy entered the medication orders on

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the eMAR at the pharmacy, but she did not know if the facility could add or remove information from the eMAR.

Interview with a medication aide (MA) on 02/26/26 at 12:23pm revealed:
-She always gave the correct dosage of Austedo 9mg 2 tablets to Resident #5.
-She knew the medication Austedo 12mg was on the electronic medication record (eMAR) incorrectly.
-She signed off on the entry for Austedo 12mg although that was wrong to show she administered the medication.
-Resident #5 did not have an order Austedo 12 mg.
-She reported the issue to the Resident Care Coordinator (RCC) but could not recall the exact date and the RCC did not follow up.
-She reported the issue to the pharmacy in January 2026, and they did not correct the order on Resident #5's eMAR.

Telephone interview with Resident #5's primary care provider (PCP) on 02/26/26 at 3:40pm revealed:
-Resident #5's family member caught the mistake of Austedo 9mg verses Austedo 12mg on Resident #5's records.
-The PCP reported the issue to the RCC to speak with the neurologist to clarify the correct dosage.

Telephone interview with Resident #5's neurology Registered Nurse (RN) on 02/26/26 at 11:42am revealed:
-Resident #5 was prescribed Austedo 9mg, 2 tablets to be administered twice daily.
-Resident #5 had been on Austedo 9mg, 2 tablets twice daily since January 2018.
-The medication was used to help with reducing

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| D 344 | Continued From page 10<br>abnormal movement due to the Huntington's Disease.<br>-The neurologist saw Resident #5 on 01/16/26 and no new order was prescribed.<br><br>Interview with the Regional Clinical Director on 02/26/26 at 4:00pm revealed:<br>-The facility did not currently have an RCC.<br>-The pharmacy had Resident #5's Austedo dosage incorrect in the eMAR system.<br>-The facility attempted to get Resident #5's Austedo dosage corrected on the eMAR, but it took longer than it should have taken.<br>-The MA signed off on the entry for Austedo 12mg although that was wrong to show they administered the medication. | D 344 | | |
| D 358 | 10A NCAC 13F .1004 (a) Medication Administration<br><br>10A NCAC 13F .1004 Medication Administration<br>(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:<br>(1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and<br>(2) rules in this Section and the facility's policies and procedures.<br><br>This Rule is not met as evidenced by:<br>Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered to 1 of 3 residents (#6) observed during the medication pass including errors with a medication used to treat vitamin deficiencies and a medication used to lower blood glucose levels. | D 358 | | |

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| D 358 | Continued From page 11<br>The findings are:<br><br>The medication error rate was 7% as evidenced by the observation of 2 errors out of 27 opportunities during the 9:00am medication pass on 02/25/26.<br><br>Review of Resident #6's current FL-2 dated 01/16/26 revealed diagnoses included dementia, osteoporosis, anemia, diabetes, hypertension, hyperlipidemia, congestive heart failure, and chronic kidney disease.<br><br>a. Review of Resident #6's current FL-2 dated 01/16/26 revealed there was an order Calcium 600mg 1 tablet once daily (Calcium is a vitamin supplement used to treat low calcium levels in the blood).<br><br>Observation of the 9:00am medication pass on 02/25/26 revealed:<br>-The medication aide (MA) prepared Resident #6's medications.<br>-The MA was unable to locate Calcium 600mg to administer to Resident #6 at 9:14am.<br><br>Observation of Resident #6's medications on hand on 02/25/26 at 9:15am there was no Calcium 600mg available on the medication cart.<br><br>Review of Resident #6's February 2026 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Calcium 600mg give 1 tablet once daily at 9:00am.<br>-Calcium 600mg tablet was documented as administered daily at 9:00am from 02/01/26 to 02/21/26 and 02/23/26 to 02/24/26.<br>-Calcium 600mg tablet was documented as not administered on 02/22/26 and 02/25/26 due to | D 358 | | |

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the drug not being available on the exception list.

Telephone interview with a pharmacist from Resident #6's pharmacy on 02/26/26 at 8:50am revealed:
-The pharmacy had never dispensed Resident #6's Calcium 600mg tablets.
-They had transferred all remaining prescriptions for Resident #6 to the facility's contracted pharmacy on 01/26/26.

Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/26/26 at 9:20am revealed:
-Resident #6's Calcium 600mg tablets were last dispensed on 01/26/26 in a quantity of 10.
-The pharmacy had not dispensed any other Calcium 600mg tablets for Resident #6.

Interview with the MA on 02/25/26 at 2:15pm revealed:
-The family provided Resident #6's medications including Calcium 600mg tablet.
-She did not know why Resident $6's Calcium 600mg tablets were not on hand and available for administration.
-She had attempted to contact Resident #6's responsible party and obtain more Calcium 600mg tablets.

Interview with the Regional Clinical Director of Operations on 02/25/26 at 11:15am revealed:
-The family provided Resident #6's medications.
-If any medication was not available, the MA should notify the primary care provider (PCP) that the medication was not available.

Telephone interview with Resident #6's PCP on 02/26/26 at 3:48pm revealed she was not concerned that Resident #6 missed two Calcium

| 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 02/26/2026 |

| 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 13<br>600mg doses.<br><br>b. Review of Resident #6's current FL-2 dated 01/16/26 revealed there was an order for Toujeo administer 30 units daily (Toujeo is an injectable insulin that lowers blood glucose levels).<br><br>Observation of the 9:00am medication pass on 02/25/26 revealed:<br>-The medication aide (MA) removed Resident #6's Toujeo insulin pen from the medication cart, put a new needle on the pen, performed an air shot to prime the pen, and dialed the dose of 30 units on the pen.<br>-The MA administered Toujeo 30 units in Resident #6's lower right abdomen at 9:14am.<br><br>Observation of Resident #6's medications on hand on 02/25/26 at 9:15am revealed there was a Toujeo insulin pen labeled with Resident #6's name but not labeled with a date that the pen was opened.<br><br>Review of Resident #6's February 2026 electronic medication administration record (eMAR) revealed:<br>-There was an entry for Toujeo inject 30 units once daily scheduled for 9:00am.<br>-Toujeo 30 units was documented as administered daily at 9:00am from 02/01/26 to 02/25/26.<br><br>Interview with the MA on 02/25/26 at 2:15pm revealed:<br>-Resident #6's Toujeo should have been labeled with the date it was opened.<br>-Labels often came off insulin pens and staff had to relabel them.<br>-Since the date was not on the pen, she should have obtained a new pen to administer Resident | 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 02/26/2026 |

| 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 14<br>#6's Toujeo during the 9:00am medication pass.<br><br>Interview with the Regional Clinical Director of Operations on 02/25/26 at 11:15am revealed:<br>-All insulin pens should be labeled with the resident's name and the date the pen was opened.<br>-If the pharmacy label comes off of the pen, the MA should relabel the pen.<br>-A new insulin pen should have been used if the opened date was missing from the pen.<br><br>Telephone interview with a pharmacist from the facility's contracted pharmacy on 02/26/26 at 9:20am revealed Toujeo insulin pens could be stored at room temperature for 8 weeks.<br><br>Telephone interview with Resident #6's PCP on 02/26/26 at 3:48pm revealed:<br>-Resident #6's Toujeo insulin pen should have been labeled with the date it was opened.<br>-Insulin that is out of date could be less effective and not work as well for residents.<br><br>Based on observations, record reviews, and interviews, Resident #6 was not interviewable. | D 358 | | |