

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual and follow-up survey and complaint investigation on March 04, 2026 through March 11, 2026. The complaint investigations were initiated by the Nash County Department of Social Services on January 12, 2026 and January 20, 2026.	D 000	Responsible to cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts in the Statement of deficiencies of Corrective Action Report: The Plan of Correction is Prepared Solely as matter of compliance with State Law.	4/25/26 ongoing
D 125	10A NCAC 13F .0403(a) Qualifications Of Medication Staff 10A NCAC 13F .0403 Qualifications Of Medication Staff (a) Adult care home staff who administer medications, hereafter referred to as medication aides, and their direct supervisors shall complete training, clinical skills validation, and pass the written examination as set forth in G.S. 131D-4.5B. Persons authorized by state occupational licensure laws to administer medications are exempt from this requirement. Readopted Eff. July 1, 2021. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure 1 of 6 staff who administered medications to residents (Staff F) completed the medication administration clinical skills validation prior to the administration of medications to residents. The findings are: Review of the facility's undated Med Tech Training policy revealed: -Employees indicating desire to be a med tech, must be a certified nursing assistant (CNA) or a	D 125	An audit of all current Medication Aides personnel files was conducted by the Clinical Support Team on 3/12/26, The ED/ designee will audit the personnel files of any new hire assigned to pass medication to ensure all training documentation is present before they are allowed to work on the floor.	4/25/26 ongoing 4/25/26 ongoing

Division of Health Service Regulation

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

[Signature]

TITLE

Executive Director

(X6) DATE

4/23/2026

STATE FORM

6899

36EZ11

If continuation sheet 1 of 147

Reviewed and Acknowledged

[Signature]

05/04/26

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

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D 125	Continued From page 1 personal care aide (PCA) with certificate or verification on file. -Run medication test verification if has previously taken med tech test. -All documentation of med tech competencies, training and qualifications will be maintained in the employee's file for review. -Employee will review the study guide for medication on the learning platform prior to training on the medication cart. -The med tech in training will shadow with a seasoned med tech for 3-5 days/shifts, once this is completed, the community will notify the nurse that the trainee is ready for skills validation. -The nurse will observe the employee in a full medication pass and meet with employee and discuss items related to medication administration as the Medication Validation Skills Check-off form is completed along with questions and answers for Validation. -Upon completion of the skills validation, the nurse will meet and continue training with the trainee on diabetes management, coumadin administration, and psychotropic medications and any other items identified during the skills validation. -The nurse will complete a North Carolina 5-hour certificate, a certificate for diabetes management, coumadin administration, and psychotropic medication administration and place in the employee's file. -The employee will reverse shadow (meaning they complete the medication pass) while the seasoned med tech observes and provides guidance) for 3 days/shifts. -If the trainee does not pass the skills validation, they will need to go through additional training before the skills validation will be completed by the RN, they are deemed not able to pass medications.	D 125	ED/ designee will audit monthly for three months, and then quarterly.	4/25/26 on file

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D 125	Continued From page 2 -The med tech will register to take (if they have not previously done so), and pass the MT state test within 60 days of the skills check-off by the RN (Please assist them in registering for the test/exam as they only have 60 days once signed off to take it and pass, best to start this at the beginning of training). -If the med tech does not pass the state test within the 60-day period, they must immediately be removed from the medication cart. -Once they pass the test, they will be re-validated by the RN before they can administer medications. -The med tech trainee will need to attend the in-person 10-hour med tech training class with the RN within 60 days of skills check-off. -The trainee has passed the state test, received the skills competency by the RN and completed the required training they will need to review and sign the med tech job description. Review of Staff F's personnel record revealed: -Staff F's hire date was 07/07/23. -Staff F was hired as a MA. -Staff F completed her 15 hour medication training on 05/22/21. -Staff F completed her medication aide test on 09/24/21. -There was no documentation of a medication clinical skills checklist or LHPS staff competency completed. Interview with Staff F on 03/10/26 at 4:54pm revealed: -She had worked at another facility the company owned back in 2017 and had her medication clinical skills checklist completed then. -She did not have a new medication clinical skills checklist completed by the LHPS nurse when she began working at the facility.	D 125		

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D 125	Continued From page 3 Interview with the Administrator on 03/06/26 at 1:49pm revealed the LHPS nurse had the clinical skills checklist for Staff F and was attempting to locate the checklist. Interview with the Administrator on 03/11/26 at 3:52pm revealed: -The Business Office Manager (BOM) completed audits of the medication clinical skills checklist. -She provided assistance to the BOM when auditing staff personnel records, usually monthly. -She did not realize that Staff F did not have a medication clinical skills checklist in her personnel file. -All MAs should have a medication clinical skills checklist in their personnel record before passing medications. Attempted telephone interview with the LHPS nurse on 03/10/26 at 3:54pm was unsuccessful.	D 125		
D 162	10A NCAC 13F .0504(c) Competency Eval & Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Evaluation and Validation For Licensed Health Professional Support Tasks (c) Evaluation and validation of competency shall be performed by the following licensed health professionals in accordance with his or her North Carolina occupational licensing laws: (1) A registered nurse shall validate the competency of staff who perform any of the personal care tasks specified in Subparagraphs (a)(1) through (a)(28) of Rule .0903 of this Subchapter; (2) In lieu of a registered nurse, a licensed respiratory care practitioner may validate the	D 162	The ED will train all managers on the hiring LHPS checklist, specifically that no staff can perform LHPS task without signed documentation from the LHPS nurse. Care manager/ED will notify the LHPS nurse of any new task when identified. Medication aides will be trained of the the new task. The ED/designee will audit new hire files weekly for three months to ensure LHPS competency documentation is present before task performance.	4/10/26 ongoing 4/10/26 ongoing

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D 162	Continued From page 4 competency of staff who perform personal care tasks specified in Subparagraphs (a)(6), (a)(11), (a)(16), (a)(18), (a)(19), and (a)(21) of Rule .0903 of this Subchapter; (3) In lieu of a registered nurse, a licensed pharmacist may validate the competency of staff who perform the personal care tasks specified in Subparagraph (a)(8) and (a)(11) of Rule .0903 of this Subchapter. An immunizing pharmacist may validate the competency of staff who perform the personal care task specified in Subparagraph (a)(15) of Rule .0903 of this Subchapter; and (4) In lieu of a registered nurse, an occupational therapist or physical therapist may validate the competency of staff who perform personal care tasks specified in Subparagraphs (a)(17) and (a)(22) through (a)(27) of Rule .0903 of this Subchapter. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews and interviews, the facility failed to ensure 6 of 6 sampled staff (Staff A, Staff B, Staff C, Staff D, Staff E, and Staff F) were competency validated for Licensed Health Professional Support (LHPS) tasks by return demonstration including the placement and monitoring of a continuous glucose monitoring (CGM) device that detects trends and tracks patterns in the detection of episodes of low blood glucose and high blood glucose for 2 of 2 sampled residents (#5, #10). The findings are: Review of the facility's undated licensed health professional support (LHPS) Initial Evaluation and	D 162	On 3/10/26 the care manager obtain the orders immediately from the PCP for fasting bloodsugars for all residents that was currently using Libre CGM device.	4/10/26 ongoing

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1385 RIVER DRIVE

ROCKY MOUNT, NC 27803

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D 162	Continued From page 5 Quarterly Review of Residents policy revealed: -The facility should ensure a LHPS was completed and documented in the resident's record. -Community management would evaluate and identify residents with LHPS tasks on admission to the facility. -LHPS tasks identified on admission should be documented on the face sheet on admission and the LHPS would be notified for the initial evaluation. -"The LHPS will perform the LHPS Initial Evaluation and complete the form in the electronic health record, which needed to be completed within 30 days of admission or within 30 days from the date a resident develops the need for a new task and quarterly thereafter." -"The LHPS form is completed in the electronic health record and will appear on the dashboard for review and completion by community management (community management included the Administrator, Director of Resident Care (DRC), Resident Care Coordinator (RCC), Special Care Unit Coordinator (SCC) and then will be electronically signed by the LHPS." -"The LHPS will review the health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care on each evaluation." -"The LHPS will participate in an on-site review and evaluation of the resident's health status, care plan, and care provided for residents requiring, but not limited to, one or more tasks of the above tasks." -"The LHPS will review any changes and follow up recommendations to meet the resident needs with community management." -"The LHPS will continue to evaluate the residents quarterly for identified tasks."	D 162	On 3/17/25 all medication aides including all new hire medication aides was in-serviced on Libre CGM device. In-service attached conducted by the community Regional Clinical Nurse Director. All medication aides will perform figure sticks until competency is evaluated and validated by the LHPS nurse by 4/27/26. The LHPS nurse will be contacted and informed within 24 hours of any new admissions with a new LHPS task to schedule a visit to evaluate and validate competency of new task, The ED/ Care managers will ensure that all staff validations are maintained in their personnel files. The Care manager / ED will complete quarterly audits on resident LHPS task to ensure that LHPS nurse has assess the resident and the staff has been competency to perform any LHPS task.	4/10/26 ongoing 4/10/26 ongoing 4/10/26 ongoing 4/10/26 ongoing

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D 162	Continued From page 6 Review of the manufacturer's quick reference guide for the Free Style Libre 3 continuous glucose monitoring (CGM) manufacturer's revealed: -A Free Style Libre 3 is a CGM for people with diabetes to track their glucose levels. -The CGM sensor should only be applied to the back of the upper arm. -The CGM sensor may not work properly in other areas. -Avoid scars, moles, stretch marks, and lumps when placing the CGM sensor. -Choose an area that stays mostly flat (no bending or folding) during the day when placing the CGM sensor. -The CGM sensor should be placed at least one inch away from insulin injection sites. Review of Staff A's personnel record revealed: -Staff A's hire date was 01/02/26. -Staff A was hired as a medication aide (MA). -There was no documentation of training on the continuous glucose monitoring (CGM) device on Staff A's LHPS competency validation. Interview with Staff A on 03/06/26 at 11:30am revealed the Resident Care Coordinator (RCC) and LHPS nurse provided training on the CGM around the beginning of February. Review of Staff B's personnel record revealed: -Staff B's hire date was 12/29/25. -Staff B was hired as a MA. -There was no documentation of training on the CGM device on Staff B's LHPS competency validation. Review of Staff C's personnel record revealed: -Staff C's hire date was 12/18/25.	D 162		

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D 162	Continued From page 7 -Staff C was hired as a MA. -There was no documentation of training on the CGM device on Staff C's LHPS competency validation. Review of Staff D's personnel record revealed: -Staff D's hire date was 09/08/25. -Staff D was hired as a MA. -There was no documentation of training on the CGM device on Staff D's LHPS competency validation. Review of Staff E's personnel record revealed: -Staff E's hire date was 07/11/25. -Staff E was hired as a MA. -There was no documentation of training on the CGM device on Staff E's LHPS competency validation. Review of Staff F's personnel record revealed: -Staff F's hire date was 07/07/23. -Staff F was hired as a MA. -There was no documentation of training on the CGM device on Staff F's LHPS competency validation. Interview with Staff F on 03/10/26 at 4:54pm revealed: -She had worked at another facility the company owned back in 2017 and her LHPS Staff Competency was completed then. -She did not have a new LHPS competency validation completed by the LHPS nurse when she began working at the facility. -She could not remember if the LHPS nurse had trained her on the placement of a CGM device and how to use the receiver. a. Review of Resident #5's FL2 dated 01/24/25 revealed diagnoses included type 2 diabetes,	D 162		

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D 162	Continued From page 8 hypertension, and cognitive communication disorder. Review of Resident #5's FL2 dated 01/08/26 revealed: -Diagnoses included type 2 diabetes, nutritional deficiency, and cognitive communication disorder. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors, use to check blood sugars four times per day. Review of Resident #5's signed physicians order sheet dated 01/08/26 revealed there was an order for FSL3 Kit Plus/Sensors to check blood sugars four times per day. Review of Resident #5's endocrinology provider notes dated 12/03/25 revealed: -The reason for the appointment was type 2 diabetes mellitus with hypoglycemia (low blood sugar) without coma. -Assessments included type two diabetes mellitus with hypoglycemia, without coma, without long-term current use of insulin. -Treatment included, start FSL3 plus Sensor, used to check blood sugars four times per day and FSL3 Reader Device used to check blood sugar four times per day. -Resident #5 had a FSL3 sensor placed in the office with a loaner reader. -She was currently on no diabetes medications. -Her blood glucose log ranged from 65 to 164. -Staff with the resident called the facility to be sure the facility could apply a new sensor and staff said the resident was able to wear a sensor and a FSL3 sensor was placed. Review of Resident #5's quarterly LHPS dated 01/28/26 revealed: -Tasks currently present were identified as	D 162		

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D 162	Continued From page 9 transferring semi-ambulatory or non-ambulatory residents, ambulation with assistive devices that required physical assistance, and collecting and testing of FSBS samples. -She was diabetic with FSBS checked four times daily, ranging from 74 to 102, controlled by oral medications, with FSBS and Injection sites within normal limits. -She had LHPS tasks including FSBS, ambulation using assistive devices requiring staff assistance, and transfer assistance from staff. -The resident was alert and oriented to person, place and was observed sitting in a wheelchair in the day room at the time of the assessment. -Her appetite was good with no weight changes reported. -She was non-ambulatory and used a wheelchair, requiring one person assistance for transfers. -The resident denied any complaints at the time of the assessment, continue plan of care. -No changes or follow-up were recommended to meet the residents' needs. -Facility staff competency was validated for transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that required physical assistance, and collecting and testing of FSBS samples. -Resident #5's quarterly LHPS evaluation was signed by the LHPS RN 01/29/26. -There were no tasks identified for placement of CGM sensor or checking blood glucose using a CGM device. Interview with a MA on 03/09/26 at 1:57pm revealed: -She was trained a few months ago on the Libre sensor by a MA that no longer worked at the facility. -When she applied the CGM sensor herself to Resident #5 she placed the sensor to the bottom	D 162		

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D 162	Continued From page 10 of the residents' left lower stomach and twisted the applicator onto the resident's skin when she injected the CGM. -She was supposed to check the resident's receiver to the sensor four times a day for her blood sugar reading, but staff had difficulties getting the sensor to provide the resident's blood glucose levels. Interview with the Resident Care Coordinator (RCC) on 03/06/26 at 10:00am revealed: -By the end of January 2026 the LHPS nurse saw that Resident #5's blood sugar readings were not populating on the eMAR from the CGM. -No LHPS training was done for the CGM. -There should be LHPS training for the CGM. -The LHPS training should be done so staff could learn to use the machine, learn to document, and get a diabetic training refresher so they can watch for hypoglycemia. Telephone interview with the primary care provider (PCP) on 03/06/26 at 2:45pm revealed: -There were issues with the CGM not working where the blood glucose was measuring low, but Resident #5 was alert and conversational. -Resident #5's presentation did not match the low blood glucose readings from the CGM at times. -MA's could not determine whether the low blood glucose reading was an error, and MAs should contact the provider via the provider triage system and get advice. -The facility should provide education on how to use the CGM and how to document the blood glucose readings. -She approved as needed (PRN) FSBS whenever the CGM was not working because she was concerned that Resident #5 would be sent to the hospital unnecessarily.	D 162		

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D 162	Continued From page 11 Attempted Interview with Resident #5 on 03/04/26 at 9:30am revealed she reported she "can't remember anything". Attempted telephone interview with the Licensed Health Professional Support (LHPS) Registered Nurse on 03/10/26 at 3:54pm was unsuccessful. Attempted telephone interview with Resident #5's endocrinology provider on 03/06/26 at 4:56pm was unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:59am, and 2:04pm were unsuccessful. Refer to interview with a MA on 03/09/26 at 1:57pm. Refer to interview with the RCC on 03/09/26 at 2:47pm. Refer to telephone interview with the facility's contracted PCP on 03/11/26 at 10:21am. Refer to interview with the Administrator on 03/11/26 at 3:52pm. b. Review of Resident #10's FL2 dated 11/10/25 revealed: -Diagnoses included mild dementia, chronic	D 162		

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D 162	Continued From page 12 kidney disease stage 4, hypertension, and diabetic morbid obesity. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors (a Freestyle Libre 3 is a continuous glucose monitoring device for people with diabetes to track their glucose levels), change every 15 days. -There was an order for Freestyle Libre 3 reader as directed for daily use. Review of Resident #10's quarterly Licensed Health Professional Support Evaluation (LHPS) dated 02/23/26 revealed: -Personal tasks currently present were identified as medication administration through injections and collecting and testing of finger stick blood sugar (FSBS) samples. -The resident was alert and oriented to person, place, and time. -The resident was ambulatory with a cane and required no assistance with transfers. -The resident experienced no weight loss or gain in the last quarter. -The resident had no falls reported in the last quarter. -The resident denied any complaints at the time of assessment. -No changes or follow-up were recommended to meet the residents' needs. -Facility staff competency was validated for collecting and testing of FSBS samples and medication administration through injections. -The LHPS evaluation was signed by the LHPS Registered Nurse on 02/23/26. -There was no documentation Resident #10 had a task to apply a CGM device. Observation of Resident #10 on 03/10/26 at 1:03pm revealed there was a CGM sensor on her upper right arm.	D 162		

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 162	Continued From page 13 Interview with Resident #10 on 03/10/26 at 1:04pm revealed: -Her "sensor" was on her right arm today. -The CGM sensor had been placed on her lower stomach and both of her arms in the past. Refer to Interview with a MA on 03/09/26 at 1:57pm. Refer to interview with the RCC on 03/09/26 at 2:47pm. Refer to telephone interview with the facility's contracted PCP on 03/11/26 at 10:21am. Refer to interview with the Administrator on 03/11/26 at 3:52pm. Interview with a MA on 03/09/26 at 1:57pm revealed: -A MA that previously worked at the facility trained her on how to place the CGM sensor. -She asked the MA that previously worked at the facility to train her. -She had never received training from a Registered Nurse. -She asked for help with training on the application of the CGM because she was concerned about applying the sensor due to how fragile the resident's skin was. -After the MA that previously worked at the facility demonstrated how to apply the Libre sensor, the MA checked her off on a list that she was trained on how to apply the Libre sensor. -She was not sure what the list was that she was checked off on. -When she applied the Libre sensor herself to Resident #6 she placed the sensor to the bottom of the residents' left lower stomach.	D 162		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1366 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 162	Continued From page 14 -She was supposed to check the resident's receiver to the sensor four times a day for her blood sugar reading but staff had difficulties getting the sensor to provide the resident's blood glucose levels. Interview with the RCC on 03/09/28 at 2:47pm revealed: -She provided one on one training to all the MAs on how to place a Libre sensor on a resident. -She instructed the MAs to apply the Libre sensor to the resident's arm or on the resident's abdomen. -After she provided the training to MAs on how to place the Libre sensor they were allowed to replace the sensor for residents with a CGM sensor independently. -She did not document the training she provided to the MAs. -She was not aware that the LHPS nurse was responsible for providing training to herself and all MAs on how to correctly place the CGM sensor on residents and use to receiver. Telephone Interview with the facility's contracted PCP on 03/11/26 at 10:21am revealed: -The CGM sensor should be placed on the back of a resident's arm. -Staff should be trained on the proper placement and use of the CGM sensor and receiver device to ensure proper blood glucose readings to prevent episodes of hypoglycemia or hyperglycemia. Interview with the Administrator on 03/11/26 at 3:52pm revealed: -The Business Office Manager (BOM) completed audits of staff competency validated LHPS task lists usually weekly. -She provided assistance to the BOM when	D 162			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1305 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 162	Continued From page 15 auditing staff personnel records. -The BOM reached out to her, the RCC, or SCC if a staff member needed an updated competency validated LHPS task list completed. -The competency validated LHPS tasks by return demonstration should be completed for all residents tasks to ensure they received the proper care from staff that were appropriately trained. -The competency validated LHPS task list ensured that staff were fully educated and understood the tasks they needed to perform for residents. -She had not considered adding staff competency validation LHPS task list for CGM's because it was not listed on the LHPS form. -She followed up on the quarterly LHPS tasks lists that were completed by the LHPS nurse and when there was a new task added for a resident. Attempted telephone interview with the Licensed Health Professional Support (LHPS) Registered Nurse on 03/10/26 at 3:54pm was unsuccessful. The facility failed to provide competency validation for Licensed Health Professional Support (LHPS) tasks by a Registered Nurse to provide return demonstration to ensure the proper use of a continuous glucose monitoring (CGM) device and reader (#5, #10). Facility staff placed a CGM sensor on a resident's abdomen and twisted the device while applying it to the resident's lower abdomen, lack of education to place the sensor in the appropriate place to obtain accurate blood glucose readings for two residents with one resident experiencing several hypoglycemic episodes and requiring an emergency room visit (#5). This failure resulted in substantial risk for serious physical harm and constitutes a Type A2 Violation.	D 162		

[illegible]

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 259	Continued From page 17 (8) a dated signature of the resident's physician or physician extender as defined in Rule .0102 of this Subchapter within 15 days of completion of the care plan certifying the resident is under this physician's care and has a medical diagnosis with associated physical or mental limitations warranting the provision of the personal care services in the above care plan in accordance with G.S. 131D-2.15. This shall not apply to residents assessed through the Medicaid State Plan Personal Care Services Assessment for the portion of the assessment covering tasks needed for each activity of daily living of this Rule for which care planning and signing are directed by Medicaid. This Rule is not met as evidenced by: Based on record reviews, and interviews, the facility failed to ensure care plans for 2 of 6 sampled residents were completed to include the residents' required level of assistance with activities of daily living (#3, #4). The findings are: Review of the facility's undated Resident Assessment and Care Planning Policy revealed: -Residents are assessed on admission and ongoing based on the individual needs in the care planning process, and the care plan is updated to reflect significant changes in resident care planning. -The initial assessment is completed by the	D 259		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 259	Continued From page 18 Director of Resident Care, Resident Care Coordinator, or the Memory Care Coordinator as assigned. -The Executive Director will complete the assessment in the absence of other members of the management team. -A resident is assessed upon admission using the Resident Register and a full assessment with care planning is completed within 30 days of admission and annually and as needed for significant change. -The assessment will include the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living. -Activities of daily living are bathing, dressing, personal hygiene, ambulation, or locomotion, transferring, toileting, and eating. -The assessor will sign the plan of care and the provider will approve and sign the plan of care within 15 days of the assessor completing the plan of care. 1. Review of Resident #4's current FL-2 dated 11/04/25 revealed: -Diagnoses included Alzheimer's Disease, dementia, type 2 diabetes, hypertensive kidney disease, chronic respiratory failure with hypoxia, and pulmonary hypertension. -Her level of care was Special Care Unit. Review of Resident #4's care plan dated 02/26/26 revealed: -Under mental health and social history, wandering, verbally abusive, and resists care were documented. -She was currently receiving medications for mental behaviors and there was a history of mental illness. -She was ambulatory with aide or devices.	D 259		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 259	Continued From page 19 -She had no problems with her upper extremities. -Nutrition was documented as oral and her weight was documented as 128 pounds. -Her respirations were documented as normal. -Bowel and bladder were documented as normal. -Orientation was documented as sometimes disoriented. -Memory was documented as forgetful, needs reminders. -She was currently receiving mental health services. -Her vision was documented as adequate for daily activities. -Her hearing was documented as adequate for daily activities. -Her speech/communication was documented as normal. -The Activities of Daily Living (ADL) section was blank. -There was no performance code documented for eating. -There was no performance code documented for toileting. -There was no performance code documented for ambulation/locomotion. -There was no performance code documented for bathing. -There was no performance code documented for grooming/personal hygiene. -There was no performance code documented for transferring. -There were no licensed health professional support personal care tasks documented. -Resident #4's care plan was signed by the Special Care Coordinator (SCC) on 02/26/26. -Resident #4's care plan was signed by her primary care provider (PCP) on 02/26/26. Refer to Interview with the Special Care Coordinator (SCC) on 03/09/26 at 3:30pm.	D 259		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 259	Continued From page 20 Refer to second interview with the SCC on 03/11/26 at 3:30pm. Refer to interview with the Administrator on 03/11/26 at 3:53pm. 2. Review of Resident #3's current FL-2 dated 12/18/25 revealed: -Diagnoses Included hypertension, hyperlipidemia, vascular dementia, osteoarthritis, and unspecified protein-calorie malnutrition. -The resident's level of care was Special Care Unit. Review of Resident #3's care plan dated 03/05/26 revealed: -Under mental health and social history there was documentation that the resident wandered. -The resident was currently receiving medications for mental behaviors and there was a history of mental illness. -The resident was ambulatory with a walker. -The resident had no problems with his upper extremities. -Nutrition was documented as oral and there was no weight documented. -The resident's respiration were documented as normal. -The resident had occasional incontinence of the bladder and bowels. -Orientation was documented as sometimes disoriented. -Memory was documented as forgetful, needs reminders. -The resident's vision was documented as adequate for daily activities. -The resident's hearing was documented as adequate for daily activities. -The resident's speech/communication was	D 259		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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)	(X6) COMPLETE DATE
D 259	Continued From page 21 documented as normal. -The Activities of Daily Living (ADL) section was blank. -There was no performance code documented for eating. -There was no performance code documented for toileting. -There was no performance code documented for ambulation/locomotion. -There was no performance code documented for bathing. -There was no performance code documented for grooming/personal hygiene. -There was no performance code documented for transferring. -There were no licensed health professional support personal care tasks documented. -Resident #3's care plan was signed by the Special Care Coordinator (SCC) on 03/05/26. -Resident #3's care plan was signed by his primary care provider (PCP) on 03/05/26. Refer to interview with the Special Care Coordinator (SCC) on 03/09/26 at 3:30pm. Refer to second interview with the SCC on 03/11/26 at 3:30pm. Refer to interview with the Administrator on 03/11/26 at 3:53pm. Interview with the SCC on 03/09/26 at 3:30pm revealed: -The Care Managers (SCC and Resident Care Coordinator) were responsible for the residents' care plans. -She did not think she had ever completed the performance codes for the resident's ADLs. -She entered the resident's information into the computer system, and she thought the ADL	D 259		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 259	Continued From page 22 performance code auto-populated from the assessment information entered. -She had noticed the ADL performance codes did not show up on the residents' care plan and thought it may be a software issue with the facility's health record system. Second interview with the SCC on 03/11/26 at 3:30pm revealed: -The residents' care plans were the responsibility of the care managers which included herself and the Resident Care Coordinator (RCC). -When she completed a care plan for a resident, she went by an assessment sheet and entered the information in the facility's health record system. -The ADL performance code let care staff know what a resident could and could not do. -The ADL performance code was also important because it served as a guide for care staff as to what type and how much assistance a resident required. Interview with the Administrator on 03/11/26 at 3:53pm revealed: -The Care Managers (SCC and RCC) were responsible for completing the residents' care plans. -Care plans were to be completed on admission, annually, and if there was a significant change in the resident's condition. -The facility had a new electronic health record system as of 12/01/25 and staff were still learning the system. -The ADL performance codes were important because it let care staff know what type care and assistance each resident required.	D 259			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 273	Continued From page 23	D 273	The care manager/designee did a 100% audit of all residents that have a CGM devices to ensure that they are functioning and all required physician follow-ups are scheduled on 3/12/26.	4/25/26 ongoing
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure health care coordination and follow-up for 1 of 5 sampled residents (#5) including failing to notify the resident's endocrinology provider immediately of a malfunctioning continuous glucose monitoring device and scheduling a follow up appointment with the endocrinology provider in a timely manner. The findings are: Review of facility's undated policy for Residents Receiving Diabetic Medications/Treatments revealed: -Residents receiving medications/treatments for diabetic care will be monitored according to physician's orders. -Every resident will have their own glucose monitor; it will be labeled with their name and placed in a bag with their name. -All medications, blood sugar monitoring, insulins will be added to the diabetic flowsheet. -The provider should include low and high parameters for resident blood sugar levels. -The medication aide (MA) will notify the Care Coordinator of any refusals/or abnormal results per parameters given by the resident's provider. -The Care Coordinator will review any refusals	D 273		
			The care managers reviewed all recent physician orders, medical provider notes, Ltrps to verify that no other medical referrals or follow-up appointment were missed. The care manager/ED will review any referrals and follow-ups in stand up that shows physician recommendations for three months.	4/25/26 ongoing

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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 273	Continued From page 24 and/or abnormal blood sugar readings and notify the provider and document the notification and any new orders in the resident's chart. Review of the facility's undated policy for Health Care Referral and Follow-up revealed: -It is the policy of the community to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident's record. -Documentation in the resident's record will include contacts with the physician/provider, other support licensed service providers, family, responsible parties, and guardians, when there are illnesses, incidents, accidents, and routine care and follow-up as needed. -Visits to providers or onsite visits by providers including any new orders, for medications, treatments, or procedures. -Hospital discharges, follow-up care, and medication reconciliation. -Lab visits, and parameters, falls, and any other routine or acute health care need of the resident. Review of the facility's undated policy for Health Care Referral and Follow-up for Vital Signs(blood pressure, pulse respirations, blood sugars) Outside of Parameters revealed: -The community will follow the provider's orders for vital signs outside of parameters. -The provider will document in the order all steps to be taken when a vital sign is below parameters. -The provider will document in the order all steps to be taken when a vital sign is above the parameters. -The staff will immediately notify the provider of any vital signs below or above parameters timely by telephone and fax using the Health Care	D 273		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 273	Continued From page 25 Notification. -The staff will document notification to the provider in the progress notes and document any physician/provider verbal orders given by the provider. Review of Resident #5's FL2 dated 01/24/25 revealed diagnoses included type 2 diabetes, hypertension, and cognitive communication disorder. Review of Resident #5's FL2 dated 01/08/26 revealed: -Diagnoses included type 2 diabetes, nutritional deficiency, and cognitive communication disorder. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors (a Free Style Libre 3 is a continuous glucose monitoring device for people with diabetes to track their glucose levels), use to check blood sugars four times per day. a. Review of Resident #5's signed physicians order sheet dated 01/08/26 revealed there was an order for Free Style Libre 3 Kit Plus/Sensors, to check blood sugars four times per day. Review of Resident #5's endocrinology provider notes dated 12/03/25 revealed: -The reason for the appointment was type 2 diabetes mellitus with hypoglycemia (low blood sugar) without coma. -Assessments included type two diabetes mellitus with hypoglycemia, without coma, without long-term current use of insulin. -Treatment included, start FSL3 plus Sensor, used to check blood sugars four times per day and FSL3 Reader Device used to check blood sugar four times per day. -Resident #5 had a FSL3 sensor placed in the office with a loaner reader.	D 273		

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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 26 -She was currently on no diabetes medications. -She was a resident at a facility and had dementia. -Her blood glucose log ranged from 65 to 164. -Staff with the resident called the facility and said the resident was able to wear a sensor and a FSL3 sensor was placed. -She was to return to the office in 2 weeks, and her next appointment was scheduled for 12/17/25 at 10:30am. Review of Resident #5's endocrinology provider notes dated 01/05/26 revealed: -The reason for the appointment was 2 week recheck for diabetes mellitus, FSL3 uploaded, and finger stick of 61 and 57. -Assessments included type 2 diabetes mellitus with hypoglycemia. -Her FSL3 readings were 76% Time In Range (the percentage of time per day the users' glucose remains in target range, typically between 70 and 180mg/dl), and 24% hypoglycemic events. -Her blood glucose was low in the office at 61 and was repeated at 57 after half of a cola. -Her blood glucose was repeated after a whole cola and was 43. -Emergency Medical Services (EMS) was called to the office and the resident was transported to the emergency department (ED). -She was to continue glucose monitoring and to return to the office in 2 to 3 weeks. Review of handwritten order sheet from Resident #5's endocrinology provider dated 01/05/26 revealed: -Resident #5's blood sugars were low in the office, 61, 57, and 43. -Her FSL3 readings were low 24%. -No diabetic medications at this time.	D 273		

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION				
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1385 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 27 -Continue wearing FSL3 sensors. Review of the facility's staff progress notes revealed: -There was an entry dated 01/05/26 by a medication aide (MA) at 9:31pm, the resident went to the doctor, was sent to the ED, and came back to the facility. -There was an entry dated 01/06/26 by a MA at 5:33am, monitored resident's blood sugar after returning from the hospital, blood sugar was checked at 12:00am and was 59, gave the resident a snack and some orange juice, and blood sugar was rechecked at 1:15am and was 79. -There was an entry dated 02/01/26 by a MA at 8:31pm, "meter is not working". -There was an entry on 02/08/26 by a MA at 5:06pm, "unable to use meter, finger stick". -There was an entry on 02/24/26 by the transportation coordinator (TC) at 10:46am, an appointment was made with the endocrinology office for 03/31/26 at 9:00am. -There was an entry on 03/03/26 by the Resident Care Coordinator (RCC) at 12:18pm, called the endocrinologist's office for earlier appointment, the FSL3 was malfunctioning and unable to get accurate blood sugar reading, she also called the company to see if she could get a new one but unable due to not being able to speak with someone and would try again. Telephone interview with a scheduler at Resident #5's endocrinology office on 03/10/26 at 11:26am revealed: -Resident #5 was seen for her initial visit in their office on 12/03/25 at 1:00pm. -The RCC from the facility contacted the office on 12/03/25 at 2:33pm and advised that a signed order was needed for Resident #5's FSL3 and	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 273	Continued From page 28 wanted it faxed to the facility. -There was a phone call from the RCC on 03/03/26 that they were unable to get accurate readings on Resident #5's FSL3 and requested an urgent appointment. -There were no phone calls prior to 03/03/26 regarding Resident #5's FSL3 malfunctioning. Review of a handwritten physician order from Resident #5's endocrinology provider dated 03/03/26 revealed: -There was an order to discontinue FSL3. -Resume finger stick blood sugars (FSBS) four times per day. -Notify provider of blood sugar less than 70. -Give orange juice and sugar and recheck in 30 minutes. Review of a handwritten physician order sheet from Resident #5's primary care provider (PCP) dated 03/04/26 revealed: -There was an order to change FSBS to twice a day at 7:00am and 7:00pm. -Notify provider of blood sugar less than 70. -Give eight ounces of orange juice with sugar and recheck FSBS in 30 minutes. Interview with a MA on 03/09/26 at 2:11pm revealed: -Resident #5 had a history of low blood sugars. -Resident #5's FSBS were not always accurate, and she thought that was why the FSL3 was ordered to monitor her blood sugar without finger sticks. -Another MA taught her how to apply the FSL3 sensors. -About a month ago, the FSL3 reader would not pair with the FSL3 sensor, and they could not get blood sugar readings on Resident #5. -The FSL3 sensor was changed out, and she	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 273	Continued From page 29 thought she notified the Resident Care Coordinator (RCC) and the RCC contacted the pharmacy about replacement sensors, thinking the sensors were bad. -She was not sure exactly when she notified the RCC that Resident #5's FSL3 was malfunctioning. -When they could not get blood sugar readings from Resident #5's FSL3, FSBS were done. -Resident #5's FSL3 was discontinued and FSBS twice a day were ordered. Interview with a second MA on 03/10/26 at 4:54pm revealed: -She had never had to change Resident #5's FSL3 sensor. -There had been sometimes when she could not get a blood sugar reading from Resident #5's FSL3. -When she was unable to get Resident #5's blood sugar reading on the FSL3, a FSBS was done. -She never reported Resident #5's malfunctioning FSL3 to Resident #5's provider or to the RCC, she reported it to the on-coming MA for the next shift. Interview with a thrd MA on 03/11/26 at 10:48am revealed: -A week or so ago, Resident #5's FSL3 was not recording her blood sugars and she notified the RCC. -She and the RCC tried changing out Resident #5's FSL3 sensor but that did not help and the RCC contacted the FSL3 manufacturer to try to obtain a new unit. Interview with the RCC on 03/10/26 at 4:07pm revealed: -She was notified that Resident #5's FSL3 was not recording blood sugars about a week ago,	D 273		

PRINTED: 04/01/2026
FORM APPROVED

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034		

NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 273	Continued From page 30 she thought either in late February 2026 or early March 2026. -Resident #5's next appointment with her endocrinologist was 03/31/26 and she contacted their office about a week ago to notify that Resident #5's FSL3 was malfunctioning and to request a sooner appointment for Resident #5. -She also attempted to contact the manufacturer of the FSL3 for a new unit for Resident #5 but was unsuccessful. -She was told there were no appointments available before 03/31/26 with the endocrinology provider and to resume FSBS on Resident #5. -She was not notified about Resident #5's malfunctioning FSL3 until about a week or so ago. -She was not aware of the progress notes from the MA on 02/01/26 and 02/08/26 that the FSL3 was not recording Resident #5's blood sugar. -The MA should have notified Resident #5's endocrinology provider and her immediately when Resident #5's FSL3 malfunctioned in early February. Interview with the Administrator on 03/11/26 at 4:10pm revealed: -The MAs were expected to contact the resident's provider when there were any medical issues or concerns. -The MAs also were expected to notify the Care Managers, either the RCC or the Special Care Coordinator (SCC), if there was a problem or concern about a resident. -The MAs should have notified Resident #5's endocrinologist and the RCC immediately when there were problems with her FSL3 recording her blood sugars. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at	D 273		

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1385 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 31 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:58am, and 2:04pm were unsuccessful. b. Review of Resident #5's endocrinology provider notes dated 12/03/25 revealed: -The reason for the appointment was type 2 diabetes mellitus with hypoglycemia (low blood sugar) without coma. -Assessments Included type two diabetes mellitus with hypoglycemia, without coma, without long-term current use of insulin. -Treatment included, start FSL3 plus Sensor, used to check blood sugars four times per day and FSL3 Reader Device used to check blood sugar four times per day. -Resident #5 had a FSL3 sensor placed in the office with a loaner reader. -She was currently on no diabetes medications. -She was a resident at a facility and had dementia. -Her blood glucose log ranged from 65 to 164. -Staff with the resident called the facility and said the resident was able to wear a sensor and a FSL3 sensor was placed. -She was to return to the office in 2 weeks, and her next appointment was scheduled for 12/17/26 at 10:30am. Review of Resident #5's endocrinology provider notes dated 01/05/26 revealed: -The reason for the appointment was 2 week recheck for diabetes mellitus, FSL3 uploaded,	D 273		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034		
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 32 and finger stick of 61 and 57. -Assessments included type 2 diabetes mellitus with hypoglycemia. -Her FSL3 readings were 76% Time in Range (the percentage of time per day the users' glucose remains in target range, typically between 70 and 180mg/dl), and 24% hypoglycemic events. -Her blood glucose was low in the office at 61 and was repeated at 57 after Resident #5 drank half of a cola. -Her blood glucose was repeated after Resident #5 drank a whole cola and was 43. -Emergency Medical Services (EMS) was called to the office and the resident was transported to the emergency department (ED). -She was to continue glucose monitoring and to return to the office in 2 to 3 weeks. Review of the facility's staff progress notes revealed: -There was an entry on 02/24/26 by the transportation coordinator (TC) at 10:46am, an appointment was made with the endocrinology office for 03/31/26 at 9:00am. -There was an entry on 03/03/26 by the Resident Care Coordinator (RCC) at 12:18pm, called the endocrinologist's office for earlier appointment, the FSL3 was malfunctioning and unable to get accurate blood sugar reading, she also called the company the see if she could get a new one but unable due to not being able to speak with someone and would try again. Telephone interview with a scheduler at Resident #5's endocrinology office on 03/10/26 at 11:26am revealed: -Resident #5 was seen for her initial visit in their office on 12/03/25 at 1:00pm. -Resident #5 had a return appointment on	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1366 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 273	Continued From page 33 12/17/25 and call was received that there was no transportation available and the appointment was rescheduled to 12/18/25. -Resident #5 kept the 12/18/25 appointment but was unable to be seen due to not having the required paperwork, she was not sure what paperwork was missing. -Resident #5's appointment was rescheduled to 01/05/26. -Resident #5 kept the 01/05/26 appointment and was given a follow-up appointment for 02/02/26. -The endocrinology office was on a 2-hour delayed opening on 02/02/26 due to a recent snowstorm and Resident #5's appointment was not kept. -There was a phone call on 02/24/26 from the facility to schedule Resident #5's follow-up appointment from 02/02/26, and an appointment was scheduled for 03/31/26 at 9:00am. -There was a phone call from the RCC on 03/03/26 that they were unable to get accurate readings on Resident #5's FSL3 and requested an urgent appointment. Interview with the Transportation Coordinator (TC) on 03/11/26 at 11:42am revealed: -She provided transportation and attended appointments with the residents. -She stayed with the residents during their appointments. -She transported Resident #5 to her endocrinology appointment on 12/03/25 and a return appointment was scheduled for 12/17/25. -She thought she was out sick on 12/17/25 and that was why Resident #5's 12/17/25 appointment was rescheduled to 12/18/25. -She transported Resident #5 to her 12/18/25 endocrinology appointment, they waited several hours to be seen because the office said they did not have the needed paperwork from the facility	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 34 and Resident #5 was not seen and her appointment was rescheduled to 01/05/26. -She transported Resident #5 to her 01/05/26 endocrinology appointment, Resident #5 was seen and a return appointment was scheduled for 02/02/26. -She was unable to transport Resident #5 to her 02/02/26 endocrinology appointment due to recent heavy snow fall. -She contacted Resident #5's endocrinology office to cancel and reschedule her 02/02/26 appointment but the office was closed and she had to leave a message. -She did not hear back from the endocrinology office and reached out to their office at the end of the first week in February 2026 and again she was unable to reach anyone and did not document the attempt. -She felt she had tried several times to reach someone at Resident #5's endocrinology office to reschedule the missed 02/02/26 appointment but she did not document the attempts. -She was finally able to reach someone at Resident #5's endocrinology office on 02/24/26 and was given an appointment for 03/31/26, which was the soonest available appointment. -The facility had a new charting system, and she had just recently learned how to enter a staff progress note. -She kept all the residents' appointments on a paper calendar and tried to follow up on appointments every couple days. Interview with the Administrator on 03/11/26 at 4:38pm revealed: -The facility had a new charting system that all staff were still trying to learn. -The new charting system did not have a calendar, so all appointments for the residents were entered by "pen and paper".	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 273	Continued From page 35 -She knew Resident #5's was unable to keep her 02/02/26 appointment due to the weather and road conditions from the recent snowfall. -She expected the TC to follow-up on scheduling the residents' appointments every 24-48 hours and to document the attempts in the staff progress notes. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:59am, and 2:04pm were unsuccessful. The facility failed to ensure healthcare referral and follow-up for Resident #5 with a history of type 2 diabetes with episodes of hypoglycemia by not reporting a malfunctioning continuous glucose monitoring device to the endocrinology provider for one month and delayed coordination of a follow-up endocrinology appointment for the resident. The failure of the facility was detrimental to the health and welfare of the resident and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/11/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2026.	D 273		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 276	Continued From page 38	D 276		4/10/26 ongoing
D 276	10A NCAC 13F .0902(c)(3-4) Health Care 10A NCAC 13F .0902 Health Care (c) The facility shall assure documentation of the following in the resident's record: (3) written procedures, treatments or orders from a physician or other licensed health professional; and (4) Implementation of procedures, treatments or orders specified in Subparagraph (c)(3) of this Rule. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, interviews, and record review the facility failed to implement orders from the endocrinology provider for 1 of 5 sampled residents (#5) with orders to check a continuous glucose monitoring device four times a day. The findings are: Review of facility's undated policy for Residents Receiving Diabetic Medications/Treatments revealed: -Residents receiving medications/treatments for diabetic care will be monitored according to physician's orders. -Every resident will have their own glucose monitor; it will be labeled with their name and placed in a bag with their name. -All medications, blood sugar monitoring, insulins will be added to the diabetic flowsheet. -The provider should include low and high parameters for resident blood sugar levels.	D 276	The Care Managers/ designee did a 100% audit of all resident that have a CGM devices to ensure that they are functioning and all required physician follow -ups are scheduled. The Care Mangers/designee will audit all residents on CGM's device monitoring for 3 times weekly for 4 weeks, then weekly for 4 weeks then monthly. Any discrepancies found	4/10/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 276	Continued From page 37 -The medication aide (MA) will notify the Care Coordinator of any refusals/or abnormal results per parameters given by the resident's provider. -The Care Coordinator will review any refusals and/or abnormal blood sugar readings and notify the provider and document the notification and any new orders in the resident's chart. Review of the facility's undated policy for Health Care Referral and Follow-up revealed: -It is the policy of the community to assure referral and follow-up to meet the routine and acute health care needs of residents with notifications to providers and documentation in the resident's record. -Documentation in the resident's record will include contacts with the physician/provider, other support licensed service providers, family, responsible parties, and guardians, when there is illnesses, incidents, accidents, and routine care and follow-up as needed. -Visits to providers or onsite visits by providers including any new orders, for medications, treatments, or procedures. -Hospital discharges, follow-up care, and medication reconciliation. -Lab visits, and parameters, falls, and any other routine or acute health care need of the resident. Review of the facility's undated policy for Health Care Referral and Follow-up for Vital Signs (blood pressure, pulse respirations, blood sugars) Outside of Parameters revealed: -The community will follow the provider's orders for vital signs outside of parameters. -The provider will document in the order all steps to be taken when a vital sign is below parameters. -The provider will document in the order all steps to be taken when a vital sign is above the	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER
THE LANDINGS OF ROCKY MOUNT MILLS

STREET ADDRESS, CITY, STATE, ZIP CODE
**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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 276	Continued From page 38 parameters. -The staff will immediately notify the provider of any vital signs below or above parameters timely by telephone and fax using the Health Care Notification. -The staff will document notification to the provider in the progress notes and document any physician/provider verbal orders given by the provider. Review of Resident #5's FL2 dated 01/24/25 revealed diagnoses included type 2 diabetes, hypertension, and cognitive communication disorder. Review of Resident #5's FL2 dated 01/08/26 revealed: -Diagnoses included type 2 diabetes, nutritional deficiency, and cognitive communication disorder. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors (a Free Style Libre 3 is a continuous glucose monitoring device for people with diabetes to track their glucose levels), use to check blood sugars four times per day. Review of Resident #5's endocrinology provider notes dated 12/03/25 revealed: -The reason for the appointment was type 2 diabetes mellitus with hypoglycemia (low blood sugar) without coma. -Assessments included type two diabetes mellitus with hypoglycemia, without coma, without long-term current use of insulin. -Treatment included, start FSL3 plus Sensor, used to check blood sugars four times per day and FSL3 Reader Device used to check blood sugar four times per day. -Resident #5 had a FSL3 sensor placed in the office with a loaner reader. -She was currently on no diabetes medications.	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 276	Continued From page 39 -She was a resident at a facility and had dementia. -Her blood glucose log ranged from 65 to 164. -Staff with the resident called the facility and said the resident was able to wear a sensor and a FSL3 sensor was placed. -She was to return to the office in 2 weeks, and her next appointment was scheduled for 12/17/25 at 10:30am. Review of Resident #5's endocrinology provider notes dated 01/05/26 revealed: -The reason for the appointment was 2 week recheck for diabetes mellitus, FSL3 uploaded, and finger stick of 61 and 57. -Assessments included type 2 diabetes mellitus with hypoglycemia. -Her FSL3 readings were 76% Time in Range (the percentage of time per day the users' glucose remains in target range, typically between 70 and 180mg/dl), and 24% hypoglycemic events. -Her blood glucose was low in the office at 61 and was repeated at 57 after Resident #5 drank half of a cola. -Her blood glucose was repeated after Resident #5 drank a whole cola and was 43. -Emergency Medical Services (EMS) was called to the office and the resident was transported to the emergency department (ED). -She was to continue glucose monitoring and to return to the office in 2 to 3 weeks. Review of handwritten order sheet from Resident #5's endocrinology provider dated 01/05/26 revealed: -Resident #5's blood sugars were low in the office, 61, 57, and 43. -Her FSL3 readings were low 24%. -No diabetic medications at this time.	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 276	Continued From page 40 -Continue wearing FSL3 sensors. Review of Resident #5's signed physicians order sheet dated 01/08/26 revealed there was an order for Free Style Libre 3 Kit Plus/Sensors, to check blood sugars four times per day. Review of Resident #5's December 2025 electronic medication administration record (eMAR) revealed: -There was an entry for Free Libre 3 Kit Plus/Sen (continuous glucose system sensor), use to check blood sugars four times a day, scheduled at 9:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 12/03/25. -There was no documentation that Resident #5's blood sugar was checked from 12/04/25 to 12/17/25 at 9:00am, and the entry spaces were blank. -There was documentation on 12/18/25 at 9:00am with a medication aide's (MA) initials and the code DNA-Drug not available per the provided abbreviations description on the eMAR. -There was no documentation that Resident #5's blood sugar was checked from 12/19/25 to 12/31/25 at 9:00am, and the entry spaces were blank. -There was no documentation that Resident #5's blood sugar was checked at 12:00pm from 12/04/25 to 12/17/25. -There was documentation on 12/18/25 at 12:00pm with a MA's initials and the code DNA-Drug not available per the provided abbreviations description on the eMAR. -There was no documentation that Resident #5's blood sugar was checked from 12/19/25 to 12/31/25 at 12:00pm, and the entry spaces were blank. -There was no documentation that Resident #5's blood sugar was checked from 12/04/25 to	D 276		

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION							
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27863			
(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 278	Continued From page 41 12/17/25 at 4:00pm, and the entry spaces were blank. -The was documentation on 12/18/25 at 4:00pm with a MA's initials but there was no documentation of the blood sugar reading. -There was no documentation that Resident #5's blood sugar was checked from 12/19/25 to 12/31/25 at 4:00pm, and the entry spaces were blank. -There was documentation on 12/03/25 at 8:00pm with a MA's initials but there was no documentation of the blood sugar reading. -There was no documentation that Resident #5's blood sugar was checked from 12/04/25 to 12/17/25 at 8:00pm, and the entry spaces were blank. -There was documentation on 12/18/25 at 8:00pm with a MA's initials but there was no documentation of the blood sugar reading. -There was no documentation that Resident #5's blood sugar was checked from 12/19/25 to 12/31/25 at 8:00pm, and the entry spaces were blank. Review of Resident #5's January 2026 eMAR revealed there was no entry for Free Libre 3 Kit Plus/Sensor, use to check blood sugars four times a day. Review of Resident #5's February 2026 eMAR revealed: -There was an entry for Free Libre 3 Kit Plus/Sensor, use to check blood sugars four times a day, scheduled at 9:00am, 12:00pm, 4:00pm, and 8:00pm with a start date of 12/03/25. -There was a second entry for "blood sugar" scheduled at 9:00am, 12:00pm, 4:00pm and 8:00pm. -There was no documentation that Resident #5's blood sugar was checked at 4:00pm and 8:00pm	D 278					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 276	Continued From page 42 on 02/01/26, and the entry spaces were blank. -There was no documentation that Resident #5's blood sugar was checked at 9:00am, 12:00pm, 4:00pm and 8:00pm on 02/04/26, and the entry spaces were blank. -There was no documentation that Resident #5's blood sugar was checked at 4:00pm on 02/09/26 and 02/17/26, and the entry spaces were blank. -Resident #5's blood glucose was recorded below 70mM on 02/05/26 reading 46mM at 9:00am, on 02/09/26 reading 46mM at 9:00am and again reading 69 mM at 8:00pm, on 02/13/26 reading 67mM at 9:00am, on 02/14/26 reading 68mM at 9:00am and reading 63mM at 12:00pm, on 02/15/26 reading 68mM at 12:00pm, on 02/19/26 reading 68mM at 12:00pm, on 02/23/26 reading 47mM at 9:00am, on 02/24/26 reading 69mM at 9:00am and again reading 69mM at 12:00pm. Review of Resident #5's handwritten 24-hour daily reports revealed: -There were no handwritten 24-hour daily reports provided for 12/04/25 and 12/05/25, for 12/12/25 to 12/14/25, for 12/16/25 to 12/18/25, for 12/21/25 to 12/23/25, for 12/26/25 to 12/28/25, for 12/30/25, and for 01/22/26 and 01/23/26. -There were no blood sugars recorded on the provided 24-hour daily reports on 12/06/25 to 12/11/25, on 12/15/25, on 12/19/25 and 12/20/25, on 12/24/25 and 12/25/25, on 12/29/25, on 12/31/25 and 01/01/26, on 01/03/26 to 01/17/26, on 01/19/26 to 01/21/26, on 01/24/26 and 01/25/26, on 01/27/26 to 01/30/26, and on 02/04/26 -There was a blood sugar of 81 documented for the 3:00pm to 11:00pm shift only on the handwritten 24-hour daily report provided for 01/02/26. -There was a blood sugar of 80 documented for the 7:00am to 3:00pm shift only on the	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1385 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 276	Continued From page 43 handwritten 24-hour daily report provided for 01/18/26. -There was a blood sugar of 89 documented for the 7:00am to 3:00pm shift only on the handwritten 24-hour daily report provided for 01/26/26. -There was a blood sugar of 126 documented for the 7:00am to 3:00pm shift only on the handwritten 24-hour report provided for 01/31/26. -There was a blood sugar of 109 documented for the 7:00am to 3:00pm shift only on the handwritten 24-hour daily report for 02/01/26. -There was a blood sugar of 143 documented for the 7:00am to 3:00pm shift only on the handwritten 24-hour shift report for 02/17/26. Based on observations and interviews it was determined that Resident #5 was not interviewable. Telephone Interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed: -Resident #5's FSL3 sensors needed to be replaced every 15 days and two sensors were dispensed with each 30-day supply. -Thirty day sensor supplies for the FSL3 were dispensed for Resident #5 on 12/18/25, 01/24/26, and 02/23/26. Interview with a MA on 03/06/26 at 11:30am revealed: -Staff was trying to figure out why Resident #5's FSL3 sensors were not calibrating. -Resident #5 needed a new FSL3 meter. -She took fingerstick blood sugars (FSBS) for Resident #5. -About two or three weeks ago she called emergency medical services (EMS) for Resident #5 and when EMS checked her sugar it was in	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 276	Continued From page 44 the 120's. -She told the Resident Care Coordinator (RCC) and the Special Care Coordinator (SCC) if the FSL3 was not working. -Resident #5's FSL3 sensor and meter did not seem to work for about two or three weeks. Second interview with a MA on 03/11/26 at 10:49am revealed: -A week or so ago, Resident #5's FSL3 was not recording her blood sugars and she notified the RCC. -The MAs were able enter Resident #5's blood sugar readings on the eMAR in late January 2026. Interview with a second MA on 03/09/26 at 2:11pm revealed: -Resident #5 had a history of low blood sugars. -Resident #5's FSBS were not always accurate, and she thought that was why the FSL3 was ordered to monitor her blood sugar without finger sticks. -Resident #5 previously had a FSL3, and her blood sugars were checked four times a day. -She always recorded Resident #5's blood sugar on her eMAR. -She was not sure why Resident #5's blood sugar readings did not show up on her December 2025 eMAR. -She was not sure why there was no entry for the FSL3 blood sugar checks on Resident #5's January 2026 eMAR. -Last week, Resident #5's FSL3 was discontinued and FSBS twice a day were ordered. Interview with a third MA on 03/10/26 at 4:54pm revealed: -There had been times when she could not get a blood sugar reading from Resident #5's FSL3.	D 276		4/1/26

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064834	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 276	Continued From page 45 -When she was unable to get Resident #5's blood sugar reading on the FSL3, a FSBS was done. -She always recorded Resident #5's blood sugar readings on the resident's eMAR. -She was not sure what a blank on a resident's eMAR meant. Interview with the Resident Care Coordinator (RCC) on 03/06/26 at 10:00am revealed: -She had contacted Resident #5's endocrinology provider in December 2025 about insurance approval and to schedule appointments but did not keep a record of the contact. -Resident #5's blood sugar results were not being recorded in the eMAR because they had just gotten a new eMAR system in December 2025. -By the end of January 2026, the Licensed Health Professional Support (LHPS) nurse saw that Resident #5's blood sugar readings were not populating on the eMAR from the FSL3. -In February 2026 there were some finger stick blood sugar (FSBS) readings and some FSL3 readings. -Recordings were not documented in the eMAR because there was not an entry for the blood sugar readings. -Once the facility realized the blood sugar readings were not going on the eMAR from the FSL3 then a new entry was created and monitoring was done four times per day. -There was not an order for blood sugar readings dated 01/31/26. -The eMAR entry dated 01/31/26 was made when the blood glucose readings were not showing on the eMAR. -Resident #5's sugars used to bottom out and Resident #5 would go to the hospital. -Resident #5's FSBS may read low due to poor circulation. -Resident #5 never showed signs of	D 276		

Division of Health Service Regulation		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034		(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026	
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS				STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803			
(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 276	Continued From page 46 hypoglycemia. Second interview with the RCC on 03/09/26 at 3:03pm revealed: -The facility started and new charting system on 12/01/25 and staff were still trying to learn the system. -There was nowhere on the eMAR to document Resident #5's blood sugar readings initially. -She was certain staff were checking Resident #5's blood sugar. -Staff also were to document Resident #5's blood sugar on the handwritten 24-hour daily report. -It was important to document Resident #5's blood sugar readings to watch for hyperglycemia and hypoglycemia and to monitor Resident #5's blood sugar. Third interview with the RCC on 03/10/26 at 4:07pm revealed: -Resident #5's FSL3 order was entered by the pharmacy after it was received at her 12/03/25 endocrinology appointment. -When she verified Resident #5's FSL3 order, she should have entered the order as a vital sign and then the MAs could enter the blood sugar reading. -She realized on 01/31/26 that Resident #5's blood sugar readings were not recorded after the LHPS nurse brought it to her attention. -She did not know why Resident #5's FSL3 order fell off her January 2026 eMAR, there was not a discontinue order for the FSL3 until 03/03/26. -She was not sure why there were blank entries for blood sugar on Resident #5's February 2026 eMAR. -Staff were still learning the new charting system but there should never be blanks on the eMAR. -If a medication or treatment was not administered, there should be documentation as	D 276					

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER
THE LANDINGS OF ROCKY MOUNT MILLS

STREET ADDRESS, CITY, STATE, ZIP CODE
**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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 276	Continued From page 47 to why. -She had not completed eMAR audits and had not been instructed how to do an eMAR audit. Interview with the Administrator on 03/11/26 at 4:38pm revealed: -The facility was still learning the new charting system that started 12/01/25. -The MAs should have documented Resident #5's blood sugars on the eMAR for December 2025 and January 2026. -If there was a problem or no space to document Resident #5's blood sugars, the MAs should have notified the Care Manager (RCC) to correct the issue. -Audits of the residents eMARS should have been performed to make sure that Resident #5's blood sugar was staying within range. -She was not aware that Resident #5's blood sugars were not documented on her eMAR for December 2025 and January 2026. Telephone Interview with Resident #5's primary care provider (PCP) on 03/06/26 at 2:45pm revealed: -Resident #5's FSL3 had issues with insurance approval and there were issues with the response from the endocrinology office. -An emergency department (ED) visit revealed that Resident #5's poor circulation was giving false readings for her FSBS, and that was when the FSL3 was ordered. -The facility should document Resident #5's blood sugar readings on the eMAR from the FSL3. -It was hard to manage Resident #5's medications when the blood sugar was not recorded on the eMAR. -There were situations where Resident #5 was disoriented and sent to the ED, but the hospital documented normal blood sugar after a	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1305 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 276	Continued From page 48 venipuncture (a venipuncture is a blood draw). -There were issues with the FSL3 not working where her blood sugar was measuring low, but Resident #5 was alert and conversational. -Resident #5's presentation did not match the low blood sugar readings at times. -Once recently, EMS was called for a low reading and Resident #5's blood sugar returned normal and Resident #5 was asymptomatic. -The MAs could not determine whether the low blood sugar reading was an error, and MAs should contact the provider via the provider triage system and get advice. -She was notified sometimes when Resident #5's blood sugar was low. -The facility should provide education on how to use the FSL3 and how to document Resident #5's blood sugar readings. -She approved FSBS whenever the FSL3 was not working because she was concerned that Resident #5 would be sent to the hospital unnecessarily. Attempted telephone interview with Resident #5's endocrinology provider on 03/06/26 at 4:56pm was unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:59am, and 2:04pm were unsuccessful.	D 276		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 276	Continued From page 49 [Refer to Tag 162, 10A NCAC 13F .0504(c) Competency Evaluation and Validation for LHPS Tasks] [Refer to Tag 280, 10A NCAC 13F .0903(c) Licensed Health Professional Support] The facility failed to ensure orders were implemented for Resident #5 who had a diagnosis of diabetes with a history of hypoglycemic episodes, some requiring emergency medical services. Resident #5 was ordered a continuous glucose monitoring device requiring the facility to change the sensor and check the glucose reading four times per day. The facility failed to document Resident #5's blood glucose results four times a day on 113 occasions in December 2025, no blood glucose results were documented in January 2026, and blood glucose results were not documented on 9 occasions in February 2026. Resident #5's documented blood glucose results ranged from 46 to 247 during the month of February 2026. This failure resulted in substantial risk for physical harm and constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 10, 2026.	D 276		4/26
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support	D 280	The ED/ designee will review any new task recorded in the LHPS nurse's binder and make available to LHPS nurse when in the community quarterly or PRN. ED/designee will audit to ensure new task are recorded in binder. LHPS nurse will be required to report to ED/Care Managers before exiting the community.	4/10/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1305 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 280	Continued From page 50 (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure the quarterly licensed health professional support (LHPS) evaluations for 2 of 6 sampled residents (#5, #10) with LHPS tasks were completed and included a physical assessment, evaluation of care provided, and recommendations based on the physical assessment and evaluation of the resident including tasks for the placement and monitoring of a continuous glucose monitoring (CGM) device that detects trends and tracks patterns in the detection of episodes of low blood glucose and	D 280	On 3/17/26 all Medication Aides and Care Managers was re-educated on the Community CGM device and on Hypoglycemia and Hyperglycemia, including notifying the nurse/provider for low blood sugar readings. The PCP dc'd the CGM device on 3/30/26 and ordered a traditional fingerstick device for resident #5.	4/10/26 ongoing	4/10/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 280	Continued From page 51 high blood glucose. The findings are: Review of the facility's undated licensed health professional support (LHPS) Initial Evaluation and Quarterly Review of Residents policy revealed: -The facility should ensure a LHPS was completed and documented in the resident's record. -Community management would evaluate and identify residents with LHPS tasks on admission to the facility. -LHPS tasks identified on admission should be documented on the face sheet on admission and the LHPS would be notified for the initial evaluation. -"The LHPS will perform the LHPS Initial Evaluation and complete the form in the electronic health record, which needed to be completed within 30 days of admission or within 30 days from the date a resident develops the need for a new task and quarterly thereafter." -"The LHPS form is completed in the electronic health record and will appear on the dashboard for review and completion by community management (community management included the Administrator, Director of Resident Care (DRC), Resident Care Coordinator (RCC), Special Care Unit Coordinator (SCC) and then will be electronically signed by the LHPS." -"The LHPS will review the health status and care provided, physical assessment as related to diagnoses/current condition, progress to care provided and recommended changes in care on each evaluation." -"The LHPS will participate in an on-site review and evaluation of the resident's health status, care plan, and care provided for residents requiring, but not limited to, one or more tasks of	D 280			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

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D 280	Continued From page 52 the above tasks." -"The LHPS will review any changes and follow up recommendations to meet the resident needs with community management." -"The LHPS will continue to evaluate the residents quarterly for identified tasks." Review of the manufacturer's quick reference guide for the Free Style Libre 3 continuous glucose monitoring (CGM) manufacturer's revealed: -A Free Style Libre 3 is a CGM for people with diabetes to track their glucose levels) -The CGM sensor should only be applied to the back of the upper arm. -The CGM sensor may not work properly in other areas. -Avoid scars, moles, stretch marks, and lumps when placing the CGM sensor. -Choose an area that stays mostly flat (no bending or folding) during the day when placing the CGM sensor. -The CGM sensor should be placed at least one inch away from insulin injection sites. 1. Review of Resident #5's FL2 dated 01/08/26 revealed: -Diagnoses included type 2 diabetes, nutritional deficiency, and cognitive communication disorder. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors (a Free Style Libre 3 is a continuous glucose monitoring device for people with diabetes to track their glucose levels), use to check blood sugars four times per day. Review of Resident #5's signed physician's order sheet dated 05/01/25 revealed an order to check finger stick blood sugar (FSBS) twice a day at 8:30am and 5:00pm, notify provider if glucose is less than 60 or greater than 400, if lower than 60	D 280		

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1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

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D 280	Continued From page 53 give 8 ounces of orange juice immediately and repeat glucose checks every 15 minutes, repeat until glucose returns to normal limits. Review of Resident #5's signed physicians order sheet dated 01/08/26 revealed there was an order for Free Style Libre 3 Kit Plus/Sensors to check blood sugars four times per day. Review of Resident #5's endocrinology provider notes dated 12/03/25 revealed: -The reason for the appointment was type 2 diabetes mellitus with hypoglycemia (low blood sugar) without coma. -Assessments included type two diabetes mellitus with hypoglycemia, without coma, without long-term current use of insulin. -Treatment included, start FSL3 plus Sensor, used to check blood sugars four times per day and FSL3 Reader Device used to check blood sugar four times per day. -Resident #5 had a FSL3 sensor placed in the office with a loaner reader. -She was currently on no diabetes medications. -She was a resident at a facility and had dementia. -Her blood glucose log ranged from 65 to 164. -Staff with the resident called facility and said the resident was able to wear a sensor and a FSL3 sensor was placed. -She was to return to the office in 2 weeks, and her next appointment was scheduled for 12/17/25 at 10:30am. Review of Resident #5's previous quarterly Licensed Health Professional Support Evaluation (LHPS) dated 11/04/25 revealed: -Personal tasks currently present were identified as collecting and testing of finger stick blood samples, ambulation using assistive devices that	D 280		

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D 280	Continued From page 54 required physical assistance, and transferring semi-ambulatory or non-ambulatory residents. -The resident was non-ambulatory with a wheelchair and required staff assistance at all times. -The resident was observed sitting in a wheelchair in the room at the time of the assessment. -The resident was alert and oriented to person, place, and time and able to make needs known to staff. -Lung, heart, and bowel sounds were normal. -Skin was intact with 2 plus bilateral lower extremity edema noted. -Her appetite was fair. -She was ambulatory with a wheelchair and required one person assistance for transfers. -Diabetes was diet-controlled. -Finger stick blood sugars (FSBS) ranged from 54 to 128, and feet and nails were within normal limits. -No falls were reported. -There was weight loss noted this quarter. -The resident followed a ground meat diet. -The resident denied any complaints at this time. -No changes or follow-up was recommended to meet the resident's needs. -Facility staff competency was validated for ambulation using assistive devices, transferring, and collecting and testing of fingerstick blood samples. -The LHPS evaluation was signed by the LHPS Registered Nurse (RN) on 11/04/25. Review of Resident #5's most recent quarterly LHPS dated 01/28/26 revealed: -Tasks currently present were identified as transferring semi-ambulatory or non-ambulatory residents, ambulation with assistive devices that requires physical assistance, and collecting and	D 280		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION							
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D 280	Continued From page 55 testing of fingerstick blood samples. -The resident was alert and oriented to person, place and was observed sitting in a wheelchair in the day room at the time of the assessment. -The resident was able to make needs known to staff. -Her blood pressure was 122/78, pulse was 54, temperature was 98.2, oxygen saturation was 94%, and respirations were 16 breathes per minute. -Her lung sounds were normal, her heart was normal and bowel sounds were present in all four quadrants. -Her skin appeared normal with 2 plus bilateral lower extremity pedal edema noted. -Her appetite was good with no weight changes reported. -She was non-ambulatory and used a wheelchair, requiring one person assistance for transfers. -She was diabetic with blood sugars checked four times daily, ranging from 74 to 102, controlled by oral medications, with FSBS and injection sites within normal limits. -Her feet and nails were within normal limits. -She had LHPS tasks including FSBS, ambulation using assistive devices requiring staff assistance, and transfer assistance from staff. -The resident denied any complaints at the time of the assessment, continue plan of care. -No changes or follow-up was recommended to meet the residents' needs. -Facility staff competency was validated for transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that required physical assistance, and collecting and testing of finger stick blood samples. -Resident #5's quarterly LHPS evaluation was signed by the LHPS RN 01/29/26. -There were no tasks identified for placement of continuous glucose monitor sensor or checking	D 280					

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D 280	Continued From page 56 blood glucose using a continuous glucose monitoring device. Interview with a medication aide (MA) on 03/09/26 at 1:57pm revealed: -When she applied the CGM sensor herself to Resident #5 she placed the sensor to the bottom of the residents left lower stomach. -She was supposed to check the resident's receiver to the sensor four times a day for her blood sugar reading. Attempted telephone interview with the LHPS RN on 03/10/26 at 3:54pm was unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:59am, and 2:04pm were unsuccessful. Refer to interview with a MA on 03/09/26 at 1:57pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to interview with the Administrator on 03/11/26 at 3:52pm. Refer to interview with the facility's contracted primary care provider (PCP) on 03/05/26 at 3:06pm.	D 280		

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**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

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D 280	Continued From page 57 2. Review of Resident #10's FL2 dated 11/10/25 revealed: -Diagnoses included mild dementia, chronic kidney disease stage 4, hypertension, and diabetic morbid obesity. -There was an order for a Free Style Libre 3 (FSL3) Kit Plus/Sensors (a Freestyle Libre 3 is a continuous glucose monitoring device for people with diabetes to track their glucose levels), change every 15 days. -There was an order for Freestyle Libre 3 reader as directed for daily use. Review of Resident #10's quarterly Licensed Health Professional Support Evaluation (LHPS) dated 02/23/26 revealed: -Personal tasks currently present were identified as medication administration through injections and collecting and testing of finger stick blood sugar (FSBS) samples. -The resident was alert and oriented to person, place, and time. -The resident was ambulatory with a cane and required no assistance with transfers. -The resident experienced no weight loss or gain in the last quarter. -The resident had no falls reported in the last quarter. -The resident denied any complaints at the time of assessment. -No changes or follow-up were recommended to meet the residents' needs. -Facility staff competency was validated for collecting and testing of FSBS samples and medication administration through injections. -The LHPS evaluation was signed by the LHPS Registered Nurse (RN) on 02/23/26. -There was no documentation Resident #10 had a task to apply a CGM device or to monitor a	D 280		

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D 280	Continued From page 58 CGM device. Observation of Resident #10 on 03/10/26 at 1:03pm revealed there was a CGM sensor on her upper right arm. Interview with Resident #10 on 03/10/26 at 1:04pm revealed: -Her sensor was on her right arm today. -The CGM sensor had been placed on her lower stomach and both of her arms in the past. Interview with a medication aide (MA) on 03/09/26 at 1:57pm revealed when she changed the CGM sensor for Resident #10, she waited an hour for the CGM sensor to sync to the receiver so she could read the results. Attempted telephone interview with the Licensed Health Professional Support (LHPS) Registered Nurse (RN) on 03/10/26 at 3:54pm was unsuccessful. Refer to interview with a MA on 03/09/26 at 1:57pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to interview with the Administrator on 03/11/26 at 3:52pm. Refer to interview with the facility's contracted primary care provider (PCP) on 03/05/26 at 3:06pm. Interview with a medication aide (MA) on 03/09/26 at 1:57pm revealed: -She asked the MA that previously worked at the facility to train her because she was concerned	D 280			

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D 280	Continued From page 59 about applying the sensor because of how fragile the resident's skin could be. -After the MA that previously worked at the facility demonstrated how to apply the CGM, the MA checked her off on a list that she was trained on how to apply the CGM. Interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm revealed: -She provided one on one training to all the MAs on how to place a CGM sensor on a resident. -After she provided the training to MAs on how to place the CGM sensor they were allowed to replace the sensor for residents with a CGM independently. -She did not document the training she provided to the MAs. -She was not aware that the LHPS nurse was the responsible party to provide training to herself and all MAs on how to correctly place the CGM sensor on residents. Interview with the Administrator on 03/11/26 at 3:52pm revealed: -The competency validated LHPS tasks by return demonstration should be completed for all residents tasks to ensure they received the proper care from staff that were appropriately trained. -The competency validated LHPS task list ensured that staff were fully educated and understood the tasks they needed to perform for residents. -She had not considered adding staff competency validation LHPS task list for CGM's because it was not listed on the LHPS form. -She followed up on the quarterly LHPS tasks lists that were completed by the LHPS nurse and when there was a new task added for a resident.	D 280		

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D 280	Continued From page 60 Telephone Interview with the facility's contracted primary care physician (PCP) on 03/05/26 at 3:06pm revealed: -The LHPS nurse should have provided education to MAs before residents used a CGM system. -She had concerns that the MAs did not know what they were doing with the placement of the CGM and monitoring of the CGM. -When the CGM was not placed on the resident properly and the MAs were not educated on reading the CGM receiver, it placed the resident at risk of hypoglycemia or hyperglycemia. The facility failed to ensure the quarterly licensed health professional support (LHPS) were completed through an evaluation of residents with LHPS tasks to properly place a continuous glucose monitoring sensor correctly on residents and to ensure the CGM receiver was properly read to ensure accurate blood glucose readings in order to monitor residents for hypoglycemia and hyperglycemia. The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/10/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2026.	D 280	a	
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	D 344	The Regional Clinical Nurse provided a training for all medication aides and Care Managers on Medication Orders on 3/17/26. See attached.	4/26/26 ongoing

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D 344	Continued From page 61 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 (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 observation, interviews, and record reviews, the facility failed to clarify medication orders for 2 of 6 sampled residents (#5 and #8) related to medications used to treat fluid retention, medications used to treat elevated blood sugar, a medication for heart health (#8), and a medication used to treat low blood sugar (#5). The findings are: 1. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an order for aspirin (used for heart health) 81mg, one daily. -There was an order for empagliflozin (used to treat elevated blood sugar) 25mg, take one every morning. -There was an order for furosemide (used to treat fluid retention caused by congestive heart failure or kidney disease) 20mg, take three daily.	D 344	The Care Manger will complete a 100% chart audits of residents. The Care Managers/designee will ensure that any identified orders that need clarification they will contact the PCP. The Care Managers will due quarterly audits of residents charts including new residents within 72 hours of admission. The ED will ensure that all audits will be reviewed.	4/26/25 4/25/26 DD ongoing 4/26/25 4/25/26 DD ongoing			

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D 344	Continued From page 62 -There was an order for acetazolamide (can be used to treat fluid retention caused by heart failure) 500mg, twice a day. -There was an incomplete order for Humalog (humalog is a fast acting insulin used to treat elevated blood sugar) quick pen 100 units. -There was an order for Lantus (Lantus is a long-acting insulin used to manage elevated blood sugar) U100, 8 units subcutaneously in the evening. Review of Resident #8's medication review report dated 02/27/26 revealed: -There was an order for aspirin ec 81mg, give one tablet one time a day for deep vein thrombosis (DVT). -There was an order for Diamox (Diamox is the brand name for acetazolamide) Sequels capsule extended release 12 hour 500mg, give one capsule two times per day for intraocular edema. -There was an order for empagliflozin 25mg, one tablet in the morning for diabetes mellitus. -There was an order furosemide 20mg, take three tablets one time a day for congestive heart failure. -There was an order for humalog Injection 100units/ml, inject per sliding scale, if FSBS 170-220=2 units, if FSBS 221-300= 4 units, if FSBS 301-400= 6 units, if FSBS 401-500=8 units, if over 500, call provider, inject subcutaneously twice per day for diabetes mellitus. -There was an order for Lantus 100units/ml, inject 8 units subcutaneously in the evening a. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for aspirin 81mg, once daily scheduled at 8:00am. -Aspirin 81mg was documented as administered	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 344	Continued From page 63 at 8:00am on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for aspirin 81mg, one daily. b. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for Diamox (acetazolamide) Sequels 500mg, one two times daily, scheduled at 8:00am 8:00pm. -Diamox (acetazolamide) 500mg capsule was documented at 8:00pm on 02/27/26 with initials with a circle around them in the entry space. -Diamox (acetazolamide) 500mg capsule was not documented as administered at 8:00am and 8:00pm on 02/28/26, the entry spaces were blank for 8:00am and 8:00pm on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for acetazolamide DR 500mg, twice a day. c. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for furosemide 20mg, take one tablet once a day, scheduled at 8:00am. -Furosemide 20mg was not documented as administered at 8:00am on 02/28/26, the entry space was blank for 8:00am on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for furosemide 20mg, 3 tablets once daily.	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 344	Continued From page 64 d. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for empagliflozin 25mg, take one tablet in the morning, scheduled at 8:00am. -Empagliflozin 25mg was not documented as administered at 8:00am on 02/28/26, the entry space was blank for 8:00am on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for empagliflozin 25mg, one tablet in the morning. e. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry Humalog insulin, inject per sliding scale, 170-220= 2 units, 221-300= 4 units, 301-400= 6 units, 401-500= 8 units, over 500, call MD, subcutaneously twice a day, scheduled at 8:00am and 8:00pm. -Humalog was documented as not administered at 8:00pm on 02/27/26 for a FSBS of 144. -Humalog was not documented as administered at 8:00am and 8:00pm on 02/28/26, the entry spaces for 8:00am and 8:00pm on 02/28/26 were blank and there was no FSBS recorded. f. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for Lantus, Inject 8 units subcutaneously in the evening, scheduled at 6:00pm. -Lantus 8 units was not documented as administered at 6:00pm on 02/27/26 and on 02/28/26.	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 344	Continued From page 65 Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for Lantus 100units/ml, inject 8 units subcutaneously every evening. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for Humalog insulin sliding scale twice daily. Interview with Resident #8 on 03/04/26 at 4:58pm revealed: -He was admitted to the facility on Friday 02/27/26. -He took many medications but could not say exactly what he took. -He was diabetic and took insulin up to three times a day depending on what his blood sugar was. -He had not had his blood sugar checked or received insulin since he was admitted to the facility on Friday 02/27/26. -He guessed it was decided that he no longer needed insulin. -The facility should have all his medical information and should know what medications he was supposed to take. Interview with the medication aide (MA) on 03/04/26 at 2:04pm revealed: -Resident #8 had insulin pens on the medication cart but she thought his orders must have changed because there was no order on his eMAR for insulin or FSBS. -She had not administered insulin for Resident #8 because there was not an order on his eMAR. -She was not aware of additional orders for aspirin, acetazolamide, furosemide, or	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 344	Continued From page 66 empagliflozin for Resident #8. -She administered medications to the residents by the eMAR. Interview with a second MA on 03/05/26 at 4:11pm revealed: -She was on duty when Resident #8 was admitted on 02/27/26. -She copied his medications from the medication card labels that he brought to a paper MAR. -Resident #8 did not bring a glucometer with him and the facility had a loaner glucometer they could use until he received a glucometer. -The Care Managers usually matched the resident's medications to their FL2 once the medications were entered into the eMAR system. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 03/04/26 at 4:18pm revealed: -The pharmacy received Resident #8's FL2 via fax on 02/27/26 at 4:30pm. -There were six medication orders that they could not read on Resident #8's FL2. -An fax was sent to the facility at 5:29pm on 02/27/26, noting that clarification was needed for 6 orders that were illegible or incomplete on Resident #8's FL2. -The pharmacy did not receive a response and reached out to the facility again on Monday 03/03/26 when there were 6 orders on Resident #8's FL2 that needed clarification. -The pharmacy did not hear back from the facility until 03/04/26 at 3:06pm regarding clarification for the orders for Resident #8 which included aspirin 81mg, take one daily, acetazolamide ER 500mg, take one two times per day, furosemide 20, gives 3 tabs once a day, empagliflozin 25mg, take one tablet every morning, and humalog kwikpen inj, check blood sugar twice a day, inject	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 344	Continued From page 67 subcutaneously as directed per sliding scale, 170-220=2 units, 221-300=4 units, 301-400=6 units, 401-500=8 units, over 500, call provider, and Lantus 100units/ml, inject 8 units every evening. -The pharmacy was currently in the process of entering the clarified orders for Resident #8 and would be dispensing the medications to the facility for Resident #8. Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm revealed: -Resident #8 was admitted to the facility on Friday 02/27/26. -She was off on Friday 02/27/26 and was not here when Resident #8 was admitted. -She thought the Administrator sent Resident #8's FL2 to the pharmacy for his orders to be entered. -A paper MAR was completed either by the Administrator or the MA for Resident #8 until his orders were entered and approved in the eMAR system. -She found the email from the pharmacy today that there were 6 orders that needed clarification for Resident #8. -She was not aware before today that there were orders that were not on the eMAR for Resident #8 including Insulin. -When a resident was first admitted, staff used a paper MAR to record a resident's medications until orders could be entered by the pharmacy and medications received. Second interview with the RCC on 03/05/26 at 2:51pm revealed: -When a resident was admitted, any medications brought with them were reviewed and recorded on a paper MAR. -The FL2 was faxed to the pharmacy for orders to be added by the pharmacy.	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 344	Continued From page 68 -Once the orders were entered by the pharmacy, the Care Managers (herself or the Special Care Coordinator) or the Administrator could verify and approve orders. -The resident's orders on the eMAR should be compared to the resident's FL2 or physician orders. -Once Resident #8's medication orders were in the eMAR system, the orders should have been compared to his FL2 at the time the orders were verified. -Any medication order clarification should be handled immediately by contacting the resident's primary care provider (PCP). -Resident #8's medication orders should have been clarified and added to his eMAR within 24 hours of his admission if not prior to his admission. Interview with the Administrator on 03/04/26 at 4:14pm revealed: -She was working when Resident #8 was admitted to the facility on 02/27/26. -She faxed Resident #8's information including his FL2 to the pharmacy on 02/27/26. -She had not noticed that some of Resident #8's medication orders were unclear and that the order for Humalog was incomplete. -The pharmacy had sent a message on Saturday about needed clarification for Resident #8's medications on his FL2. -She thought the RCC had addressed Resident #8's needed medication clarifications on Monday 03/03/26. Second interview with the Administrator on 03/05/26 at 3:15pm revealed: -When a resident was admitted, the MAs or the Care Managers receive a copy of the resident's FL2 for the medication orders.	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 344	Continued From page 69 -The FL2 was sent to the pharmacy and the pharmacy enters the orders into the eMAR system, the Care Managers were responsible for verifying and approving the orders by comparing them to the resident's FL2 once they were placed in the eMAR system by the pharmacy. -Resident #8 was admitted to the facility in the afternoon on 02/27/26. -She sent the FL2 to the pharmacy on 02/27/26. -Resident #8's FL2 was a poor copy because it had been emailed and copied several times making it difficult to read. -The MA on duty 02/27/26, filled out a paper MAR for Resident #8 with the medications that he brought with him. -The paper MAR was used for Resident #8 until his orders were entered into the eMAR system and verified. -The only medications that were signed in or counted were narcotics, so there was no type of medication received documentation for Resident #8. -When the MA noticed there were medications not available for Resident #8 on the medication, they should have notified herself, one of the Care Managers and the pharmacy. -She felt the pharmacy should have called the facility about the unclear medications on Resident #8's FL2 instead of sending an email. Telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm revealed: -Resident #8 was new to the facility. -Low dose aspirin was prescribed for heart health, cardiac disease, heart failure, and/or coronary artery disease. -She was not too concerned about Resident #8 going without his low dose aspirin. -She was not sure why Resident #8 was	D 344		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034		A. BUILDING: _____ B. WING: _____
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 344	Continued From page 70 prescribed acetazolamide, but it could be used as a diuretic and help with his congestive heart failure. -Going without the acetazolamide could cause Resident #8 to experience swelling. -Furosemide was prescribed for swelling and could help with Resident #8's diagnosis of congestive heart failure. -Going with the furosemide could cause Resident #8 to experience swelling and fluid retention. -Resident #8 had a diagnosis of diabetes and empagliflozin was prescribed to help control his blood sugar and was also used for heart health. -Missed doses of empagliflozin could cause Resident #8's blood sugar to be elevated. -Humalog was a fast-acting insulin used to treat elevated blood sugar associated with diabetes. -Missed doses of Humalog and Lantus could cause Resident #8 to experience elevated blood sugar which could lead to headache, dizziness, and unconsciousness. -Resident #8 should have had his FSBS checked as ordered, to know what his blood sugar readings were and to know if he needed the sliding scale Humalog as ordered. -She expected the facility to obtain clarification of medication orders and to administer the resident's medications as ordered. -She felt the pharmacy should have contacted the facility immediately regarding orders that they could not read on Resident #8's FL2. 2. Review of Resident #5's FL-2 dated 01/08/26 revealed: -Diagnoses included muscle wasting and atrophy, not elsewhere classified, multiple sites; Type II diabetes mellitus without complications; other specified inflammatory spondylopathies, lumbar region; nutritional deficiency, unspecified; respiratory disorders in diseases classified	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 344	Continued From page 71 elsewhere; dysphagia, oropharyngeal phase; cognitive communication deficit; muscle weakness (generalized). -The recommended level of care was domiciliary. Review of Resident #5's Resident Register revealed she was admitted to the facility on 12/27/24. Review of Resident #5's physician order dated 01/22/26 revealed there was an order for glucose gel take 15 grams as needed for low blood glucose (glucose gel is medication given to treat low blood sugar). Review of Resident #5's emergency department after visit summary dated 01/05/26 revealed: -Resident #5 was evaluated after low finger stick blood sugar (FSBS) at her doctor's office. -It was possible that the FSBS readings were inaccurate due to Resident #5's history of inaccurate FSBS readings. -Resident #5's blood glucose (BG) was within normal limits on lab work. Review of Resident #5's January 2026 eMAR revealed: -There was an entry for lemon glucose 15 gel 40% give one entire tube as needed for low blood sugar if no response in 15 minutes, contact provider (Lemon glucose 15 gel 40% is a type of glucose gel). -Lemon glucose 15 gel 40% was not administered in January 2026. -One BG result was recorded on the eMAR for January 2026, which was on 01/31/26 reading 126mM at 9:00am. Review of Resident #5's February 2026 eMAR revealed:	D 344		

Division of Health Service Regulation		(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	A. BUILDING: _____ B. WING: _____	R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803	
(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)
D 344	Continued From page 72 -There was an entry for lemon glucose 15 gel 40% give one entire tube as needed for low blood sugar if no response in 15 minutes, contact provider. -Lemon glucose 15 gel 40% was administered and documented as effective on 02/05/26 at 9:09am, 02/09/26 at 10:07am, and 02/23/26 at 11:48am. -Resident #5's BG was recorded below 70 mM on 02/05/26 reading 46mM at 9:00am, on 02/09/26 reading 46mM at 9:00am and again reading 69mM at 8:00pm, on 02/13/26 reading 67mM at 9:00am, on 02/14/26 reading 68mM at 9:00am and reading 63mM at 12:00pm, on 02/15/26 reading 68mM at 12:00pm, on 02/19/26 reading 68mM at 12:00pm, on 02/23/26 reading 47mM at 9:00am, on 02/24/26 reading 69mM at 9:00am and again reading 69mM at 12:00pm. Review of Resident #5's March 2026 eMAR revealed: -There was an entry for lemon glucose 15 gel 40% give one entire tube as needed for low blood sugar if no response in 15 minutes, contact provider. -There was no documentation that lemon glucose 15 gel 40% was administered in March 2026. -Resident #5's BG was recorded below 70 mM on 03/03/26 reading 61mM at 4:00pm and again reading 58mM at 8:00pm. Observation of Resident #5's medications on hand on 03/05/26 at 3:20pm revealed there was one tube of lemon glucose 15 gel 40% with a dispense date of 02/23/26. Telephone Interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed: -Resident #5's lemon glucose was dispensed for a	D 344	

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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D 344	Continued From page 73 quantity of one tube on 02/23/26, 02/10/26, 02/06/26, 02/02/26, and 01/22/26. -Resident #5's lemon glucose was prescribed on 01/22/26. -Facility staff was to give one glucose tube as needed for low BG, if no response contact MD. Based on observations and interviews it was determined that Resident #5 was not interviewable. Telephone interview with the responsible person for Resident #5 on 03/06/26 at 10:37am revealed: -She had no problems with the care Resident #5 was receiving at the facility. -She mostly dealt with Resident #5's finances and was not sure if there were any concerns at this time. Interview with a medication aide (MA) on 03/05/26 at 3:20pm revealed: -She just started working at the facility in the last 6 weeks. -She has not had to give glucose to Resident #5. -There was just one tube of glucose on the cart for Resident #5. -Most people have parameters to administer glucose. -When MA's put in the BG the eMAR may give the MA directions to administer the glucose. -She was not sure how they figured out the number to administer glucose to Resident #5. -She would contact the Resident Care Coordinator (RCC) for a low BG reading under the 70's. -She had never checked Resident #5's BG when it was below 70. Interview with a second MA on 03/06/26 at 11:30am revealed:	D 344		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 344	Continued From page 74 -The profile overview of the resident on the eMAR system gave the MA's information. -She would watch to see if Resident #5 was shaky or if she had fluid in her legs. -She had never given glucose to Resident #5. -She had seen Resident #5 have low BG readings before and would say 69 or less was low. -For low readings she would give sugar, orange juice, and wait 10 to 30 minutes to recheck the BG. -She would notify the provider if the Resident had BG below the parameters. -She would give the provider a call or use the provider triage system. -She had only called once for Resident #5's low BG. Attempted telephone interview with Resident #5's endocrinology provider on 03/06/26 at 4:56pm was unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/09/26 at 11:47am and 1:52pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/10/26 at 8:17am, 11:26am, and 2:11pm were unsuccessful. Attempted telephone interviews with Resident #5's endocrinology provider on 03/11/26 at 8:59am, and 2:04pm were unsuccessful.	D 344		
D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358	The Regional Clinical Nurse in-service all medication aides and care managers on medication administration on 3/17/26. See attachment.	4/10/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 75 (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: TYPE A2 VIOLATION Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered to 2 of 4 residents (#8, #9) observed during the morning medication pass on 03/04/26 including errors with medications used to treat fluid retention (#8, #9), a medication used for heart health, medications used to treat elevated blood glucose (#8) and for 5 of 5 sampled residents, (#1, #2, #3, #4, and #5) including errors for medications used to treat low thyroid levels, (#2, #5), medications used to treat high blood pressure, a blood thinner, an antibiotic (#2), medications used to treat mild and moderate pain (#1), and two vitamin supplements (#3, #4, #5). The findings are: 1. The medication error rate was 22% as evidenced by 6 errors out of 27 opportunities during the 9:00am medication pass on 03/04/26. a. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an order for aspirin (used for heart	D 358	The ED/desingnee in-serviced all medication aides and Care Managers on Medication Administration Technique Reminders and Medication Administration for Adult Care Home on 4/15/26. See attachment The Care Manager in-serviced all medication aides on Medication Administration on 4/18/26. See attachment. The ED/ Care Managers started random medication pass observation on the week of 4/1/26. The ED/Care Managers will observe 3 random medication passes for the next 4 weeks to observe medication administration. The RCC provided 1on1 training with medication aide involved was re-trained on the 5 Rights of Medication Administration. The Care managers in-service all medication aides on daily cart audits. The ED/ Care managers will review all daily cart audits in morning standup. The Care managers will review any resident care issues that involves medication administration with the medication aides during stand down.	4/10/26 ongoing 4/10/26 ongoing 4/10/26 ongoing 4/10/26 ongoing 4/10/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 76 health) 81mg, one daily. Review of Resident #8's medication review report dated 02/27/26 revealed an order for aspirin 81mg, give one tablet one time a day for deep vein thrombosis (DVT). Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 6 oral medications for Resident #8. -The MA administered the 6 oral medications to Resident #8 with a cup of water at 8:44am. -There was no aspirin 81mg included in Resident #8's medications administered during the 9:00am medication pass. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for aspirin 81mg, once daily scheduled at 8:00am. -Aspirin 81mg was documented as administered at 8:00am on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for aspirin 81mg, one daily. Refer to interview with Resident #8 on 03/04/26 at 4:58pm. Refer to telephone interview with the pharmacist from the facility's contracted pharmacy on 03/04/26 at 4:18pm. Refer to interview with the medication aide (MA) on 03/04/26 at 2:04pm.	D 358	The ED/designee will do random chart audits of residents MARs to ensure that all medication are being administered correctly.	4/10/26 Ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 358	Continued From page 77 Refer to interview with a second MA on 03/05/26 at 4:11pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm. Refer to second interview with the RCC on 03/05/26 at 2:51pm, Refer to interview with the Administrator on 03/04/26 at 4:14pm. Refer to second interview with the Administrator on 03/05/26 at 3:15pm. Refer to telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm. b. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an order for acetazolamide (can be used to treat fluid retention caused by heart failure) 500mg, twice a day. Review of Resident #8's medication review report dated 02/27/26 revealed an order for Diamox (Diamox is the brand name for acetazolamide) Sequels capsule extended release 12 hour 500mg, give one capsule two times per day for intraocular edema. Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 6 oral medications for Resident #8. -The MA administered the 6 oral medications to	D 358		

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D 358	Continued From page 78 Resident #8 with a cup of water at 8:44am. -There was no acetazolamide DR 500mg included in Resident #8's medications administered during the 9:00am medication pass. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for Diamox (acetazolamide) Sequels 500mg, one two times daily, scheduled at 8:00am 8:00pm. -Diamox (acetazolamide) 500mg capsule was documented at 8:00pm on 02/27/26 with initials with a circle around them in the entry space. -Diamox (acetazolamide) 500mg capsule was not documented as administered at 8:00am and 8:00pm on 02/28/26, the entry spaces were blank for 8:00am and 8:00pm on 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for acetazolamide DR 500mg, twice a day. Refer to interview with Resident #8 on 03/04/26 at 4:58pm. Refer to telephone interview with the pharmacist from the facility's contracted pharmacy on 03/04/26 at 4:18pm. Refer to interview with the medication aide (MA) on 03/04/26 at 2:04pm. Refer to interview with a second MA on 03/05/26 at 4:11pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE

ROCKY MOUNT, NC 27803

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D 358	Continued From page 79 Refer to second interview with the RCC on 03/05/26 at 2:51pm, Refer to interview with the Administrator on 03/04/26 at 4:14pm. Refer to second interview with the Administrator on 03/05/26 at 3:15pm. Refer to telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm. c. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an order for furosemide (used to treat fluid retention caused by congestive heart failure or kidney disease) 20mg, take three tablets daily. Review of Resident #8's medication review report dated 02/27/26 revealed: -There was an order furosemide 20mg, take three tablets one time a day for congestive heart failure. Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 6 oral medications for Resident #8. -The MA administered the 6 oral medications to Resident #8 with a cup of water at 8:44am. -There was no furosemide 20mg Included in Resident #8's medications administered during the 9:00am medication pass. Review of Resident #8's paper medication administration record (MAR) for February 2026	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

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D 358	Continued From page 80 revealed: -There was a handwritten entry for furosemide 20mg, take one tablet once a day, scheduled at 8:00am. -Furosemide 20mg was not documented as administered at 8:00am on 02/28/26, the entry space was blank for 8:00am 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for furosemide 20mg, 3 tablets once daily. Refer to Interview with Resident #8 on 03/04/26 at 4:58pm. Refer to telephone interview with the pharmacist from the facility's contracted pharmacy on 03/04/26 at 4:18pm. Refer to Interview with the medication aide (MA) on 03/04/26 at 2:04pm. Refer to Interview with a second MA on 03/05/26 at 4:11pm. Refer to Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm. Refer to second Interview with the RCC on 03/05/26 at 2:51pm. Refer to Interview with the Administrator on 03/04/26 at 4:14pm. Refer to second Interview with the Administrator on 03/05/26 at 3:15pm. Refer to telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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1365 RIVER DRIVE
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D 358	Continued From page 81 2:14pm. d. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an order for empagliflozin (used to treat elevated blood sugar) 25mg, take one every morning. Review of Resident #8's medication review report dated 02/27/26 revealed an order for empagliflozin 25mg, one tablet in the morning for diabetes mellitus. Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 6 oral medications for Resident #8. -The MA administered the 6 oral medications to Resident #8 with a cup of water at 8:44am. -There was no empagliflozin 25mg included in Resident #8's medications administered during the 9:00am medication pass. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry for empagliflozin 25mg, take one tablet in the morning, scheduled at 8:00am. -Empagliflozin 25mg was not documented as administered at 8:00am on 02/28/26, the entry space was blank for 8:00am 02/28/26. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for empagliflozin 25mg, one tablet in the morning.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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D 358	Continued From page 82 Refer to interview with Resident #8 on 03/04/26 at 4:58pm. Refer to telephone interview with the pharmacist from the facility's contracted pharmacy on 03/04/26 at 4:18pm. Refer to interview with the medication aide (MA) on 03/04/26 at 2:04pm. Refer to interview with a second MA on 03/05/26 at 4:11pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm. Refer to second interview with the RCC on 03/05/26 at 2:51pm, Refer to interview with the Administrator on 03/04/26 at 4:14pm. Refer to second interview with the Administrator on 03/05/26 at 3:15pm. Refer to telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm. e. Review of Resident #8's FL2 dated 02/24/26 revealed: -Diagnoses included diabetes mellitus, congestive heart failure, chronic kidney disease and polyneuropathy. -There was an incomplete order for Humalog (humalog is a fast acting insulin used to treat elevated blood sugar) quick pen 100 units. Review of Resident #8's medication review report	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 358	Continued From page 83 dated 02/27/26 revealed: -There was an order for humalog Injection 100units/ml, inject per sliding scale, If FSBS 170-220=2 units, If FSBS 221-300= 4 units, If FSBS 301-400= 6 units, if FSBS 401-500=8 units, If over 500, call provider, inject subcutaneously twice per day for diabetes mellitus. Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 6 oral medications for Resident #8. -The MA administered the 6 oral medications to Resident #8 with a cup of water at 8:44am. -Resident #8 did not receive a fingerstick blood sugar (FSBS) check and Humalog Insulin was not administered during the 9:00am medication pass. Review of Resident #8's paper medication administration record (MAR) for February 2026 revealed: -There was a handwritten entry Humalog insulin, inject per sliding scale, 170-220= 2 units, 221-300= 4 units, 301-400= 6 units, 401-500= 8 units, over 500, call MD, subcutaneously twice a day, scheduled at 8:00am and 8:00pm. -Humalog was documented as not administered at 8:00pm on 02/27/26 for a FSBS of 144. -Humalog was not documented as administered at 8:00am and 8:00pm on 02/28/26, the entry spaces for 8:00am and 8:00pm on 02/28/26 were blank and there was no FSBS recorded. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed there was no entry for Humalog insulin sliding scale twice daily. Refer to interview with Resident #8 on 03/04/26 at 4:58pm.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 358	Continued From page 84 Refer to telephone interview with the pharmacist from the facility's contracted pharmacy on 03/04/26 at 4:18pm. Refer to interview with the medication aide (MA) on 03/04/26 at 2:04pm. Refer to interview with a second MA on 03/05/26 at 4:11pm. Refer to interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm. Refer to second interview with the RCC on 03/05/26 at 2:51pm. Refer to interview with the Administrator on 03/04/26 at 4:14pm. Refer to second interview with the Administrator on 03/05/26 at 3:15pm. Refer to telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm. Interview with Resident #8 on 03/04/26 at 4:58pm revealed: -He was admitted to the facility on Friday 02/27/26. -He took many medications but could not say exactly what he took. -He was diabetic and took insulin up to three times a day depending on what his blood sugar was. -He had not had his blood sugar checked or received insulin since he was admitted to the facility on Friday 02/27/26.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 358	Continued From page 85 -He guessed it was decided that he no longer needed Insulin. -The facility should have all his medical information and should know what medications he was supposed to take. Interview with the MA on 03/04/26 at 2:04pm: -Resident #8 had Insulin pens on the medication cart but she thought his orders must have changed because there was no order on his eMAR for Insulin or FSBS. -She had not administered Insulin for Resident #8 because there was not an order on his eMAR. -She was not aware of additional orders for aspirin, acetazolamide, furosemide or empagliflozin for Resident #8. -She administered medications to the residents by the eMAR. Interview with a second MA on 03/05/26 at 4:11pm revealed: -She was on duty when Resident #8 was admitted on 02/27/26. -She copied his medications from the medication card labels that he brought to a paper MAR. -Resident #8 did not bring a glucometer with him and the facility had a loaner glucometer they could use until he received a glucometer. -The Care Managers usually matched the resident's medications to their FL2 once the medications were entered into the eMAR system. Telephone Interview with a pharmacist from the facility's contracted pharmacy provider on 03/04/26 at 4:18pm revealed: -The pharmacy received Resident #8's FL2 via fax on 02/27/26 at 4:30pm. -There were six medication orders that they could not read on Resident #8's faxed FL2. -A fax was sent to the facility at 5:29pm on	D 358		

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D 358	Continued From page 86 02/27/26, noting that clarification was needed for 6 orders that were illegible or incomplete on Resident #8's FL2. -The pharmacy did not receive a response and reached out to the facility again on Monday 03/03/26 when there were 6 orders on Resident #8's FL2 that needed clarification. -The pharmacy did not hear back from the facility until 03/04/26 at 3:06pm regarding clarification for the orders for Resident #8 which included aspirin 81mg, take one daily, acetazolamide ER 500mg, take one two times per day, furosemide 20, gives 3 tabs once a day, empagliflozin 25mg, take one tablet every morning, and humalog kwikpen inj, check blood sugar twice a day, inject subcutaneously as directed per sliding scale, 170-220=2 units, 221-300=4 units, 301-400=6 units, 401-500=8 units, over 500, call provider. -The pharmacy was currently in the process of entering the clarified orders for Resident #8 and would be dispensing that medications to the facility for Resident #8. Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 3:54pm revealed: -Resident #8 was admitted to the facility on Friday 02/27/26. -She was off on Friday 02/27/26 and was not at the facility when Resident #8 was admitted. -She thought the Administrator sent Resident #8's FL2 to the pharmacy for his orders to be entered. -A paper MAR was completed either by the Administrator or the MA for Resident #8 until his orders were entered and approved in the eMAR system. -She found the email from the pharmacy today (03/04/26) that there were 6 orders that needed clarification for Resident #8. -She was not aware before today that there were orders that were not on the eMAR for Resident #8	D 358		

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D 358	Continued From page 87 including insulin. -When a resident was first admitted, staff used a paper MAR to record a resident's medications from the resident's FL2 until orders could be entered by the pharmacy and medications received. Second interview with the RCC on 03/05/26 at 2:51pm revealed: -When a resident was admitted, any medications brought with them were reviewed and recorded on a paper MAR. -The FL2 was faxed to the pharmacy for orders to be added by the pharmacy. -Once the orders were entered by the pharmacy, the Care Managers (herself or the Special Care Coordinator) or the Administrator could verify and approve orders. -The resident's orders on the eMAR should be compared to the resident's FL2 or physician orders. -Once Resident #8's medication orders were in the eMAR system, the orders should have been compared to his FL2 at the time the orders were verified. -Any medication order clarification should be handled immediately by contacting the resident's primary care provider (PCP). -Resident #8's medication orders should have been clarified and added to his eMAR within 24 hours of his admission if not prior to his admission. Interview with the Administrator on 03/04/26 at 4:14pm revealed: -She was working when Resident #8 was admitted to the facility on 02/27/26. -She faxed Resident #8's information including his FL2 to the pharmacy on 02/27/26. -She had not noticed that some of Resident #8's	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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)	(X6) COMPLETE DATE
D 358	Continued From page 88 medication orders were unclear and she had not noticed that the order for Humalog was incomplete. -The pharmacy had sent a message on Saturday (02/28/26) about needed clarification for Resident #8's medications on his FL2. -She thought the RCC had addressed Resident #8's needed medication clarifications on Monday 03/03/26. Second Interview with the Administrator on 03/05/26 at 3:15pm revealed: -When a resident was admitted, the MAs or the Care Managers receive a copy of the resident's FL2 for the medication orders. -The FL2 was sent to the pharmacy and the pharmacy entered the orders into the eMAR system, the Care Managers were responsible for verifying and approving the orders by comparing them to the resident's FL2 once they were placed in the eMAR system by the pharmacy. -Resident #8 was admitted to the facility in the afternoon on 02/27/26. -She sent the FL2 to the pharmacy on 02/27/26. -Resident #8's FL2 was a poor copy because it had been emailed and copied several times making it difficult to read. -The MA on duty 02/27/26, filled out a paper MAR for Resident #8 with the medications that he brought with him. -The paper MAR was used for Resident #8 until his orders were entered into the eMAR system and verified. -The only medications that were signed in or counted were narcotics, so there was no type of medication received documentation for Resident #8. -When the MA noticed there were medications not available for Resident #8 on the medication cart, they should have notified herself, one of the	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 89 Care Managers and the pharmacy. -She felt the pharmacy should have called the facility about the unclear medications on Resident #8's FL2 instead of sending an email. Telephone Interview with Resident #8's primary care provider (PCP) on 03/06/26 at 2:14pm revealed: -Resident #8 was new to the facility. -Low dose aspirin can be prescribed for heart health, cardiac disease, heart failure, and/or coronary artery disease. -She was not too concerned about Resident #8 going without his low dose aspirin. -She was not sure why Resident #8 was prescribed acetazolamide, but it could be used as a diuretic and help with his congestive heart failure. -Going without the acetazolamide could cause Resident #8 to experience swelling. -Furosemide was prescribed for swelling and could help with Resident #8's diagnosis of congestive heart failure. -Going with the furosemide could cause Resident #8 to experience swelling and fluid retention. -Resident #8 had a diagnosis of diabetes and empagliflozin was prescribed to help control his blood sugar and was also used for heart health. -Missed doses of empagliflozin could cause Resident #8's blood sugar to be elevated. -Humalog was a fast-acting insulin used to treat elevated blood sugar associated with diabetes. -Missed doses of Humalog could cause Resident #8 to experience elevated blood sugar which could lead to headache, dizziness, and unconsciousness. -Resident #8 should have had his FSBS checked as ordered, to know what his blood sugar readings were and to know if he needed the Humalog as ordered.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 90 -She expected the facility to administer the resident's medications as ordered. -She felt the pharmacy should have contacted the facility immediately regarding orders that they could not read on Resident #9's FL2. f. Review of Resident #9's FL2 dated 01/05/26 revealed: -Diagnoses included muscle weakness, muscle wasting and atrophy, type 2 diabetes, cognitive communication disorder, and dysphagia. -There was an order furosemide (furosemide is used to treat fluid retention caused by congestive heart failure or kidney disease) 40mg, one daily. Review of Resident #9's signed physicians order sheet dated 01/08/26 revealed an order for furosemide 40mg, one tablet once a day. Review of Resident #9's March electronic medication administration record (eMAR) revealed: -There was an entry for furosemide 40mg, take one tablet once daily scheduled at 9:00am. -Furosemide 40mg was documented as administered at 9:00am on 03/01/26 and 03/02/26. -Furosemide 40mg was documented as not administered at 9:00am on 03/03/26 with the exception documented as DNA (per the exception key with the eMAR, DNA was drug not available). -Furosemide 40mg was documented as administered at 9:00am on 03/04/26. Observation of the 9:00am medication pass on 03/04/26 revealed: -The medication aide (MA) prepared 11 oral medications for Resident #9 at 8:36am from two multi-dose packs (MDP). -Resident #9's two MDPs of medication did not	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 91 Include furosemide 40mg. -The MA administered the 11 oral medications to Resident #9 with a cup of water at 8:41am -There was no furosemide 40mg included in Resident #9's medications administered during the 9:00am medication pass. Observation of Resident #9's medications on hand on 03/04/26 at 2:06pm revealed there was no furosemide 40mg on the medication cart for Resident #9. Interview with the MA on 03/04/26 at 2:06pm revealed: -Most of the residents' medications were batch filled weekly in MDPs. -Resident #9 was supposed to receive furosemide 40mg but there was no bubble card of furosemide on the medication cart for Resident #9. -Furosemide 40mg was not included in Resident #9's MDPs. -She was not sure why there was no furosemide 40mg on the medication cart for Resident #9. -She documented in error on Resident #9's eMAR that she received furosemide this morning. -She should have documented that furosemide was not available on the medication cart for Resident #9. -The third shift MA and the Care Managers were responsible for medication cart audits to make sure medications were available for the residents. -She had nothing to do with medication cart audits. Telephone interview with the pharmacist from the facility's contracted pharmacy provider on 03/04/26 at 4:33pm revealed: -An order was received for Resident #9's furosemide 40mg, to take once daily on 01/06/26.	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 358	Continued From page 92 -Furosemide 40mg was dispensed for Resident #9 on 01/20/26 for 7 tablets for seven-day supply, on 01/27/26 for 7 tablets for a seven-day supply, and on 02/03/26 for 2 tablets for a two-day supply. -The pharmacy was in need of a new prescription for furosemide 40mg and was waiting for the furosemide prescription for Resident #9. Interview with the Resident Care Coordinator (RCC) on 03/05/26 at 2:51pm revealed: -Most medications were batch filled weekly for the residents in MDPs. -If a resident had bubble card packaged medications, the MAs requested medications when the medication reached the blue line on the medication bubble card which usually meant there were 5 to seven doses remaining. -The MAs and the RCC were responsible to make sure medications were on the medication cart and available for the residents. -The MA should have contacted the pharmacy about Resident #9's furosemide when she realized it was not available on the medication cart. -She expected to be notified if there was a problem getting a resident's medication from the pharmacy. -If a new prescription was needed, she expected the resident's primary care provider (PCP) to be notified immediately for a refill. -The third shift MA conducted medication cart audits weekly when the new batch medications came in to verify that all ordered medications were in the building and available on the medication cart. -She was not aware that furosemide was not available on the medication cart for Resident #9. -The MA should always compare the resident's medication package to the eMAR.	D 368			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 93 -The MA should not have documented that Resident #9 received furosemide when she did not. Interview with the Administrator on 03/05/26 at 3:08pm revealed: -Most medications were received weekly from the pharmacy in MDPs. -The third shift MA was responsible to check the batch weekly to make sure all ordered medications were received and on the medication cart. -If a new prescription was needed for a resident, the pharmacy would notify the facility and send a prefilled prescription request to the resident's PCP for signature. -When the third shift MA checked the weekly batch, she was expected to print a copy of the current physician's orders and compare it to the medications received for each resident. -If a medication was not available for a resident, she expected the MA to contact the pharmacy to find out why the medication was not sent. -The MAs were to contact the resident's PCP when a medication was not available for a resident to notify and obtain a hold order until the medication was received from the pharmacy. -She expected medications to be administered as ordered and documented accurately on the eMAR. Telephone Interview with Resident #9's PCP on 03/06/26 at 2:14pm revealed: -She did not prescribe Furosemide 40mg for Resident #9. -She thought furosemide was prescribed for Resident #9 from a previous emergency department visit for swelling in her lower extremities and fluid buildup. -She saw Resident #9 yesterday (03/05/26) and	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 358	Continued From page 94 she did not have swelling in her lower extremities. -She had not been notified that Resident #9 needed a new prescription for furosemide. 2. Review of Resident #2's FL2 dated 11/06/25 revealed: -Diagnoses included essential hypertension, thyrotoxicosis, Alzheimer's Disease, and type 2 diabetes. -She was constantly disoriented. -Her level of care was special care unit. Review of Resident #2's Resident Register revealed she was admitted to the facility on 05/01/25. a. Review of her signed physicians order sheet dated 11/06/25 revealed an order for levothyroxine (levothyroxine is used to treat underactive thyroid) 150mcg, take one tablet every morning. Review of Resident #2's primary care provider (PCP) progress note dated 02/19/26 revealed: -There was an order to discontinue levothyroxine 150mcg with a start date of 02/23/26. -There was an order to start levothyroxine 200mcg once daily, with a start date of 02/23/26. Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 200mcg, take one every morning, scheduled at 6:00am with a start date of 02/24/26. -Levothyroxine 200mcg was documented as not administered at 6:00am on 02/25/26 with the exception documented as resident refused. -Levothyroxine 200mcg was documented as not administered at 6:00am on 02/26/26 through	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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D 358	Continued From page 95 02/28/26 with the exception documented as drug not available (DNA). Review of Resident #2's March 2026 eMAR revealed: -There was an entry for levothyroxine 200mcg, take one every morning, scheduled at 6:00am. -Levothyroxine 200mcg was documented as administered at 6:00am on 03/01/26. -Levothyroxine 200mcg was documented as not administered at 6:00am on 03/02/26, with the exception documented as "DNA". -Levothyroxine 200mcg was documented as administered at 6:00am on 03/03/26. -Levothyroxine 200mcg was documented as not administered at 6:00am on 03/04/26, with the exception documented as charted in error, awaiting delivery. Observation of Resident #2's medications on hand on 03/06/26 at 10:55am revealed there was no levothyroxine 200mcg on the medication cart for Resident #2. Observation of Resident #2's medications on hand on 03/09/26 at 11:26am revealed there was no levothyroxine 200mcg on the medication cart for Resident #2. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:50pm revealed: -An order was received to discontinue Resident #2's levothyroxine 150mcg, once daily on 02/23/26. -An order and an electronic prescription for levothyroxine 200mcg, take one daily was received on 02/23/26 for Resident #2. -Levothyroxine 200mcg was dispensed for Resident #2 on 02/24/26 for a quantity of 30	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803			
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D 358	Continued From page 96 tablets for a thirty-day supply. Interview with a medication aide (MA) on 03/06/26 at 11:05am revealed: -Most of the residents' medications were batch filled weekly. -The third shift MA processed the weekly batch filled medications to make sure all the medications were received. -If a medication was missing, the third shift MA passed the information as to what was missing along to the day shift MA. -The MAs were responsible to request medication refills. -Resident #2 frequently refused her oral medications. -Resident #2's levothyroxine was scheduled at 6:00am, so it was administered by the third shift MA and she had not noticed there was no levothyroxine 200mcg available for Resident #2. -She did not know why Resident #2's levothyroxine 200mcg was not on the medication cart. Interview with a second MA on 03/06/26 at 3:44pm revealed: -Resident #2 frequently refused her oral medications almost daily, the Care Managers and her PCP were aware. -The MAs were responsible to order refills for the residents and she requested refills when a resident had about 4 days of medication remaining if the medication was not included in the weekly batch filled medications. Interview with the Special Care Coordinator (SCC) on 03/06/26 at 10:04am revealed: -Medications should be re-ordered by the MA when a resident has 2 days of medication remaining, if the medication was not part of the	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 358	Continued From page 97 weekly batch fill cycle. -When a new prescription was sent for a resident, it used to take 2-3 days to arrive, but the pharmacy had gotten better and medications usually arrived within 24 hours. -If a medication did not arrive after two days, she expected the MAs to notify her so she could find out why and follow-up with the MA to make sure the medication arrived. Second interview with the SCC on 03/09/26 at 3:42pm revealed: -The third shift MA checked in the weekly batch filled medications. -The Care Managers (herself or the Resident Care Coordinator used to perform medication cart audits monthly but had recently started doing the medication cart audits weekly. -The resident's physician's orders were printed and compared to their eMAR, and the resident's medications were compared to the eMAR. -The purpose of the medication cart audit was to make sure all orders were current and all medications were available for the residents. -She was not sure why levothyroxine 20mcg was not available on the medication cart for Resident #2. -If the pharmacy delivered Resident #2's levothyroxine 200mcg, it was possible that it was misplaced on the medication cart. -She expected the MAs to notify her if a medication was not available for a resident. -She expected the MAs to always compare the medication labels to the eMAR and to document accurately when a medication was not administered. -She did not perform eMAR audits. Interview with the Administrator on 03/11/26 at 4:04pm revealed:	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	
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D 358	Continued From page 98 -The MAs were expected to check the resident's eMAR against the medication label prior to administering medications, to make sure the residents received all of their medications. -It was important that all medications be available and administered as ordered to preserve quality of care for the residents. -If a medication was not available for a resident, she expected the MA to contact the pharmacy, the resident's PCP, and the Care Manager (RCC or SCC) to follow-up. -Management had been working with the pharmacy to make sure medications arrive in a timely manner and were available for the residents. -She expected eMAR audits to be done by the Care Managers weekly looking for omissions or holes in the eMARs. -She expected the Care Managers and the resident's PCP to be notified of any medication or treatment omissions on the eMAR Telephone interview with Resident #2's PCP on 03/06/26 at 2:34pm revealed: -Levothyroxine was prescribed for Resident #2 for hypothyroidism. -She was well aware Resident #2 frequently refused her medications including levothyroxine. -Resident #2's thyroid stimulating hormone (TSH) was elevated on her recent blood work and she ordered the levothyroxine to be increased from 150mcg to 200mcg. -If Resident #2 did not receive the levothyroxine she would not be able to maintain a therapeutic level of the medication and low thyroid could cause weight gain and fatigue. -She expected the facility to administer Resident #2's levothyroxine as ordered and if the medication was not on the medication cart for Resident #2, she expected the facility to contact	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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D 358	Continued From page 99 the pharmacy to find out why the medication was not available. Attempted telephone interview with Resident #2's Responsible Party on 03/06/26 at 9:15am was unsuccessful. b. Review of Resident #2's hospital discharge summary dated 02/13/26 revealed: -Resident #2 was hospitalized on 02/03/26 through 02/13/26 for a cerebrovascular event and a fall. -There was an order for Resident #2 to start clopidogrel (clopidogrel is an anti-platelet medication used to prevent serious blood clots, reducing the risk of heart attacks and strokes in high risk individuals) 75mg, take one tablet daily. Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for clopidogrel 75mg, take one tablet daily for clot prevention, scheduled at 8:00am with a start date of 02/16/26. -Clopidogrel 75mg was documented as administered at 8:00am from 02/17/26 to 02/19/26. -Clopidogrel 75mg was documented as discontinued from 02/20/26 to 02/28/26. -There was a second entry for clopidogrel 75mg, take one tablet daily for clot prevention, scheduled at 8:00am. -Clopidogrel 75mg was documented as administered at 8:00am on 02/25/26. -Clopidogrel 75mg was documented as discontinued from 02/26/26 to 02/28/26. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for clopidogrel 75mg, take	D 358		

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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 368	Continued From page 100 one tablet daily for clot prevention scheduled at 9:00am. -Clopidogrel 75mg was documented as not administered at 9:00am on 03/01/26, with the exception documented as DNA (drug not available). -Clopidogrel 75mg was documented as administered at 9:00am on 03/02/26. -Clopidogrel 75mg was documented as not administered at 9:00am on 03/03/26 and 03/04/26 with the exception documented as resident refused. Observations of Resident #2's medications on hand on 03/06/26 at 10:55am revealed there were two multi-dose pack (MDP) of medications, that included clopidogrel 75mg, labeled to take one tablet once daily for clot prevention in one of the 2 MDPs labeled "morning", there were 6 morning MDPs remaining dated 03/07/26 through 03/12/26. Telephone interview with the pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:50pm revealed: -An order was received for clopidogrel 75mg, take one tablet daily on 02/12/26. -Clopidogrel 75mg, take one tablet daily was dispensed for Resident #2 on 02/12/26 for a quantity of 8 tablets to take one daily for an eight supply. -Clopidogrel 75mg, take one tablet daily was dispensed for Resident #2 on 02/17/26, 02/24/26, and 03/03/26 for a quantity of 7 tablets for a seven-day supply on each occasion. -No discontinue order was received for Resident #2's clopidogrel 75mg and she did not know why Resident #2's February 2026 eMAR was documented as discontinued. -Clopidogrel had an anti-platelet effect and not	D 368		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 101 having clopidogrel could make Resident #2 more prone to blood clotting. Interview with a medication aide (MA) on 03/06/26 at 11:05am revealed: -When a resident returned from the hospital, an emergency department visit, or an outside provider appointment, the paperwork was always given to the Special Care Coordinator (SCC), if the resident returned after the SCC left the facility, the information was slid under the SCC's door. -She thought Resident #2 started clopidogrel after a recent hospital visit. -She knew Resident #2 frequently refused her medications but did not think her clopidogrel had been discontinued. Interview with the SCC on 03/06/26 at 9:48am revealed: -She expected the MAs to always compare the medication label to the eMAR entry at least 3 times to make sure the residents received all their medications as ordered. -She had provided Resident #2's primary care provider (PCP) with Resident #2's 02/12/26 discharge information and she knew the PCP was aware that clopidogrel had been ordered. -She thought it was possible Resident #2's PCP stopped Resident #2's clopidogrel but she did not have a discontinuation order. -She was not aware clopidogrel was documented as discontinued on Resident #2's February eMAR. -She could not explain why Resident #2's clopidogrel was documented as discontinued on her February 2026 eMAR. -There appeared to be two orders for clopidogrel for Resident #2 in February, but she could not explain why there would be two orders for	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1305 RIVER DRIVE ROCKY MOUNT, NC 27803
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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)	(X6) COMPLETE DATE
D 358	Continued From page 102 clopidogrel or why clopidogrel was documented as discontinued on her February 2026 eMAR. Second Interview with the SCC on 03/09/26 at 3:42pm revealed: -The third shift MA checked in the weekly batch filled medications. -The Care Managers (herself or the Resident Care Coordinator used to perform medication cart audits monthly but had recently started doing the medication cart audits weekly. -The resident's physician's orders were printed and compared to their eMAR, and the resident's medications were compared to the eMAR. -The purpose of the medication cart audit was to make sure all orders were current and all medications were available for the residents. -The supervising MA on duty on the unit when a resident returned from the hospital was responsible to fax orders to the pharmacy. -If a new medication was electronically prescribed, the hospital was to let the facility know and she was to be notified. -The pharmacy would not accept orders from a hospital after visit summary and physical order was needed. -She was not sure why Resident #2's clopidogrel was stopped and restarted. -If eMAR system discontinued Resident #2's clopidogrel, she did not know why. -If there were any questions about a resident's medication or orders, she expected the MAs to notify her. -She still did not know why clopidogrel was documented as discontinued on the February 2026 eMAR for Resident #2. -She did not perform eMAR audits. -An eMAR audit may have caught the discontinued clopidogrel order for Resident #2.	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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 103 Interview with the Administrator on 03/11/26 at 4:04pm revealed: -The MAs were expected to check the resident's eMAR against the medication label prior to administering medications, to make sure the residents received all their medications. -It was important that all medications be available and administered as ordered to preserve quality of care for the residents. -She expected eMAR audits to be done by the Care Managers weekly looking for omissions or holes in the eMARs. -She expected the Care Managers and the resident's PCP to be notified of any omissions on the eMAR Telephone interview with Resident #2's primary care provider (PCP) on 03/06/26 at 2:36pm revealed: -She saw that clopidogrel was prescribed for Resident #2 on a recent hospital discharge summary. -Clopidogrel was a blood thinner and was used to prevent blood clots in the heart and throughout the body. -She was not exactly sure why clopidogrel was prescribed for Resident #2, except there was mention of a possible stroke on Resident #2's discharge paperwork from 02/12/26. -She knew Resident #2 frequently refused her medications including clopidogrel. -She did not discontinue Resident #2's clopidogrel and did not know why her February 2026 eMAR indicated clopidogrel had been discontinued. -Resident #2 going without the clopidogrel could put her at risk for developing blood clots that could increase her risk for stroke. c. Review of Resident #2's signed physician's	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 104 order sheet dated 02/05/26 revealed an order for losartan (losartan is used to treat high blood pressure) 50mg, take one tablet once daily. Review of Resident #2's hospital discharge summary dated 02/13/26 revealed: -Resident #2 was hospitalized on 02/03/26 through 02/13/26 for a cerebrovascular event and a fall. -There was an order for Resident #2 to stop losartan 50mg. Review of Resident #2's February 2026 electronic medication administration record (eMAR) revealed: -There was an entry for losartan 50mg, take one tablet once daily, scheduled for 8:00am. -Losartan 50mg was documented as administered at 8:00am on 02/01/26 through 02/03/26. -Losartan 50mg was documented as not administered at 8:00am on 02/04/26 through 02/13/26 with the exception documented as leave of absence. -Losartan 50mg was documented as administered at 8:00am from 02/14/26 through 02/28/26. Review of Resident #2's March 2026 eMAR revealed: -There was an entry for losartan 50mg, take one tablet once daily, scheduled for 8:00am. -Losartan 50mg was documented as not administered at 8:00am on 03/01/26 with the exception documented as drug not available (DNA). -Losartan 50mg was documented as administered at 8:00am on 03/02/26. -Losartan 50mg was documented as not administered at 8:00am on 03/03/26 and	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1385 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 105 03/04/26 with the exception documented as resident refused. Observations of Resident #2's medications on hand on 03/06/26 at 10:55am revealed there were two multi-dose packs (MDP) of medications, that included losartan potassium 50mg, labeled to take one tablet once daily in one of the 2 MDPs labeled "morning", there 6 morning MDPs remaining dated 03/07/26 through 03/12/26. Telephone interview with a pharmacist from the facility's contracted pharmacy provider on 03/06/26 at 1:50pm revealed: -Losartan Potassium 50mg was dispensed for Resident #2 on 01/06/26, 01/13/26, 01/20/26, 01/27/26, 02/03/26, 02/10/26, 02/17/26, 02/24/26, and on 03/03/26 for a quantity of 7 tablets for a seven-day supply on each occasion. -There had been no order received to discontinue losartan 50mg for Resident #2. Interview with a medication aide (MA) on 03/06/26 at 11:05am revealed: -She did not process new orders or discontinue orders for the residents. -When a resident returned from the hospital, an emergency department visit, or an outside provider appointment, the paperwork was always given to the Special Care Coordinator (SCC), if the resident returned after the SCC left the facility, the information was slid under the SCC's door. -She knew Resident #2 frequently refused her medications but did not know Resident #2 was to stop her losartan. Interview with a second MA on 03/06/26 at 3:44pm revealed: -The Care Managers (RCC and SCC) were	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1385 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 106 responsible for processing new orders for the residents. -If a resident returned from the hospital or an outside provider, she gave the paperwork to the SCC. Interview with the SCC on 03/06/26 at 10:05am revealed: -The Care Managers or the MAs could send new orders to the pharmacy. -When a resident returned from the hospital, the MA on duty in the unit who received the resident, was responsible to fax any hospital paperwork or orders to the facility's pharmacy then the paperwork was given to the Care Managers to follow-up on any new orders. Interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm revealed: -When a resident returned from the hospital, the first contact was the MA on duty on the unit when the resident returned. -The MA was expected to send any paperwork to the pharmacy, notify the resident's primary care provider (PCP) the resident had returned via telemedic, and give the resident's hospital paperwork to the Care Manager, or place it in the Care Managers' box for review. -If a medication was discontinued, the order was sent to the pharmacy and either she or the SCC could remove the order from the system by verifying the discontinued order and then the discontinued medication was removed from the medication cart and either returned to the pharmacy or destroyed in the facility. Second interview with the SCC on 03/09/26 at 3:53pm revealed: -The supervising MA on duty on the unit when a resident returned from the hospital was	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 107 responsible to fax orders to the pharmacy. -If a new medication was electronically prescribed, the hospital was to let the facility know and she was to be notified. -She thought someone from the hospital told her a new prescription for losartan had been sent to the pharmacy. -The pharmacy would not accept orders from a hospital after visit summary. -She was not sure she saw Resident #2's hospital discharge summary that noted her losartan was to be stopped. Interview with the Administrator on 03/11/26 at 4:18pm revealed: -When a resident returned from the hospital, the MAs could send the paperwork to the pharmacy and if the resident was seen by the facility's contracted PCP, the resident's paperwork was scanned in and given to the Care Managers. -The Care Managers were expected to review the resident's hospital paperwork for orders and then place it in the PCP's folder for review and signature. -The pharmacy would not accept a hospital after visit summary or discharge summary and required a physical order, so many times the PCP reviewed the paperwork and wrote the new orders. -She expected all hospital paperwork to be reviewed for new orders. Telephone interview with Resident #2's primary care provider (PCP) on 03/06/26 at 2:34pm revealed: -Losartan 50mg was prescribed for Resident #2 to treat high blood pressure. -She knew Resident #2 frequently refused her medications including losartan. -She was not aware that losartan had been	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 368	Continued From page 108 discontinued for Resident #2. -She had not seen Resident #2's hospital discharge summary dated 02/13/26 that noted to stop losartan. -She was not sure why losartan was discontinued and would like to know how Resident #2's blood pressure looked. -Continuing to receive losartan after it was discontinued could cause Resident #2's blood pressure to bottom out resulting in dizziness, light headedness, loss of consciousness and unstable blood pressure. d. Review of Resident #2's emergency department (ED) after visit summary dated 02/17/26 revealed: -Resident #2 was seen in the emergency department for a rash on the left arm and chest with 2 small spots on the right arm. -Resident #2's rash was consistent with folliculitis (a common skin condition characterized by inflammation or infection of the hair follicles). -Start taking doxycycline (doxycycline is an antibiotic used to treat bacterial infections) 100mg, one capsule two times per day for 10 days. Review of Resident #2's February 2026 electronic medication record (eMAR) revealed: -There was an entry for doxycycline 100mg, take one capsule twice daily for 10 days, scheduled at 8:00am and 8:00pm, with a start date of 02/18/26. -Doxycycline 100mg was not documented as administered at 8:00am from 02/19/26 to 02/24/26 with no exception documented. -Doxycycline 100mg was not documented as administered at 8:00pm from 02/18/26 to 02/23/26 with no exception documented. -Doxycycline 100mg was documented as administered at 8:00am from 02/25/26 to	D 368		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 109 02/27/26. -Doxycycline 100mg was documented as administered at 8:00pm from 02/24/26 to 02/27/26. -Doxycycline 100mg was documented as administered only on seven occasions out of 20 opportunities from 02/18/26 to 02/27/26. Review of Resident #2's March 2026 eMAR revealed there was no entry for doxycycline 100mg capsules. Telephone interview with the pharmacist with the facility's contracted pharmacy on 03/06/26 at 1:50pm revealed: -An order was received for Resident #2 for doxycycline 100mg, take one capsule twice a day for 10 days on 02/18/26. -The doxycycline 100mg order received for Resident #2 was profiled to be started on 02/18/26 and completed 02/28/26 but was not dispensed. Telephone interview with a pharmacist with a local retail pharmacy on 03/09/26 at 4:43pm revealed: -An order was received for Resident #2 on 02/17/26 for doxycycline 100mg, 20 capsules, to take one capsule twice a day for 10 days. -Doxycycline 100mg, 20 capsules, take one capsule twice a day for a 10-day supply for Resident #2 was dispensed and picked up on 02/18/26. Interview with a medication aide (MA) on 03/09/26 at 10:30am revealed: -Resident #2 recently went to the ED for a rash. -Resident #2's family member brought in a prescription for antibiotics for Resident #2. -The MAs could not administer any medications to the residents if the medication was not listed	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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)	(X6) COMPLETE DATE
D 368	Continued From page 110 on their eMAR. -She remembered administering antibiotics to Resident #2 but could not say for sure how long she was on them. Interview with a second MA on 03/10/26 at 2:07pm revealed: -Resident #2 had been to the ED recently for a rash and received antibiotics. -She remembered Resident #2 had a bottle of doxycycline on the medication cart and she remembered administering doxycycline to Resident #2. -If a resident had medications on the medication cart, the medication had to be listed on their eMAR before the MAs could administer the medication. Interview with the Special Care Coordinator (SCC) on 03/06/26 at 10:04am revealed: -Resident #2's went to the ED on 02/17/26 for a rash. -At the 02/17/26 ED visit, a prescription was sent for Resident #2 to a local retail pharmacy for antibiotics. -Resident #2's family member picked up the antibiotic prescription for Resident #2. -The facility's contracted pharmacy did not receive the prescription for Resident #2's doxycycline and required a copy of the prescription to add to Resident #2's eMAR. Second interview with the SCC on 03/06/26 at 3:53pm revealed: -Doxycycline was sent to a local retail pharmacy for Resident #2 at her family's request so there would not be a delay in Resident #2 receiving the medication. -The local retail pharmacy had to contact the facility's retail pharmacy and give the prescription	D 368		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 111 information for Resident #2's doxycycline so it could be added to her eMAR. -The MAs could not administer doxycycline to Resident #2 until the order was added to her eMAR by the contracted pharmacy. -She was not sure when the facility's contracted pharmacy was contacted by the local retail pharmacy about Resident #2 doxycycline. -She knew Resident #2's family brought the doxycycline to the facility for Resident #2, but she could not say when the doxycycline was started or if Resident #2 received the entire 10 days of doxycycline. -She did not know why Resident #2's February eMAR reflected only 7 of the 20 scheduled doses of doxycycline being administered. Interview with the Administrator on 03/11/26 at 4:04pm revealed: -When a resident returned from the hospital, the MAs could send the paperwork to the pharmacy and if the resident was seen by the facility's contracted PCP, the resident's paperwork was scanned in and given to the Care Managers. -The pharmacy would not accept a hospital after visit summary or discharge summary and required a physical order. -Resident #2's family member had her prescription for doxycycline sent to a local pharmacy. -The local pharmacy had to contact the facility's contracted pharmacy to be able to profile the doxycycline for Resident #2's doxycycline to be administered. -Resident #2 should have received the full course of doxycycline for her rash as ordered. Telephone interview with Resident #2's primary care provider (PCP) on 03/10/26 at 8:17am revealed:	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 358	Continued From page 112 -She had been treating Resident #2 for a rash on her arms. -She had ordered a skin culture and hydrocortisone cream for Resident #2 because the rash seemed itchy. -Resident #2's Responsible Party (RP) wanted the resident sent to the ED before the culture could be obtained so there would not be a delay in treating her rash. -She had planned to prescribe doxycycline 100mg twice a day for 7 days for Resident #2 because she also felt Resident #2 had folliculitis which was easily treated with doxycycline. -She knew medications could be sent to a local pharmacy after hours and there had been some difficulty when a local pharmacy needed to contact the facility's contracted pharmacy so medications could be profiled. -She was not aware that there were only seven doses of doxycycline documented as administered for Resident #2. -Not receiving the entire course of doxycycline could cause Resident #2 to have a relapse with the rash and have continued symptoms if the rash did not totally clear up. -She had recently seen Resident #2 and the rash had cleared up. Attempted telephone interview with Resident #2's Responsible Party on 03/06/26 at 9:15am was unsuccessful. 3. Review of Resident #5's FL-2 dated 01/08/26 revealed: -Diagnoses included muscle wasting and atrophy, not elsewhere classified, multiple sites; Type II diabetes mellitus without complications; other specified inflammatory spondylopathies, lumbar region; nutritional deficiency, unspecified; respiratory disorders in diseases classified	D 358		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 368	Continued From page 113 elsewhere; dysphagia, oropharyngeal phase; cognitive communication deficit; muscle weakness (generalized). -The recommended level of care was domiciliary. Review of Resident #5's Resident Register revealed she was admitted to the facility on 12/27/24. a. Review of Resident #5's FL-2 dated 01/08/26 revealed there was an order for levothyroxine 75mcg take one tablet every morning. Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for levothyroxine 75mcg take one tablet every morning. -Levothyroxine was documented as not administered on 01/08/26 to 01/10/26, from 01/13/26 to 01/16/26, from 01/18/26 to 01/19/26 and on 01/21/26 with exception notes "waiting on pharmacy". -Levothyroxine was documented as not administered on 01/20/26 with exception notes "awaiting refill". Review of Resident #5's February 2026 eMAR revealed: -There was an entry for levothyroxine 75mcg take one tablet every morning. -Levothyroxine was not documented as administered on 02/21/26 and 02/22/26. Observation of Resident #5's medications on hand on 03/05/26 at 3:20pm revealed there was a card containing Levothyroxine 75mcg with 18 tablets remaining of 30 tablets dispensed on 02/19/26.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064934	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 114 Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed: -Resident #5's levothyroxine was dispensed for a quantity of 30 on 12/23/25, 01/21/26, and 02/19/26. -Resident #5's levothyroxine dispensed 12/23/25 was delivered on 12/24/25 and none of the medication was returned. Based on observations and interviews it was determined that Resident #5 was not interviewable. Telephone interview with the responsible person for Resident #5 on 03/06/26 at 10:37am revealed: -She had no problems with the care Resident #5 was receiving at the facility. -She mostly dealt with Resident #5's finances and was not sure if there were any concerns at this time. Interview with a medication aide (MA) on 03/06/26 at 11:30am revealed: -She was training in January 2026 and could not remember if there was a concern about Resident #5's levothyroxine. -If a medication was not available she would call the pharmacy and ensure a refill request and chart in the eMAR system saying drug not available. Interview with the Resident Care Coordinator (RCC) on 03/06/26 at 10:00am revealed: -She was not aware of any changes with Resident #5's levothyroxine. -She tried to educate the MA's and give them knowledge and they could notify her of any issues. -She was responsible for monitoring what was on	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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 115 the cart or not on the cart. -She was still learning the new eMAR system and this was a trial and error period for the new eMAR system. Telephone interview with the primary care provider (PCP) on 03/06/26 at 2:45pm revealed: -Resident #5 did miss doses of her levothyroxine in January 2026. -She usually told the facility to call the pharmacy and ask questions, and if pharmacy could clarify then it was solved. -The pharmacy could escalate any concerns to her. -If levothyroxine was missed Resident #5's thyroid conditions could be affected. -She asked Resident #5's endocrinologist whether the thyroid could affect Resident #5's blood sugar and was waiting on a response. -The thyroid could affect the blood sugar, so she asked the specialist. -There could be symptoms of hyperthyroidism or hypothyroidism based on Resident #5's past labs. Attempted telephone interview with Resident #5's endocrinology provider on 03/06/26 at 4:56pm was unsuccessful. b. Review of Resident #5's physician order dated 01/08/26 revealed there was an order for zinc 50mg one tablet daily. Review of Resident #5's physician order dated 01/29/26 revealed there was an order to discontinue zinc. Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for zinc 50mg take one tablet	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

**1365 RIVER DRIVE
ROCKY MOUNT, NC 27803**

(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 116 once daily with a start date of 01/08/26. -Zinc 50mg was documented as administered on 01/30/26, and 01/31/26. Review of Resident #5's February 2026 eMAR revealed: -There was an entry for zinc 50mg take one tablet once daily. -Zinc 50mg was documented as administered on 02/01/26. Telephone Interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed zinc was dispensed for Resident #5 for a 9-day supply on 01/07/26, a 7-day supply on 01/13/26, a 7-day supply on 01/20/26, and a 7-day supply on 01/27/26. Based on observations and interviews it was determined that Resident #5 was not interviewable. Telephone Interview with the responsible person for Resident #5 on 03/06/26 at 10:37am revealed: -She had no problems with the care Resident #5 was receiving at the facility. -She mostly dealt with Resident #5's finances and was not sure if there were any concerns at this time. Interview with the RCC on 03/06/26 at 10:00am revealed: -She was still learning the new eMAR system and this was a trial and error period for the new eMAR system. -The orders for zinc may have been verified or sent late, which caused delays. Interview with a MA on 03/06/26 at 11:30am revealed Resident #5's zinc was available	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 117 whenever the medications were on the eMAR. Refer to telephone interview with Resident #5's primary care provider (PCP) on 03/06/26 at 2:14pm. c. Review of Resident #5's physician order dated 01/08/26 revealed there was an order for vitamin C 500mg one tablet daily. Review of Resident #5's physician order dated 01/29/26 revealed there was an order to discontinue vitamin C. Review of Resident #5's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for vitamin C 500mg take one tablet once daily with a start date of 01/08/26. -Vitamin C 500mg was documented as administered on 01/30/26, and 01/31/26. Review of Resident #5's February 2026 eMAR revealed: -There was an entry for vitamin C 500mg take one tablet once daily. -Vitamin C 500mg was documented as administered on 02/01/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed vitamin C was dispensed for Resident #5 for a 9-day supply on 01/07/26, a 7-day supply on 01/13/26, a 7-day supply on 01/20/26, and a 7-day supply on 01/27/26. Based on observations and interviews it was determined that Resident #5 was not interviewable.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 118 Telephone interview with the responsible person for Resident #5 on 03/06/26 at 10:37am revealed: -She had no problems with the care Resident #5 was receiving at the facility. -She mostly dealt with Resident #5's finances and was not sure if there were any concerns at this time. Interview with a MA on 03/06/26 at 11:30am revealed Resident #5's vitamin C was available whenever the medications were on the eMAR. Interview with the RCC on 03/06/26 at 10:00am revealed: -She was still learning the new eMAR system and this was a trial and error period for the new eMAR system. -The orders for vitamin C may have been verified or sent late, which caused delays. Refer to telephone interview with Resident #5's primary care provider (PCP) on 03/06/26 at 2:14pm. _____ Telephone interview with Resident #5's primary care provider (PCP) on 03/06/26 at 2:14pm revealed: -The facility had some cases of flu in January and she prescribed Vitamin C and zinc for all her residents at the facility as a prophylactic measure. -She had no concern that Resident #5 received Vitamin C and zinc after she discontinued it but she did expect the facility to administer and discontinue medications as ordered. 4. Review of Resident #1's FL-2 dated 09/18/25 revealed: -Diagnoses included epilepsy, candidal stomatitis,	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 119 anemia, nutritional deficiency, periodontitis, hypomagnesemia, history of COVID, alcohol abuse, anemia in chronic disease, acute respiratory failure, stroke, difficulty walking, muscle weakness, lack of coordination, dysphagia, aphasia. -There was an order for tramadol 50mg take one tablet twice daily as needed (PRN) for pain (tramadol is a controlled substance medication that can be used to treat pain). -There was an order for acetaminophen take two tablets three times daily PRN administer prior to tramadol, if ineffective after one hour then give tramadol (acetaminophen is medication that can be used to treat pain or fever). Review of Resident #1's Resident Register revealed she was admitted to the facility on 12/03/24. Review of Resident #1's physician order sheet dated 12/18/25 revealed: -There was an order for tramadol 50mg take one tablet once daily PRN for pain. -There was an order for acetaminophen take two tablets three times daily PRN administer prior to tramadol, if ineffective after one hour then give tramadol. Review of Resident #1's January 2026 eMAR revealed: -There was an entry for tramadol 50mg take one tablet once daily as needed for pain. -Tramadol 50mg was documented as administered on 01/20/26 and 01/23/26 and documented as effective. -There was an entry for acetaminophen 500mg take two tablets three times daily as needed administer prior to tramadol, if ineffective after one hour then give tramadol.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 120 -Acetaminophen 500mg take two tablets was administered on 01/18/26 at 12:47am and documented as effective. -Tramadol was administered on two occasions without prior administration of acetaminophen. Review of Resident #1's February 2026 eMAR revealed: -There was an entry for tramadol 50mg take one tablet once daily as needed for pain. -Tramadol 50mg was documented as administered on 02/04/26 and documented as effective. -There was an entry for acetaminophen 500mg take two tablets three times daily as needed administer prior to tramadol, if ineffective after one hour then give tramadol. -Acetaminophen 500mg take two tablets was administered on 02/19/26 at 12:45am and documented as effective. -Tramadol was administered once without prior administration of acetaminophen. Review of a handwritten Controlled Substance Log for Resident #1 revealed: -The log was for Tramadol 50mg dispensed 09/29/25 for a quantity of 30 tablets. -One tramadol 50 mg tablet was administered on 11/16/25 at 2:00pm -There were 29 tramadol 50mg tablets remaining. Review of an electronic Controlled Substance Log for Resident #1 revealed: -The log was for Resident #1's Tramadol 50mg. -Tramadol 50mg was documented as administered once on 01/20/26, 01/23/26 and 02/04/26. -There were 26 tramadol 50mg tablets remaining. Observation of Resident #1's medications on	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 121 hand on 03/05/26 at 3:20pm revealed: -There was a card of Resident #1's Tramadol 50mg which had 26 tablets remaining of 30 dispensed on 09/29/25. -There was a bottle of Acetaminophen 500mg available for Resident #1. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:28pm revealed: -Resident #1's tramadol 50mg was dispensed once on 09/29/25 in a quantity of 30 tablets. -Resident #1's family provided all over the counter (OTC) medicines. -Acetaminophen was not dispensed from the pharmacy for Resident #1. Interview with a medication aide (MA) on 03/05/26 at 3:20pm revealed: -Resident #1 never asked her for any pain medications. -If Resident #1 had pain she would read the orders, give acetaminophen, check for efficacy an hour later, and if it was ineffective then give tramadol. Interview with a second MA on 03/06/26 at 11:30am revealed: -She had never administered Resident #1's acetaminophen or tramadol -The orders sounded a little skeptical for Resident #1's acetaminophen and tramadol. Interview with the Resident Care Coordinator (RCC) on 03/06/26 at 10:00am revealed: -To give Resident#1's PRN pain medication the MA should administer acetaminophen, wait one hour and check for efficacy, and if it was ineffective then give tramadol. -The MA's did not follow the 6 Rights of	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 122 medication administration. -The MA's did not read the eMAR correctly. -Resident #1's tramadol needed to be clarified to comment on the acetaminophen. 6. Review of Resident #3's current FL-2 dated 12/18/25 revealed diagnoses included hypertension, hyperlipidemia, vascular dementia, osteoarthritis, and unspecified protein-calorie malnutrition. a. Review of Resident #3's signed physician order dated 01/08/26 revealed there was an order for Vitamin C 500mg, take one tablet once a day (Vitamin C is used to help support the immune system). Review of Resident #3's signed physician order dated 01/29/26 revealed there was a discontinue order for Vitamin C 500mg. Review of Resident #3's January 2026 electronic medication record (eMAR) revealed: -There was an entry for Vitamin C 500mg, take one tablet once a day at 8:00am. -Vitamin C 500mg was documented as administered at 8:00am from 01/09/26 to 01/31/26. Review of Resident #3's February 2026 eMAR revealed: -There was an entry for Vitamin C 500mg, take one tablet once a day at 8:00am. -Vitamin C 500mg was documented as administered at 8:00am from 02/01/26 to 02/09/26. Observation of medications on hand on 03/06/26 at 1:30pm revealed there were no Vitamin C 500mg tablets available for Resident #3.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 123 Telephone interview with a pharmacist from the facilities contracted pharmacy on 03/06/26 at 1:28pm revealed: -The pharmacy dispensed Vitamin C 500mg for Resident #3, take one tablet once a day on 01/07/26 with a quantity of 9 tablets for 9 days. -The pharmacy dispensed Vitamin C 500mg for Resident #3, take one tablet once a day on 01/13/26 with a quantity of 7 tablets for 7 days. -The pharmacy dispensed Vitamin C 500mg for Resident #3, take one tablet once a day on 01/20/26 with a quantity of 7 tablets for 7 days. -The pharmacy dispensed Vitamin C 500mg for Resident #3, take one tablet once a day on 01/27/26 with a quantity of 7 tablets for 7 days. -The pharmacy received a discontinue order for Resident #3 from the facility for Vitamin C 500mg on 02/09/26 at 5:53am. Refer to interview with a medication aide (MA) on 03/06/26 at 11:22am. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to telephone interview with Resident #3's primary care provider (PCP) on 03/06/26 at 2:14pm. b. Review of Resident #3's signed physician orders dated 01/08/26 revealed there was an order for Zinc 50mg, take one tablet once a day (Zinc is used to help the immune system). -There was an entry for Zinc 50mg, take one tablet once a day at 8:00am. -Zinc 50mg was documented as administered at 8:00am from 01/09/26 to 02/09/26. Review of Resident #3's signed physician order	D 358			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 124 dated 01/29/26 revealed there was a discontinue order for Zinc 50mg. Review of Resident #3's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Zinc 50mg, take one tablet once a day at 8:00am. -Zinc 50mg was documented as administered at 8:00am from 01/09/26 to 01/31/26. Review of Resident #3's February 2026 eMAR revealed: -There was an entry for Zinc 50mg, take one tablet once a day at 8:00am. -Zinc 50mg was documented as administered at 8:00am from 02/01/26 to 02/09/26. Observation of medications on hand on 03/06/26 at 1:30pm revealed there were no Zinc 50mg tablets available for Resident #3. Telephone interview with a pharmacist from the facilities contracted pharmacy on 03/06/26 at 1:28pm revealed: -The pharmacy dispensed Zinc 50mg for Resident #3, take one tablet once a day on 01/07/26 with a quantity of 9 tablets for 9 days. -The pharmacy dispensed Zinc 50mg for Resident #3, take one tablet once a day on 01/12/26 with a quantity of 7 tablets for 7 days. -The pharmacy dispensed Zinc 50mg for Resident #3, take one tablet once a day on 01/20/26 with a quantity of 7 tablets for 7 days. -The pharmacy dispensed Zinc 50mg for Resident #3, take one tablet once a day on 01/27/26 with a quantity of 7 tablets for 7 days. -The pharmacy received a discontinue order for Resident #3 from the facility for Zinc 50mg on 02/09/26 at 5:53am.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 125 Refer to interview with a medication aide (MA) on 03/06/26 at 11:22am. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to telephone interview with Resident #3's primary care provider (PCP) on 03/06/26 at 2:14pm. Based on observations, interviews, and record reviews it was determined that Resident #3 was not interviewable. Interview with a medication aide (MA) on 03/06/26 at 11:22am revealed: -When there was an order to discontinue a medication, a notification came up on the eMAR. -When this occurred she would check with the Resident Care Coordinator (RCC) or the Special Care Unit Coordinator (SCC) to get directions of how to proceed. -The pharmacy sent medications in a multidose pack, and they were started on Wednesday and ended on Tuesday. Interview with the RCC on 03/09/26 at 2:47pm revealed: -When there was a discontinue order, she sent the order to the pharmacy. -She then removed the medication from the cart after it was entered by her, the SCC or Administrator into the electronic medication administration record (eMAR) to discontinue the medication. -Once the discontinue order was entered into the eMAR system, she, the SCC or Administrator discontinued the medication from the eMAR. -She was not sure why the discontinue order did	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 126 not arrive at the pharmacy until 02/09/26. Telephone interview with Resident #3's primary care provider (PCP) on 03/06/26 at 2:14pm revealed: -The facility had some cases of flu cases in January and she prescribed Vitamin C and zinc for all her residents in the facility as a prophylactic measure. -She brought it to the attention of facility staff that Vitamin C and zinc had not been discontinued as she ordered. -She had no concern that Resident #3 received Vitamin C and zinc for 10 days after she discontinued it but she did expect the facility to administer and discontinue medications as ordered. 6. Review of Resident #4's current FL-2 dated 11/04/25 revealed: -Diagnoses included Alzheimer's Disease, dementia, type 2 diabetes, hypertensive kidney disease, chronic respiratory failure with hypoxia, and pulmonary hypertension. -Her level of care was Special Care Unit. a. Review of Resident #4's signed physician orders dated 01/08/26 revealed an order for Vitamin C (Vitamin C is a supplement used to boost the immune system) 500mg, take one tablet once daily. Review of Resident #4's signed physician orders dated 01/29/26 revealed an order to discontinue Vitamin C 500mg. Review of Resident #4's January 2026 electronic medication record (eMAR) revealed: -There was an entry for Vitamin C 500mg, take one tablet once daily, scheduled at 9:00am with a	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 127 start date of 01/08/26. -Vitamin C 500mg was documented as not administered at 9:00am from 01/09/26 to 01/11/26 with the exception documented as resident refused. -Vitamin C 500mg was documented as administered at 9:00am on 01/12/26. -There was a second entry for Vitamin C 500mg, take one tablet once daily, scheduled at 8:00am. -Vitamin C 500mg was documented as administered at 8:00am on 01/13/26 and 01/14/26. -Vitamin C 500mg was documented as not administered at 8:00am on 01/15/26, with the exception documented as resident refused. -Vitamin C 500mg was documented as administered at 8:00am on 01/16/26 through 01/22/26. -Vitamin C 500mg was documented as not administered at 8:00am on 01/23/26, with the exception documented as resident refused. -Vitamin C 500mg was documented as administered at 8:00am on 01/24/26 through 01/26/26. -Vitamin C 500mg was documented as not administered at 8:00am on 01/27/26 and 01/28/26, with the exception documented as resident refused. -Vitamin C 500mg was documented as administered at 8:00am on 01/29/26 through 01/31/26. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Vitamin C 500mg, take one tablet once daily, scheduled at 8:00am. -Vitamin C 500mg was documented as not administered at 8:00am on 02/01/26, with the exception documented as resident refused. -Vitamin C 500mg was documented as	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HA1064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1366 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 128 administered at 8:00am from 02/02/26 to 02/09/26. Telephone interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:46pm revealed: -Vitamin C 500mg, take one tablet once daily was dispensed for Resident #4 on 01/07/26 for a quantity of 9 tablets for a 9-day supply. -Vitamin C 500mg, take one tablet once daily was dispensed for Resident #4 on 01/13/26 for a quantity of 7 tablets for a 7-day supply. -Vitamin C 500mg, take one tablet once daily was dispensed for Resident #4 on 01/20/26 for a quantity of 7 tablets for a 7-day supply. -Vitamin C 500mg, take one tablet once daily was dispensed for Resident #4 on 01/27/26 for a quantity of 7 tablets for a 7-day supply. -An order to discontinue Vitamin C 500mg for Resident #4 was dated 01/29/26 but was received by the pharmacy on 02/09/26 at 5:53am. Refer to interview with a medication aide (MA) on 03/06/26 at 11:22am. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to telephone interview with Resident #4's primary care provider (PCP) on 03/06/26 at 2:14pm. b. Review of Resident #4's signed physician orders dated 01/08/26 revealed an order for Zinc (Zinc is a supplement used to boost the immune system) 50mg, take one tablet once a day Review of Resident #4's signed physician orders dated 01/29/26 revealed an order to discontinue Zinc 50mg.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL004034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 358	Continued From page 129 Review of Resident #4's January 2026 electronic medication administration record (eMAR) revealed: -There was an entry for Zinc 50mg, take one tablet once daily, scheduled at 9:00am with a start date of 01/08/26. -Zinc 50mg was documented as not administered at 9:00am from 01/09/26 to 01/11/26 with the exception documented as resident refused. -Zinc 50mg was documented as administered at 9:00am on 01/12/26. -There was a second entry for Zinc 50mg, take one tablet once daily scheduled at 8:00am. -Zinc 50mg was documented as administered at 8:00am on 01/13/26 and 01/14/26. -Zinc 50mg was documented as not administered at 8:00am on 01/15/26, with the exception documented as resident refused. -Zinc 50 mg was documented as administered at 8:00am on 01/16/26 through 01/22/26. -Zinc 50mg was documented as not administered at 8:00am on 01/23/26, with the exception documented as resident refused. -Zinc 50mg was documented as administered at 8:00am on 01/24/26 through 01/26/26. -Zinc 50mg was documented as not administered at 8:00am on 01/27/26 and 01/28/26, with the exception documented as resident refused. -Zinc 50mg was documented as administered at 8:00am on 01/29/26 through 01/31/26. Review of Resident #4's February 2026 eMAR revealed: -There was an entry for Zinc 50mg, take one tablet once daily scheduled at 8:00am. -Zinc 50mg was documented as not administered at 8:00am on 02/01/26, with the exception documented as resident refused. -Zinc 50mg was documented as administered at	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 130 8:00am from 02/02/26 to 02/09/26. Telephone Interview with a pharmacist from the facility's contracted pharmacy on 03/06/26 at 1:46pm revealed: -Zinc 50mg, take one tablet once daily was dispensed for Resident #4 on 01/07/26 for a quantity of 9 tablets for a 9-day supply. -Zinc 50mg, take one tablet once daily was dispensed for Resident #4 on 01/13/26 for a quantity of 7 tablets for a 7-day supply. -Zinc 50 mg, take one tablet once daily was dispensed for Resident #4 on 01/20/26 for a quantity of 7 tablets for a 7-day supply. -Zinc 50 mg, take one tablet once daily was dispensed for Resident #4 on 01/27/26 for a quantity of 7 tablets for a 7-day supply. -An order to discontinue Zinc 50mg for Resident #4 was dated 01/29/26 but was received by the pharmacy on 02/09/26 at 5:53am. Refer to interview with a medication aide (MA) on 03/06/26 at 11:22am. Refer to interview with the Resident Care Coordinator (RCC) on 03/09/26 at 2:47pm. Refer to telephone interview with Resident #4's primary care provider (PCP) on 03/06/26 at 2:14pm. Interview with a medication aide (MA) on 03/06/26 at 11:22am revealed: -When there was an order to discontinue a medication, a notification came up on the eMAR. -When this occurred, she would check with the Resident Care Coordinator (RCC) or the Special Care Unit Coordinator (SCC) to get directions of how to proceed.	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 131 Interview with the RCC on 03/09/26 at 2:47pm revealed: -When there was a discontinue order, she sent the order to the pharmacy. -She then removed the medication from the cart after it was entered by her, the SCC or Administrator into the electronic medication administration record (eMAR) to discontinue the medication. -Once the discontinue order was entered into the eMAR system, she, the SCC or Administrator verified the discontinued medication in the eMAR system. -She was not sure why the discontinue order for Resident #4's Vitamin C and zinc was not sent to the pharmacy until 02/09/26. Telephone interview with Resident #4's primary care provider (PCP) on 03/06/26 at 2:14pm revealed: -The facility had some cases of flu in January and she prescribed Vitamin C and zinc for all her residents at the facility as a prophylactic measure. -Resident #4 frequently refused her medications because she only wished to take "white tablets" and she had discussed discontinuing some of Resident #4's medications due to her frequent refusals but Resident #4's family wanted her medications continued. -She brought it to the attention of facility staff that Vitamin C and zinc had not been discontinued for Resident #4 as she ordered. -She had no concern that Resident #4 received Vitamin C and zinc for 10 days after she discontinued it, but she did expect the facility to administer and discontinue medications as ordered. The facility failed to administer medications as	D 358		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 132 ordered to 2 of 4 residents observed during the medication pass on 03/04/26. Resident #8 did not receive medications used to treat elevated blood sugar, or a medication used for heart health. Resident #8 and Resident #9 did not receive medications for fluid retention. Also, Resident #8, who was recently admitted to the facility did not receive 5 medications including rapid-acting insulin for at least 5 days after admission putting the resident at risk for elevated blood sugar. Two sampled residents (#2, #5) did not have medication available to treat underactive thyroid. Resident #2 did not receive a blood thinner for at least 9 days which put her at risk for blood clots, and she continued to receive a medication for high blood pressure after it was discontinued putting her at risk for unstable blood pressure, and she did not receive a complete course of antibiotic to treat a skin rash. Resident #1 did not receive pain medication as ordered. The failure of the facility to administer medications as ordered put the residents at substantial risk of serious physical harm and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/04/26 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED APRIL 10, 2026.	D 358		
D 371	10A NCAC 13F .1004 (n) Medication Administration 10A NCAC 13F .1004 Medication Administration (n) The facility shall assure that medications are administered in accordance with infection control	D 371	On 4/17/26 the ED conducted an in-service for all staff on infection control given by the Nash County Health Department Communicable Disease Nurse.	4/25/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 371	Continued From page 133 measures that help to prevent the development and transmission of disease or infection, prevent cross-contamination and provide a safe and sanitary environment for staff and residents. This Rule is not met as evidenced by: Based on observations, record reviews, and interviews, the facility failed to ensure medications were administered in accordance with infection control measures by 1 of 2 medication aides (Staff A) observed during the 8:00am to 9:00am medication pass on 03/04/26, who did not sanitize her hands between the preparation and administration of medications to each resident to prevent the transmission of disease, infection, prevent cross-contamination, to provide a safe and sanitary environment for residents. The findings are: Review of the facility's undated Hand-Washing policy revealed: -Hands will be washed with soap and running water, if hands have visible soil on them, after using the restroom, after blowing your nose, after sneezing into your hands, after changing incontinent briefs, after cleaning a spill, blood, or other bodily fluids, and before and after using shared medical equipment. -Proper hand washing techniques include removal of rings and watches before using, if a hands-free paper towel dispenser is not available, get the paper towels before washing, wet your hands, apply soap, rub your hands together for 20 seconds being sure to wash all surfaces (backs of hands, wrists, between fingers and under nails), rinse well, dry hands, turn off water, open	D 371	The infection control in-service included handwashing and hand sanitizer prior to opening resident medications. The ED/ Care Managers during medication observation pass. Medication aides was monitored for using the handwashing and hand sanitizer prior to opening resident medications.	4/25/26 ongoing 4/25/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL084034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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)	(X6) COMPLETE DATE
D 371	Continued From page 134 the door with paper towel and throw the paper towel in the trash. Observation of the medication aide (MA), Staff A, during the medication pass on 03/04/26 between 8:21am and 8:41am revealed: -There was hand sanitizer on the medication cart located on the assisted living side of the facility. -The MA used keys to unlock the medication cart. -She did not sanitize her hands. -She reviewed a resident's electronic medication administration record (eMAR) using the computer keyboard on the medication cart. -She removed medication cards from the medication cart and prepared six oral medications for a resident. -She poured a cup of water. -She locked the medication cart. -She took the medication cup that contained the six oral medications to a resident in the dining room and handed the resident the medication cup of six tablets and set the cup of water on the table in front of him and observed him swallowing the 6 oral medications with the cup of water provided. -She took the empty medication cup from the resident. -She returned to the medication cart, disposed of the empty medication cup and documented the resident's medications on the eMAR using the computer keypad. -She did not sanitize or wash her hands. -She reviewed the eMAR for the next resident using the computer keyboard on the medication cart. -She unlocked the medication cart using keys and removed a multi-dose pack of medication and prepared three oral medications for the next resident and poured a cup of water. -She locked the medication cart. -She took the medication cup containing the three	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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 371	Continued From page 135 oral medications to a resident in the dining room. -She handed the resident the medication cup of three oral medications and set the cup of water on the table in front of the resident and observed the resident swallowing the medications and took the empty medication cup from the resident. -She returned to the medication cart, disposed of the empty medication cup and documented the resident's medications on the eMAR using the computer keyboard. -She did not wash or sanitize her hands. -She reviewed the eMAR for the next resident using the computer keyboard on the medication cart. -She used keys to unlock the medication cart. -She removed two multi dose packs of medication for the next resident and prepared eleven oral medications and placed them in a medication cup and poured a cup of water. -She locked the medication cart. -She retrieved a wrist blood pressure cuff from the top of the medication cart. -She took the medication cup of eleven oral medications with the cup of water and blood pressure cuff to the resident in the dining room. -She sat the medication cup of 11 oral medications and the cup of water on the table in front of the resident. -She checked the resident's blood pressure using the wrist blood pressure cuff. -She watched the resident swallow the medications with the cup of water and took the empty medication cup from the resident. -She returned to the medication cart with the blood pressure cuff, disposed of the empty medication cup and documented the resident's medications and blood pressure on the eMAR using the computer keyboard. -She unlocked the medication cart to prepare medication for the next resident.	D 371		

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS			STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 371	Continued From page 136 -She did not sanitize or wash her hands. Interview with Staff A on 03/04/26 at 2:06pm revealed: -She washed her hands before starting the medication pass. -She was supposed to use hand sanitizer between each resident. -The MAs were to wash their hands after every third resident or if her hands were visibly soiled. -She usually used hand sanitizer between each resident but was nervous during the medication pass. Interview with the Resident Care Coordinator (RCC) on 03/04/26 at 2:19pm revealed: -The MAs were to wash their hands at the start of the medication pass. -The MAs were to wash their hands after every third resident during medication pass or if their hands were visibly soiled. -The MAs were to wash or sanitize their hands after touching medical equipment such as blood pressure cuffs, and glucometers. -Ideally, the MAs were to use hand sanitizer between each resident. Interview with the Administrator on 03/05/26 at 2:34pm revealed: -The MAs were expected to wash their hands at the beginning of the medication pass and between every 3rd resident or if visibly soiled. -The MAs were to use hand sanitizer between each resident. -It was important for the MAs to follow hand hygiene guidelines to prevent the spread of infection. Telephone Interview with the facility's contracted primary care provider (PCP) on 03/11/26 at	D 371			

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 371	Continued From page 137 10:21am revealed: -The MAs should sanitize their hands between each resident. -Good hand hygiene was important to stop the spread of disease in the facility.	D 371		
D 610	10A NCAC 13F .1801(a) Infection Prevention & Control Policies & Pro 10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL POLICIES AND PROCEDURES (a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement infection prevention and control policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control. The Department shall approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall either: (1) utilize the set of policies and procedures for infection prevention and control approved by the Department; (2) develop policies and procedures for infection prevention and control that are consistent with the set of Department approved policies and procedures; or (3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the	D 610	On 4/17/26 the ED conducted an inservice for all staff on infection control given by the Nash county Health Department Communicable Disease Nurse.	4/25/26 ongoing

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
(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 610	Continued From page 138 federal CDC published guidelines on infection prevention and control. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to implement infection control procedures for glucometers used to obtain fingerstick blood sugar (FSBS) readings for 1 of 3 sampled residents (#8) with an order for FSBS monitoring. The findings are: Review of the facilities undated diabetic medications and treatment policy revealed: -Residents receiving medication and/or treatments for diabetic care should be monitored according to physician orders. -Every resident should have their own glucose monitor (glucometer), it should be labeled with the resident's name and placed in a bag labeled with the resident's name. Review of manufacturer's user manual for Brand A glucometers revealed:	D 610	On 3/17/26, Regional clinical nurse educated all medication aides on infection control policy and procedure. 100% audit for all residents that requires blood glucose monitoring was conducted by ED/REC to ensure every resident has a labeled glucometer assigned to them. Care manager/designee will audit all med carts weekly for 4 weeks, then monthly for 3 months to verify that all glucometers are labeled and present.	4/25/26 ongoing

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS	STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803
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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)	(X6) COMPLETE DATE
D 610	Continued From page 139 -Page 7 of the device manual indicated of the device manual indicated that the device was intended for single patient use only, do not share with anyone including family members, and do not use on multiple patients. -Page 7 of the device manual referenced for further information refer to the Food and Drug Administration (FDA) Public Health Notification use of fingerstick devices on more than one person poses risk for transmitting bloodborne pathogens. -Page 7 of the device manual referenced for further information refer to the Centers for Disease Control (CDC) use of fingerstick devices on more than one person poses risk for transmitting bloodborne pathogens. Request for the facilities infection prevention policy missing pages on 03/11/26 at 10:46am was unsuccessful. Review of Resident #8's FL-2 dated 02/24/26 revealed diagnoses included type 2 diabetes, congestive heart failure, polyneuropathy, and chronic kidney disease. Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 02/27/26. Observation of a medication cart in the medication room on 03/06/26 at 2:42pm revealed: -There was a transparent plastic biohazard specimen zipper bag containing a glucometer labeled with Resident #8's name. -There was no label on the front or back of the plastic biohazard specimen bag. Review of Resident #8's glucometer history	D 610		

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NAME OF PROVIDER OR SUPPLIER

STREET ADDRESS, CITY, STATE, ZIP CODE

THE LANDINGS OF ROCKY MOUNT MILLS

1365 RIVER DRIVE
ROCKY MOUNT, NC 27803

(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 610	Continued From page 140 (Brand A) on 03/08/26 at 2:42pm revealed: -Turning the glucometer on revealed the screen showed a current date of 01/17 and time of 2:06pm. -There was no year displayed with the date on the glucometer screen. -The first reading on the glucometer was a 7 Day Average with a blood glucose reading of 210. -The second reading on the glucometer was a 14 Day Average with a blood glucose reading of 210. -The third reading on the glucometer was a 28 Day Average with a blood glucose reading of 198. -The next readings included daily finger stick blood sugar (FSBS) readings with the date, time, and FSBS readings. -The following 18 FSBS results were shown consecutively on the glucometer. -There was a FSBS reading of 210 on 01/17 at 2:06pm. -There was a FSBS reading of 203 on 12/31 at 4:18am. -There was a FSBS reading of 201 on 12/25 at 2:43am. -There was a FSBS reading of 188 on 12/24 at 2:43am. -There was a FSBS reading of 172 on 12/23 at 3:01am. -There was a FSBS reading of 277 on 12/22 at 3:21am. -There was a FSBS reading of 136 on 12/22 at 2:41am. -There was a FSBS reading of 88 on 10/10 at 12:18am. -There was a FSBS reading of 181 on 10/09 at 1:33pm. -There was a FSBS reading of 88 on 10/08 at 11:52pm. -There was a FSBS reading of 341 on 10/08 at 6:15pm. -There was a FSBS reading of 109 on 10/08 at	D 610		

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STATE FORM

6800

36EZ11

If continuation sheet 141 of 147

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____		(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1366 RIVER DRIVE ROCKY MOUNT, NC 27803			
(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 610	Continued From page 141 2:24pm. -There was a FSBS reading of 63 on 10/07 at 11:57pm. -There was a FSBS reading of 62 on 10/07 at 11:55pm. -There was a FSBS reading of 61 on 10/07 at 11:52pm. -There was a FSBS reading of 63 on 10/07 at 11:51pm. -There was a FSBS reading of 63 on 10/07 at 11:45pm. -There was a FSBS reading of 64 on 10/07 at 11:44pm. Review of Resident #8's February 2026 medication administration record (MAR) revealed: -The MAR was handwritten. -There was an entry for Humalog Insulin, inject per sliding scale (SSI), 170-210 inject 2 units, 221-300 inject 4 units, 301-400 inject 6 units, 401-500 inject 8 units, over 500 call primary care provider (PCP). -There was no entry to check finger stick blood sugars (FSBS). -There was an entry beside the Humalog Insulin with times of 8:00am and 8:00pm. -There was no documentation a FSBS was obtained on 02/26/26 at 8:00am. -FSBS was documented as 144 on 02/26/26 at 8:00pm. -There was no documentation a FSBS was obtained on 02/27/26 at 8:00am. -FSBS was documented as 144 on 02/27/26 at 8:00pm. Review of Resident #8's March 2026 electronic medication administration record (eMAR) revealed: -There was an entry for FSBS, check blood sugar twice a day at 9:00am and 8:00pm.	D 610			

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NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803			
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D 610	Continued From page 142 -FSBS was documented as 117 on 03/07/26 at 8:47pm, which matched the FSBS recorded in the glucometer history. -The next FSBS recorded in the glucometer history was 03/08/26 at 6:26am was 58, which was not recorded on the eMAR. -FSBS was documented as 350 on 03/08/26 at 9:00am, which matched the FSBS recorded in the glucometer history. -FSBS was documented as 146 on 03/08/26 at 8:00pm on the eMAR, but was not recorded in the glucometer history. -The next FSBS recorded in the glucometer history was on 06/01/25 at 12:00pm, which was not recorded on the eMAR. -FSBS was documented as 210 on 03/09/26 at 9:37am, which matched the FSBS recorded in the glucometer history. -FSBS was documented as 136 on 03/09/26 at 8:31pm, which matched the FSBS recorded in the glucometer history. -FSBS was documented as 179 on 03/10/26 at 8:21am, which matched the FSBS recorded in the glucometer history. Based on review of Resident #8's February 2026 and March 2026 eMAR, the glucometer recordings did not match the eMAR. Interview with the Resident Care Coordinator (RCC) on 03/06/26 at 2:45pm revealed: -Resident #8 was admitted in the afternoon on 02/27/26. -The glucometer with the resident's name typed on a label on the front of the glucometer in the biohazard bag was not the resident's glucometer. -The glucometer labeled with the residents first and last name was not the glucometer the pharmacy sent for the resident. -The glucometer labeled with Resident #8's name	D 610			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
NAME OF PROVIDER OR SUPPLIER THE LANDINGS OF ROCKY MOUNT MILLS		STREET ADDRESS, CITY, STATE, ZIP CODE 1365 RIVER DRIVE ROCKY MOUNT, NC 27803		
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D 610	Continued From page 143 was a mistake because his glucometer had not been used yet. -She had 2 new glucometers in black zip up bags in her office. -She thought Resident #8's had a new glucometer because he was supposed to have a new one. -It was a mistake for staff to be using a glucometer that belonged to another resident to check Resident #8's FSBS. Observation of the RCC on 03/06/26 at 2:48pm revealed: -She removed two new glucometers from her file cabinet. -Both glucometers were in a new black zip up bag with a manual for the glucometer and a new glucometer. -She placed Resident #8's name on the back of the glucometer and on the outside of the glucometer zip up bag and placed the new glucometer on the medication cart. Interview with a medication aide (MA) on 03/09/26 at 1:57pm revealed: -If a resident was admitted to the facility and did not have a glucometer, staff were not supposed to use another resident's glucometer. -Staff should check with the RCC or Special Care Coordinator (SCC) to obtain a new glucometer for the resident. -Staff should not use a glucometer on more than one resident, each resident should have their own glucometer to prevent contact with bloodborne pathogens. -Sharing a glucometer between residents placed residents risk of contracting Human Immunodeficiency Virus (HIV) and other communicable diseases.	D 610		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HAL064034	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING: _____	(X3) DATE SURVEY COMPLETED R 03/11/2026
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D 610	Continued From page 144 Interview with a second MA on 03/10/26 at 4:45pm revealed: -Residents were supposed to have their own glucometers that were labeled with their first and last name. -MAs were supposed to use each resident's own glucometer when they checked for FSBS to prevent contamination from sharing glucometers. -There was a risk of cross contamination if resident's glucometers were shared. -Infectious diseases could be transmitted if glucometers were shared with other residents. Interview with the RCC on 03/09/26 at 2:47pm revealed: -Residents glucometers should not be shared with other residents. -Each resident should have their own glucometer; the glucometer should be labeled and the container that the glucometer was stored in should be labeled with the resident's name. -When there was a new admission or a current resident started on finger stick blood sugar (FSBS) checks they should be issued a new glucometer. -She kept new glucometers in her office in a filing cabinet. -There were not any new glucometers in the medication room or on the medication cart. -There was a risk of cross contamination with bloodborne pathogens if glucometers were shared between residents. -Resident #8's first labeled glucometer belonged to another resident because there were FSBS readings in the glucometer more days than the resident had resided at the facility. Telephone interview with a pharmacist from the facilities contracted pharmacy on 03/06/26 at 3:25pm revealed the pharmacy had not received	D 610		

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D 610	Continued From page 145 an order for a glucometer for Resident #8. Interview with the Administrator on 03/10/26 at 9:40am revealed there were no residents in the facility with any communicable diseases. Interview with the Administrator on 03/11/26 at 3:52pm revealed: -Staff should not share resident's glucometers to prevent the risk of the spread of infectious diseases. -She expected each resident to have their own glucometer that was labeled to prevent the sharing of glucometers. Telephone interview with Resident #8's primary care provider (PCP) on 03/06/26 at 3:06pm revealed: -Resident's glucometers should not be shared. -It was standard infection control precautions to only use one glucometer for each resident and to ensure there was no sharing of glucometers. -The facility placed residents who had FSBS checks at risk of bloodborne pathogen diseases such as HIV and Hepatitis. Attempted telephone interview with the Licensed Health Professional Support (LHPS) nurse on 03/10/26 at 3:54pm was unsuccessful. The facility failed to implement infection control procedures for glucometers used to obtain finger stick blood sugar (FSBS) readings for 1 of 3 sampled residents (#8) with an order for FSBS monitoring, resulting in significant risk of transmission of bloodborne pathogens due to the sharing of glucometers between the residents that required FSBS checks. The facility's failure was detrimental to the health, safety and welfare of residents and constitutes a Type B Violation.	D 610			

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D 610	Continued From page 146 The facility provided a plan of protection in accordance with G.S. 131D-34 on 03/06/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED APRIL 25, 2026.	D 610			