STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 and the Forsyth County Department of Social Services conducted an initial survey and complaint investigation on August 4, August 5, and August 6, 2015 with an exit conference via telephone on August 10, 2015.	D 000		
D 161	10A NCAC 13F .0504(a) Competency Validation For LHPS Tasks 10A NCAC 13F .0504 Competency Validation For Licensed Health Professional Support Task (a) An adult care home shall assure that non-licensed personnel and licensed personnel not practicing in their licensed capacity as governed by their practice act and occupational licensing laws are competency validated by return demonstration for any personal care task specified in Subparagraph (a)(1) through (28) of Rule .0903 of this Subchapter prior to staff performing the task and that their ongoing competency is assured through facility staff oversight and supervision. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure 5 of 6 sampled staff (Staff A, C, D, E and F) were competency validated by a registered nurse (RN) by return demonstration prior to staff performing the required tasks such as Fingerstick Blood sugars (FSBS), injections of insulin, application of anti-embolic hose, Oxygen administration and administration of nebulizer medication. The findings are:	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 1 A. Review of Staff A's personnel record review revealed: -She was hired on 1/27/15 as Nurse Aide/Medication Aide. -She worked mostly second shift as a Medication Aide (MA). -Documentation of successful passage of Medication Aide test on 6/3/09. -There was no documentation Staff A had completed a Licensed Health Professional Support (LHPS) skills validation. Interview with Staff A, MA, on 8/6/15 at 3:40 pm revealed -She regularly applied anti-embolic hose, monitored and administered Oxygen, collected FSBS and administered medication by injection. -She did not remember working with an RN at the facility regarding demonstration of her ability to perform FSBSs and other tasks. -She did remember working with an RN at a previous facility but that had been two or more years ago. Refer to interview with the LHPS nurse on 8/9/15 at 10:00 am. Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm. B. Review of Staff C's personnel record revealed: -She was hired as a Nurse Aide (NA)/Medication Aide (MA) on 5/22/2014. -The medication administration skills checklist was completed 6/19/14. -The pharmacy nurse did validate competency for fingerstick blood sugars and insulin administration on the medication administration skills checklist.	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 2	D 161		

-There was no diabetic training prior to insulin administration.
-There was no documentation of Staff C's Licensed Health Professional Support (LHPS) skills validation.

Interview with Staff C, Med Aide, on 8/6/15 at 3:45 pm revealed:
-She currently worked second shift as a Medication Aide and Nurse Aide.
-She remembered being checked off by the nurse from the facility pharmacy for medication administration.
-She did not remember the nurse at the facility providing teaching or validating competency for tasks such as oxygen administration and anti-embolism stockings hose application.
-She had worked elsewhere and was taught by an RN about these types of tasks.
-She regularly administered oxygen, insulin, obtained finger stick blood sugars and removed anti-embolism stockings at this facility.
Review of Resident #3's July 2015 Treatment Administration Record (TAR) for revealed Staff C obtained finger stick blood sugars 36 times.
Review of Resident #3's July 2015 Medication Administration Record (MAR) for revealed Staff C administered insulin 8 times
Refer to interview with the LHPS nurse on 8/9/15 at 10:00 am.

Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm.

C. Review of Staff D's personnel record revealed:
-She was hired as a Nurse Aide/Medication Aide (MA) on 01/13/2015.
-There was no documentation of the medication administration skills checklist.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 3 -There was no documentation of Staff D's Licensed Health Professional Support (LHPS) skills validation. Review of Resident #3's August 2015 Treatment Administration Record (TAR) for revealed Staff D applied anti-embolism stockings. Staff D was unavailable for interview 8/6/2015. Refer to interview with the LHPS nurse on 8/9/15 at 10:00 am. Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm. C. Review of Staff E's personnel record review revealed: - She was hired on 10/21/13 as a Nurse Aide/Medication Aide. - She worked on third shift. - The medication skills checklist was completed 12/20/13. - There was no documentation of Staff E's Licensed Health Professional Support (LHPS) skills validation. Telephone interview with Staff E on 08/06/15 at 5:05 pm revealed: - She worked third shift as Medication aide. - She remembered being checked off with a nurse on the medication cart. - She was not familiar with the term LHPS. - She had worked in a similar type facility before and knew how to take care of residents. - She did not remember having someone specifically training her on everything she did for the residents. Refer to interview with the LHPS nurse on 8/9/15	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 4 at 10:00 am. Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm. D. Review of Staff F's personnel record revealed: - She was employed as a Nurse Aide/Medication Aide at the facility from April 2011 to July 2014 and left the facility for 7 months. - She was re-hired as a Nurse Aide/Medication Aide (MA) on 03/05/15. - The Medication Administration Clinical Skills Validation was completed 03/18/15. (She started giving medications after being validated.) - She had a Licensed Health Professional Support (LHPS) skills validation checklist completed on 04/04/11. - There was no documentation for a LHPS skills validation checklist completed after the re-hire on 03/05/15. Observation on 8/04/15 at 4:22 pm revealed Staff F preformed a fingerstick blood sugar check on a resident. Interview with on 8/6/15 at 3:30 pm revealed: -She currently worked second shift as a Medication Aide and Nurse Aide. -She remembered being checked off by the nurse from the facility pharmacy for medication administration but did not know if she had a new LHPS skills validation completed since re-hire. -She reported she routinely administered oxygen, insulin, obtained finger stick blood sugars and removed TED hose at this facility. Refer to interview with the LHPS nurse on 8/06/15 at 10:00 am. Refer to interview with the facility's Director of	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 5 Nursing on 8/06/15 at 2:40 pm. _____ Interview with the LHPS Nurse on 8/6/15 at 10:00 am revealed: -She had completed a number of LHPS Skills validation for the facility. -She always left the Skills validation with the RCD when she completed one. -The RCD or the DON would let her know when she was to complete an LHPS Skills validation. -She did not keep a copy nor did she keep a list of those staff for whom she had completed a validation. -She relied on the facility to tell her who needed validation. Interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm revealed: -She was responsible for training records and classes for staff. -The management staff had completed a record audit within the last month and identified missing staff requirements. -She was trying to get the missing requirements caught up and was able to complete some training for 3 new staff. -She did not have a system in place currently to tell her who needed LHPS Skills validations. _____ The facility provided a Plan of Protection on 8/06/15 as follows: - The facility will immediately audit employee staff records for Licensed Health Professional Support (LHPS) skills validations. - The facility Nurse will complete skills validations for affected staff. - LHPS skills validation will be completed on all new hires, effective immediately, within the first	D 161		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 161	Continued From page 6 week of hire by the facility Nurse. - The Business Office Manager will complete an audit at the completion of employee orientation for monitoring. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D 161		
D 164	10A NCAC 13F .0505 Training On Care Of Diabetic Resident 10A NCAC 13F .0505 Training On Care Of Diabetic Residents An adult care home shall assure that training on the care of residents with diabetes is provided to unlicensed staff prior to the administration of insulin as follows: (1) Training shall be provided by a registered nurse, registered pharmacist or prescribing practitioner. (2) Training shall include at least the following: (a) basic facts about diabetes and care involved in the management of diabetes; (b) insulin action; (c) insulin storage; (d) mixing, measuring and injection techniques for insulin administration; (e) treatment and prevention of hypoglycemia and hyperglycemia, including signs and symptoms; (f) blood glucose monitoring; universal precautions; (g) universal precautions; (h) appropriate administration times; and (i) sliding scale insulin administration. This Rule is not met as evidenced by:	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 164	Continued From page 7 TYPE B VIOLATION Based on interview, record review and observation, the facility failed to assure 4 of 6 Staff (Staff A, C, D and E) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to diabetic residents. The findings are: A. Review of Staff A's personnel record revealed: -She was hired as a Nurse Aide/Medication Aide (MA) on 1/27/15. -There was no documentation Staff A completed the medication skills checklist. -There was no documentation Staff A had received training in the care of diabetic residents. Interview with Staff A on 8/6/15 at 3:40 pm revealed: -She currently worked second shift as a Medication Aide and Nurse Aide, usually in the memory care unit. -She thought she might have had diabetic training during orientation along with 6 other staff members, but did not remember a nurse providing the training. -She regularly administered insulin injections and collected Fingerstick Blood Sugars (FSBS). Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm. Refer to interview with the LHPS pharmacy contract nurse on 8/6/15 at 10:00 am. B. Review of Staff C's personnel record revealed: -She was hired as a Medication Aide (MA) on 5/22/2014.	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 164	Continued From page 8	D 164		

-The Medication Administration Skills Checklist was completed 6/19/14.
-There was no documentation Staff C had completed training in the care of diabetic residents.

Interview with Staff C on 8/6/15 at 3:45 pm revealed:
-She currently worked second shift as a Medication Aide and Nurse Aide.
-She remembered the pharmacy nurse going through a medication check off for the medication cart but did not remember having specific training related to Diabetes, high and low blood sugars or types of insulin.
-She regularly administered insulin injections and collected finger stick blood sugars (FSBS).

Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm.

Refer to interview with the LHPS pharmacy contract nurse on 8/6/15 at 10:00 am.

C. Review of Staff D's personnel record revealed:
-She was hired as a Nurse Aide (NA)/Medication Aide (MA) on 01/13/2015.
-She passed the Medication Aide Test on 4/26/2006.
-There was no documentation of the medication administration skills checklist.
-There was no documentation Staff D had completed training in the care of diabetic residents.

Staff D was unavailable for interview 8/6/2015.

Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 164	Continued From page 9 Refer to interview with the LHPS pharmacy contract nurse on 8/6/15 at 10:00 am. D. Review of Staff E's personnel record revealed: -She was hired as a Nurse Aide/ Medication Aide on 10/21/13. -She passed the Medication Aide test on 12/05/13. -She was checked off on the Medication Clinical Skills Checklist on 12/20/13. -There was no documentation Staff E had received training in the care of diabetic residents . Interview with Staff E on 08/06 15 at 5:05 pm revealed: -She worked as a Medication Aide on third shift. -She did not remember receiving a training on diabetic care since she was hired. -She had worked in a similar type facility prior to working here. _____ Interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm revealed: -She was responsible for training records and classes for staff. -The management staff had completed a record audit within the last month and identified missing staff requirements. -She was trying to get the missing requirements caught up and was able to complete some training for 3 new staff. -She had not contacted anyone for assistance in completing the required training for care of a diabetic resident. -She thought the 5 hour Medication Aide training class met the requirement for the training for care of a diabetic resident. Interview with the facility's contract LHPS nurse	D 164		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 164	Continued From page 10 on 8/6/15 at 10:00 am revealed: -She had not been contacted by the facility staff to provide additional training for the care of a diabetic resident. -She included some diabetic training during the Medication Skills Check list when she completed the checklist for new staff. _____ The facility provided a Plan of Protection on 8/06/15 as follows: - The facility will immediately audit employee staff records for Medication Aide staff requiring diabetic care training. - The facility will in-service the identified staff before their next scheduled medication pass. - Diabetic training will be added to the employee orientation process. - The Business Office Manager will complete an audit at the completion of employee orientation for monitoring and ensure compliance for training on the care of diabetics. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D 164		
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.	D 276		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 11	D 276		

This Rule is not met as evidenced by:
Based on record review, interview and observation, the facility failed to assure implementation of physician's orders for 1 of 5 sampled residents (Resident #3) for skilled nursing to assess and provide wound care and treatment to Resident #3's right finger.

The findings are:

Review of Resident #3's current FL-2 dated 05/15/2015 included the following:
-Diagnoses of Intracranial hemorrhage, Atrial Fibrillation and Hemiplegia affecting dominant side, Cerebral Vascular Accident (CVA).

Observation of Resident #3 on 8/04/15 at 10:15am revealed a white, mildly soiled dressing of kerlix gauze and translucent medical tape on her right fifth finger. The edges of the tape had started to peel up collecting debris. The dressing was not dated.

Interview with Resident #3 on 8/4/2015 at 10:15 am revealed:
-Her friend was cutting her fingernails and "accidentally cut the top of her right pinky finger."
-She was seen in the emergency department but was concerned because "the dressing had only been changed one time since then and it was over a week ago."
-She reported a nurse was supposed to come dress the wound but she had not been seen by a nurse.

Review of an emergency room encounter dated 7/26/15 for Resident #3 revealed:
-She had been seen in the emergency room on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 12	D 276		

7/26/15.
-She was treated for an "avulsion" injury to the finger tip.
-It was recommended not to apply cream or ointment to the area. After 24-48 hours, wash the cut with clean water 2 times a day.
-Leave the skin adhesive on the skin until it falls off which may take 5-10 days.
-To call your doctor now or seek immediate medical care if: You have pain or if pain gets worse, skin near the cut is cool or pale or changes color, tingling, weakness, or numbness near the cut, trouble moving the area, signs or symptoms of infection or if the cut re-opens or does not get better as expected.

Continued review of Resident #3's record revealed a physician order dated 7/30/2015 for "Home Health RN to assess and provide wound care/treatment to pt's fifth digit wound on right hand."

Interview with the Intake Department at the Home Health Agency on 8/04/15 at 4:42 pm revealed:
-A skilled nursing referral was received on 8/4/15.
-Staff reported "It's just being entered right now. We got it today just before 3:00pm."
-The referral had not been received by home health prior to this time.

Interview with Resident Care Director (RCD), a Licensed Practical Nurse, at 8/05/15 at 4:45pm revealed:
-Medication Aide (MA) faxed it but the home health agency did not receive it.
-RCD requested MA fax it again but did not have any documentation that it was faxed on 7/30/15.
-RCD reported someone usually called to make sure the home health agency received orders.
-RCD reported that there was no system in place

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 13	D 276		

to to verify referrals have been received.
-RCD reported she checked the right fifth finger yesterday, 8/04/15, and slipped the same dressing back over the right fifth finger.
-She did not have wound care orders so she did not change the dressing.

Interview with the Nurse Practitioner on 8/05/2015 at 10:06 am revealed:
-She thought the facility faxed the order to the home health agency but may have faxed it to the wrong number.
-She reported that she knew they faxed it recently because she got a call from the home health agency yesterday (8/04/15) and they were going to send a nurse out today.
-The Nurse Practitioner reported, "She would have expected the resident would have been seen by home health within a day or two after issuing the order since it does take time for insurance to process."

Interview with the Manager of Clinical Practice from the home health agency on 8/05/2015 at 11:24 am revealed:
-This was the first time that the home health agency had visited Resident #3.
-They were there to remove, assess and recommend treatment for the injured finger.

Observation during the dressing change 8/05/15 at 11:32am revealed:
-A closed wound, approximately 1cmx1cm to the distal to medial aspect of fifth finger. No drainage, odor or erythema.
-The nurse recommended dry, dressing changes everyday until healed.
-The nurse reported she would pass this recommendation on to the facility as well as the nurse practitioner.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (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: Based on observations, interviews and records reviews, the facility failed to assure that a licensed health professional participated in the on-site review and completed a Licensed Health Professional Support (LHPS) assessment for 1 of 5 sampled residents (Resident #3) with LHPS tasks including anti-embolism stockings, and application of a brace or splint. The findings are:	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 15 Review of Resident #3's current FL-2 dated 05/15/2015 included the diagnoses of Intracranial hemorrhage, Atrial Fibrillation and Hemiplegia affecting dominant side Cerebral Vascular Accident (CVA). Review of Resident #3's History and Physical for the initial assessment for "Transition into Care" dated 06/11/15 included the following diagnoses: -Stroke -Atrial Fibrillation -Pulmonary Embolism (PE) (blood clot in lungs) -Deep Vein Thrombosis (blood clot in lower extremities) -Acute Right Lower Extremity and Chronic Lower Extremity Thrombosis -Transient Ischemic Attack (mini-stroke) -Inferior Vena Cava Filter Placement (filter surgically placed to prevent PE) Review of Resident #3's record revealed: -Resident was admitted to facility on 5/26/2015. -No Licensed Health Professional Support in resident record. -A physician's order for TED Hose (anti-embolism stockings) dated 6/11/15. Observation of Resident #3 and her room on 8/4/15 at 10:15 am revealed: -A wrist splint lying on the dresser. -TED hose on bilateral lower extremities. -An Oxygen concentrator (off) in her room (order to be applied during hours of sleep). -A slightly soiled white gauze dressing, to right fifth finger which was secured with translucent medical tape with debris collected on the tapes edges. Interview with Resident #3 on 8/4/15 at 10:15 am revealed:	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 16 -The Resident recently had a stroke which affected her right side and that is why she was in this assisted living. -She wore the wrist splint on her right wrist when she was at rehab but had not worn it since she had been in the assisted living facility but once or twice. -The occupational therapist had provided her with the wrist splint while she was in the nursing home being rehabilitated from her stroke which affected her right, dominant side. -She would like to wear the wrist splint because she thought it might help her in the future. -Her friend was cutting her fingernails and accidentally cut the top of her right pinky finger. -She was seen in the emergency department but was concerned because the dressing had only been changed one time since then and it was over a week ago. -She reported that a nurse was supposed to come dress the wound but she hadn't been seen by a nurse. -Staff applied the TED hose every morning and at night the sitter would remove the TED hose. -The oxygen was "a new thing" and staff only applied it at night. Interview with Administrator and RCD on 08/04/15 at 5:40pm revealed: -Administrator looked through the resident record and was unable to find the LHPS. -He went to get RCD so she could locate the LHPS for Resident #3. -RCD produced a blank LHPS form with Resident #3's name, "W/C" (wheelchair for ambulation) written in the assessment section and signed by the RCD (an LPN) on 6/03/15. -RCD reported that she will list tasks for a new resident on a blank LHPS, sign it and the RN will co-sign the LHPS.	D 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 17	D 280		

-RCD reported that a new LHPS would be devised after this by either the pharmacy nurse or the facility RN.
-RCD reported that for new tasks she will add tasks to the existing LHPS and then give it to the RN to co-sign and the RN may or may not do an assessment at that time.
-The Administrator instructed the RCD to call the pharmacy nurse so she could supply a copy of the LHPS for Resident #3.
-They both agreed that she would have a copy because she had completed most of the LHPS forms for the facility.

Interview with the pharmacy nurse on 8/05/15 at 9:24 am revealed:
-RCD or staff usually report resident decline or change to the Director of Nursing (DON).
-If the "DON does not have time or cannot get to it then the DON will email the pharmacy nurse and she will come and complete the LHPS."
-She did not do the LHPS on Resident #3.
-She did speak with the DON this morning and she told me they couldn't locate the LHPS.
-She reported the DON did complete the LHPS on Resident #3.

Interview with Director of Nursing on 8/05/15 at 9:47 am revealed:
-She did an LHPS for Resident #3 and re-printed it for the RCD yesterday (8/04/15) and that the RCD should have it in her office.

Interview with RCD on 8/05/15 at 9:55 am revealed:
-The RN printed the LHPS for Resident #3 from her computer.
-The LHPS provided was dated 5/28/2015 and included the LHPS tasks "Transferring semi-ambulatory or non-ambulatory residents"

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 18 and "Ambulation using assistive devices that requires physical assistance". -Resident #3 was receiving prescribed physical therapy and occupational therapy and this was not included on the 5/28/15 LHPS. -A subsequent LHPS was not written for the new LHPS task of applying and removing anti-embolism stockings ordered by the physician on 6/11/15. -There was no formal system for reporting to the RN when there was a new resident or when a new LHPS task was ordered.	D 280		
D 309	10A NCAC 13F .0904(e)(3) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (3) The facility shall maintain an accurate and current listing of residents with physician-ordered therapeutic diets for guidance of food service staff. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to maintain an accurate and current listing of residents with physician-ordered therapeutic diets (mechanical soft ground, mechanical soft chopped, puree, no concentrated sweets, no added salt, cut meat, and chopped meat) for guidance of food service staff. The findings are: Observation on 08/04/15 at 3:45 pm of the therapeutic diet lists posted in the kitchen revealed there was a separate listing for the assisted living (AL) side of the facility and the	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 309	Continued From page 19 Memory Care Unit (MCU). Review of the therapeutic diet posting for the MCU revealed: -"Regular 14; Mech-Soft-Chop 0; Mech-Soft-Ground 2; Cut Meats 2; Pureed 0 w/nectar liquids Total 18". -There were no resident names listed to indicate which residents were ordered therapeutic diets by the physician. -The therapeutic diet posting was dated 06/28/15. Review of the therapeutic diet posting for the AL portion of the facility revealed: -The list was dated 04/14/14. -The list included all the room numbers for the assisted living portion of the facility along with the residents' names and ordered diets. -Diets listed on the posting included Regular, No Concentrated Sweets, No Added Salt, Cut Meat, and chopped meat. -There were 48 residents and corresponding diets listed, with 12 names marked through, as if deleted. -Comparison of the posted list with the facility's current census revealed there were different residents currently residing in the rooms which were marked through on the facility's therapeutic diet list posted in the kitchen. -There was no information posted to indicate the names of the 12 current residents or their ordered diets. Interview on 08/04/15 at 3:45 pm with the lunch cook revealed: -He had worked at the facility as a cook for four months and routinely prepared 5 to 8 meals per week. -There was not a "list of therapeutic diets--just numbers".	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 309	Continued From page 20 -The kitchen maintained a list of the ordered diet consistencies for the MCU so the cook would know how much food to prepare for the MCU. -Food for the MCU was prepared "homestyle", meaning the food items were sent to the MCU in large serving bowls, and was served to the residents by staff in the MCU. -On the AL side of the facility, there were menus on the tables to indicate the food choices available for the day. -Servers waited on tables and took orders on a guest check. -The cook plated whatever was indicated on the guest check order unless there was a diet order from a physician hanging on the wall. -The cook pointed out a diet order for an AL resident, taped to the wall in the kitchen and stated it was "the only special diet back here" except for one resident who got "meats cut into bite-size pieces". -The cook stated if there were any other residents on a therapeutic diet, there would be an order hanging on the wall with the other one. -The cook was unaware of the therapeutic diet list dated 04/14/14 posted on the wall for the assisted living residents. Interview on 08/04/15 at 10:15 am with the Sous Chef revealed there was no posted list of ordered therapeutic diets for the AL or MCU and stated, "We only have numbers". Interview on 08/06/15 at 8:05 am with the Resident Care Director (RCD) revealed: -It was her responsibility to update the therapeutic diet list. -She was not aware there was no listing to indicate which residents were on a therapeutic diet in the MCU. -She was not aware the posted list for the	D 309		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 309	Continued From page 21 Assisted Living side of the facility was dated 04/14/14 and was not accurate.	D 309		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes: (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets (no concentrated sweets and mechanical soft) were served as ordered by the physician for 2 of 5 sampled residents (Residents #10 and #11) in the Memory Care Unit (MCU). The findings are: Observation on 08/05/15 at 11:15 am of the MCU kitchen revealed there was a book with therapeutic menus laying on top of the microwave and open to the correct day and meal. A. Review of Resident #10's current FL-2 dated 06/02/15 revealed: -Diagnoses included diabetes with ketoacidosis, type I, uncontrolled. -The FL-2 included an order for a diabetic, puree diet with nectar thick liquids. Review of Resident #10's record revealed:	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 22	D 310		

-A physician's order dated 07/23/15 to upgrade the diet consistency to mechanical soft with ground meat and to continue nectar thickened liquids.
-A physician's order dated 08/03/15 for "no concentrated sweets".

1. Review of the therapeutic spreadsheet for mechanical soft with ground meat for the 08/04/15 lunch meal revealed Resident #10 was to receive 6 ounces lasagna with meat sauce, chopped, with no top cheese layer, baked beans, chopped vegetables, 8 ounces low fat or skim milk, and water or diet tea with sugar substitute.

a. Observation on 08/04/14 from 11:30 am to 12:30 pm of the lunch meal revealed:
-A dietary staff person delivered to the MCU a cart containing a large pan of lasagna with a browned, cheese topping, two large bowls of baked beans, one large bowl of chopped Italian-style vegetables, and a plate of rolls.
-Various MCU staff went around the dining room with each food item and served the residents.
-The MCU staff did not remove the cheese layer from the lasagna prior to serving it to Resident #10.
-The resident consumed 100% of the lasagna without problems.

Interviews on 08/04/15 at 3:15 pm and 08/05/15 at 9:20 am with a staff person in the MCU revealed:
-The food arrived to the MCU in serving bowls and was served by the MCU staff to the residents.
-If menu items required consistency changes, the kitchen staff sent serving bowls of the correct consistency for those residents.
-If there were no separate bowls of menu items

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 23	D 310		

with consistency changes, such as chopped or ground, the staff person knew it was "okay" to be served to all residents.
-The staff person was not aware Resident #10's lasagna should have had no cheese topping.
-The staff person stated she had "never seen" a therapeutic spreadsheet to indicate menu item changes for residents on therapeutic diets.

Interviews on 08/04/15 at 2:50 pm and 08/05/15 at 12:20 pm with a second staff person revealed:
-She helped serve the lunch meal to the residents in the MCU on 08/04/15.
-The staff person confirmed there was no mechanically altered lasagna sent to the MCU for the lunch meal on 08/04/15.
-If menu items were sent without a corresponding mechanically-altered dish, staff assumed the original item was appropriate for all residents.
-She "had seen" the therapeutic spreadsheets in the MCU kitchen before, but had never been taught how to use them, and stated, " I don't use them because I don't know how".

Interviews on 08/05/15 at 12:18 pm and 12:55 pm with the cook revealed:
-The cook initially stated he prepared two bowls of "chopped up" lasagna without cheese and sent it to the MCU with the other food items for the 08/04/15 lunch meal.
-The cook later stated he prepared a total of 4 bowls of consistency-altered lasagna: two bowls chopped and two bowls ground.
-When informed there was only one large pan of lasagna sent to the MCU, the cook stated, "No, I sent it" (chopped without cheese).

Interview on 08/05/15 at 12:00 pm with the Dietary Manager (DM) revealed the facility used "home-style" dining in the MCU, but he thought

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 24	D 310		

the kitchen cooks separately plated food for the residents on therapeutic diets.

Refer to interview on 08/05/15 at 11:00 am with the Sous Chef.

b. Observation on 08/04/14 from 11:30 am to 12:30 pm of the lunch menu revealed:
-Resident #10 was served approximately 10 ounces prethickened, nectar consistency, sweet tea.
-The resident consumed 100% of the sweetened tea.

Observation on 08/04/15 at 12:00 noon of the contents of the MCU refrigerator revealed there was no prethickened unsweetened tea available to serve to Resident #10.

Interview on 08/05/15 at 10:50 am with the dietary staff member who delivered food items to the MCU revealed:
-He delivered beverages based on the list posted in the kitchen, which only indicated there was one resident on nectar thickened liquids, so he sent "some of everything" in nectar consistency.
-He was not aware the resident was also on a no concentrated sweets diet.
-He routinely delivered pitchers of thin, sweet and unsweet tea.

Interview on 08/04/15 at 3:15 with a staff person revealed:
-Resident #10 was routinely served prethickened beverages, including the sweet tea, which were delivered to the MCU from the kitchen.
-The MCU did not have or use thickening agents to thicken thin tea; they only used prethickened beverages.
-She did not realize the prethickened tea was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 25	D 310		

sweet, and therefore not appropriate for residents on a no concentrated sweets diet.
-The staff person stated she had "never seen" a therapeutic spreadsheet to indicate menu item changes for residents on therapeutic diets.

Interview on 08/04/15 at 3:21 pm with a second staff person revealed:
-Staff "try to give sugar-free beverages" to residents who are diabetic, but she just uses her "judgement".
-The staff person stated, "It doesn't specify in their diet, I just know it (serving sugar-free) is best practice."

Interview on 08/04/15 at 2:40 pm with a third staff person revealed:
-The decision to serve sweet tea or unsweet tea depended on what the resident's fingerstick blood sugar (FSBS) was.
-If the FSBS was high, the Medication Aide (MA) would inform the staff to serve unsweetened tea.

Interview on 08/04/15 at 2:50 pm with the MA revealed:
-Resident #10 should be served unsweetened beverages and the decision was not based on his FSBS.
-The staff had been ensuring the resident received nectar-thickened beverages and did not realize the beverages should also have been sugar free.

Review of Resident #10's FSBS results revealed:
-The FSBS ranged from 73-344 in June 2015.
-The FSBS ranged from 45-447 in July 2015.
-The FSBS from 08/01/15 through 08/04/15 ranged from 169-443.

Review of Resident #10's FSBSs completed on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 26	D 310		

08/04/15 revealed:
-At 7:00 am, FSBS was 344.
-At 11:09 pm, FSBS was 463.
-At 4:08 pm, FSBS was 399.
-At 7:54 pm, FSBS was 221.

Refer to interview on 08/05/15 at 11:00 am with the Sous Chef.

c. Observation on 08/04/14 from 11:30 am to 12:30 pm of the lunch menu revealed:
-Resident #10 was served approximately 10 ounces of prethickened milk (nectar consistency).
-The resident consumed 50% of the milk.

Review of the nutritional label for the prethickened milk revealed it contained 26 grams of carbohydrates and 15 grams of sugar.

Review of other milk nutritional labels revealed:
-Whole milk contained 11 grams of carbohydrates and 11 grams of sugar.
-Low fat (2%) milk contained 12 grams of carbohydrates and 11 grams of sugar.
-Nonfat (skim) milk contained 12 carbohydrates and 11 grams of sugar.

Observation on 08/04/15 at 12:00 pm of the milk available in the MCU revealed there was no skim milk or low fat milk available to be served to the residents.

Interviews on 08/04/15 and 08/05/15 at various times with staff members revealed:
-Staff always ensured Resident #10 received nectar-thickened milk but did not realize it was supposed to be low fat or nonfat milk, according to the no-concentrated-sweets portion of his ordered diet.
-One staff member stated she had "never seen" a

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 27	D 310		

therapeutic spreadsheet to indicate menu item changes for residents on therapeutic diets.
-A second staff member stated she "had seen" the therapeutic spreadsheets in the MCU kitchen before, but had never been taught how to use them, and stated, "I don't use them because I don't know how".

Review of Resident #10's FSBS results revealed:
-The FSBS ranged from 73-344 in June 2015.
-The FSBS ranged from 45-447 in July 2015.
-The FSBS from 08/01/15 through 08/04/15 ranged from 169-443.

Review of Resident #10's FSBSs completed on 08/04/15 revealed:
-At 7:00 am, FSBS was 344.
-At 11:09 pm, FSBS was 463.
-At 4:08 pm, FSBS was 399.
-At 7:54 pm, FSBS was 221.

Based on observations on 8/4/15-8/5/15 and record review, it was determined Resident #10 was not interviewable.

Refer to interview on 08/05/15 at 11:00 am with the Sous Chef.

B. Review of Resident #11's current FL-2 dated 03/31/15 revealed:
-Diagnoses included diabetes and dementia.
-The FL-2 included an order for a no concentrated sweets diet.

Review of the therapeutic spreadsheet for the 08/04/15 lunch meal revealed Resident #11 should have received 8 ounces of low fat or skim milk.

Observation on 08/04/15 at 12:00 pm of the milk

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 28 available in the MCU revealed there was no skim milk or low fat milk available to be served to the residents. Observation on 08/04/14 from 11:30 am to 12:30 pm of the lunch meal revealed: -Staff served approximately 10 ounces of whole milk to Resident #11. -The resident consumed 90% of the milk. Interview on 08/05/15 at 9:15 am with a staff person revealed: -She knew there were "different milks with different colored lids" but she did not know diabetic residents were supposed to have a certain kind. -Sometimes the MCU had all three types of milk and sometimes only one or two kinds. -If there were more than one type of milk available, she routinely served the one with the blue lid (2%), but if not, she served whatever was available. -She was not aware Resident #11 should have received low fat or skim milk. Interview on 08/05/15 at 9:20 am with a second staff person revealed: -She did not know Resident #11 should have received low fat or skim milk. -She routinely served milk based on "whatever was there". -This morning, there was milk with a red cap (whole) and milk with a white cap (skim). -Staff "used up" the milk with the white cap this morning at breakfast, so staff served the milk with the red cap (whole) at lunch. -She had "never seen" a therapeutic spreadsheet to indicate menu item changes for residents on therapeutic diets.	D 310		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 310	Continued From page 29 Based on observations on 8/4/15-8/5/15 and record review, it was determined Resident #11 was not interviewable. Refer to interview on 08/05/15 at 11:00 am with the Sous Chef. Interview on 08/05/15 at 11:00 am with the Sous Chef revealed: -He was "in charge" of the kitchen but someone from the independent living facility next door was responsible for monitoring the food service staff to ensure they were serving food according to the therapeutic menus. -The MCU had its own copy of the therapeutic spreadsheet to use as a guide when serving residents. On 08/06/15, the Administrator submitted a Plan of Protection as follows: -Beginning immediately, all therapeutic diets would be served as ordered by the physician. -Training of staff had already begun regarding the types of therapeutic diets and how they should be served. -The therapeutic spreadsheet would be available at each facility kitchen area. -Any changes to a resident's diet would be reported to the Dining Services Manager, who would update the posted list daily. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D 310		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 30 (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 observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 6 residents (#3 and #6) observed during medication administration which included errors with administration of Novolin 70/30 insulin and Xarelto 20 mg and 2 of 5 sampled residents (#3, and #5) which included errors with medications for blood clotting, constipation, and altered thyroid function. The findings are: A. Review of Resident #3's current FL-2 dated 05/15/2015 included the following: -Diagnoses included of Intracranial hemorrhage, Atrial Fibrillation and Hemiplegia affecting dominant side, Cerebral Vascular Accident (CVA). Review of the current FL-2 dated 5/15/15 revealed an order for Xarelto 20mg once daily (used to reduce the risk of stroke and blood clots secondary to Atrial Fibrillation, treats and prevents Deep Vein Thrombosis and Pulmonary Embolism blood clots). Review of the Resident Register revealed	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 31 Resident #3 was admitted to the facility 5/26/15. Review of Resident #3's physician's care note dated 06/11/15 included the following additional diagnoses: -Pulmonary Embolism (PE) (blood clot in lungs) -Acute Right Lower Extremity and Chronic Lower Extremity Thrombosis -Transient Ischemic Attack (mini-stroke) -Inferior Vena Cava Filter Placement (filter surgically placed to prevent PE) Review of Resident #3's Physician's Orders dated 6/30/15 and signed 7/7/15 continued Xarelto 20mg daily. Review of Resident #3's electronic Medication Administration Record (eMAR) for May 27-31, 2015 revealed: -Xarelto 20mg daily was transcribed to the eMAR and documented as administered daily at 8:00 am. Review of Resident #3's eMAR for June 2015 revealed: -Xarelto 20mg daily was entered onto the eMAR and documented as administered daily at 8:00 am except for the morning of 6/11/2015 and it was documented that resident was "OUT OF FACILITY". Review of Resident #3's eMAR for July 2015 revealed: -Xarelto 20mg daily was entered onto the eMAR and documented as administered daily at 8:00 am except for the morning of 7/10, 7/11, 7/12, 7/14, 7/15, 7/16, 7/17, 7/22, 7/23, 7/25, 7/26, 7/27, 7/29, 7/30 and 7/31/2015 and it was documented that resident was "PHYSICALLY UNABLE TO TAKE", an option provided a drop	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 32	D 358		

down list on the eMAR. She was not sick and was able to take all of her other medication.

Review of Resident #3's eMAR for August 2015 revealed:
-Xarelto 20mg daily was entered onto the eMAR and documented as administered daily at 8:00 am except for the morning of 8/1 and 8/3/2015 and it was documented that resident was "PHYSICALLY UNABLE TO TAKE". She was able to take all of her other medications.

Telephone interview with a pharmacy technician at the facility's pharmacy on 8/5/15 at 10:35 am revealed the following:
-30 tablets of Xarelto 20mg were dispensed on 5/26/15
-30 tablets of Xarelto 20mg were dispensed on 8/03/15
-Between 6/20/15 and 6/23/15 the pharmacy tried to refill Xarelto 20mg and insurance rejected it and required Prior Authorization.
-A prior authorization form was faxed to the facility and the physician.
-On 7/10/15 a Medication Aide (MA) at the facility requested a refill from the pharmacy and was informed the pharmacy had not received the Prior Authorization required for refill.
-On 7/14/15 the pharmacy received a completed prior authorization with clinical information and the pharmacy forwarded this prior authorization to the insurance company.
-On 7/23/15 a MA at facility requested a refill again and the pharmacy did not have an approved Prior Authorization to refill the medication from the insurance company.
-On 7/23/15 pharmacy re-faxed the paperwork to the insurance company.
-On 7/28/15 a MA at the facility requested refill again and the pharmacy did not have an Prior

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 33	D 358		

Authorization to refill the medication from the insurance company.
-7/28/15 pharmacy re-faxed the completed paperwork to insurance company.
-8/3/15 the pharmacy filled the prescription and dispensed 30 tablets of Xarelto 20mg.

Review of the eMARs from May 27, 2015 through August 4, 2015 revealed:
-Xarelto 20 mg daily was entered onto the eMAR and 70 tablets were entered to be administered daily.
-52 tablets of Xarelto were documented as administered.
-18 tablets of Xarelto were documented as not given and denoted as "PHYSICALLY UNABLE TO TAKE."
-One tablet of Xarelto was documented as not given and denoted as "OUT OF FACILITY."

Telephone interview with a pharmacy technician at the facility's pharmacy on 8/5/15 at 10:35 am revealed that the quantity of Xarelto 20mg dispensed from May 27, 2015 through August 2, 2015 was 30 tablets

Review of Resident #3's eMAR's from May 27th, 2015 thorough August 2, 2015 revealed 68 tablets were needed to administer the Xarelto 20 mg as ordered.

Observation of Resident #3's medication on hand on 8/5/15 at 10:30 am revealed a bubble pharmacy card of 30 tablets of Xarelto 20mg dispensed on 8/3/2015 and 1 tablet had been administered.

Interview with Resident #3 on 8/06/15 at 11:00 am revealed:
-She did not know she took Xarelto or why it was

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 34	D 358		

indicated.
-She had never refused any medication or treatments since she has been at facility.
-She would not know if a pill was missing from her pill cup but, " I just take what I am given."
-Staff never informed resident of medication changes or if she was out of medication.

Interview with Resident #3's Nurse Practitioner on 8/5/2015 at 10:35am revealed she was unaware that the doses of Xarelto were not administered as ordered and was unaware that Prior Authorization or refills were requested.

Interview with a MA on 8/5/2014 at 12:02 pm revealed:
-The Physician or Nurse Practitioner visited the 300 hall weekly or more if there was a resident health concern.
-They fax the refill request or Prior Authorization to the physician office and document in the physician visit notebook that refills or Prior Authorization are needed.
-The MA reported she did request a refill July 10, 2015 and did fax the Prior Authorization to the nurse practitioner.
-She did not have a confirmation of the receipt of the fax by the physician's office.
-There was no documentation in the physician visit notebook regarding the need for refill or Prior Authorization.
-When a resident starts to get low on medication, staff faxed the pharmacy.
-If there was a problem in getting the medication, staff reported this to the Resident Care Director (RCD).
-Staff reported there was no documentation of Xarelto being borrowed from another resident.
-Med Aide reported they documented, "PHYSICALLY UNABLE TO TAKE" on the eMAR

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 35	D 358		

because there was no Xarelto in the building and therefore the resident was unable to take it.
-Med Aide reported they are to inform the doctor after 3 doses are not administered.

Interview with RCD on 8/5/2015 at 4:45 pm revealed:
-She was unaware that Resident #3 did not have Xarelto 20mg until today.
-She reports when refills or Prior Authorization are required staff is to put the Prior Authorization form in the physician visit notebook and call to get a hold order until they can get the medication in the facility.
-She stated, "We should have got a hold order to hold the medication and inform the doctor."
-RCD reported that they are to inform the doctor after 2 doses are not administered.

2. Review of Resident #3's record revealed:
-A FL-2 dated 5/15/15 included a physician's order for Colace 100mg twice daily as needed. (Colace, also known as Docusate sodium, is a stool softener for preventing and alleviating constipation)
-A subsequent prescription dated 5/22/15 for Colace 100mg twice daily (routinely).
-A list of routine physician orders dated 7/07/2015 with a hand written "D/C" over Docusate Sodium 100mg 1 tablet twice daily needed.
-The list of routine physician orders dated 7/07/2015 did not have a routine order for Colace.

Review of Resident #3's electronic Medication Administration Record (eMAR) for May 27-31, 2015 revealed:
-Stool Softener 100mg 1 capsule twice daily as needed was transcribed to the eMAR.
-No documented administration

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 36 Review of Resident #3's eMAR for June 2015 revealed: -Docusate Sodium 100mg 1 tab twice daily was entered onto the eMAR and documented as administered at 8:00pm on 6/30/2015. -No entry for prn Docusate Sodium Review of Resident #3's eMAR for July 2015 revealed: -Docusate Sodium 100mg 1 tab twice daily was transcribed to the eMAR and documented as administered at 8:00am and 8:00pm from 7/01/2015 - 7/31/2015. -No entry for prn Docusate Sodium Review of Resident #3's eMAR for August 2015 revealed: -Docusate Sodium 100mg 1 tab twice daily was transcribed to the eMAR and documented as administered at 8:00 am and 8:00 pm from 8/01/2015 - 8/4/2015. -No entry for prn Docusate Sodium Observation of Resident #3's medication on hand on 8/05/2015 at 10:30 am available for administration revealed: -One card of 30 capsules of Colace with 18 left on card dispensed 7/28/15 with instructions to give Colace 100mg twice daily as needed with no direction change sticker present. -One card of 30 capsules of Colace with 30 left on card dispensed 7/28/15 with instructions to give Colace 100mg twice daily as needed with no direction change sticker present. Phone interview with a pharmacy technician at the facility's pharmacy on 8/4/2015 at 4:42 pm revealed: -The pharmacy did not have the orders to change the Colace from "as needed" to twice daily.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 37	D 358		

-The pharmacy did not have orders to discontinue the "as needed" Colace.
-The pharmacy did receive a request and did dispense 60 capsules of Colace 100mg - one capsule twice daily as needed, on 7/28/15.
-The pharmacy did not discontinue the "as needed" order on 6/30/15, this change was initiated by the facility.
-The pharmacy did not enter the twice daily order on 6/30/15.
-The facility entered the physician order dated 5/22/15 for routine Colace 100mg 1 tab twice daily on 6/30/15 onto the eMAR and did not fax the order to the pharmacy.

Interview with resident on 8/06/15 at 2:30 pm revealed:
-She was constipated at one time.
-She does not remember when she had this problem (constipation).
-She is not constipated now.

Interview with RCD on 8/5/15 at 4:45 pm revealed:
-She was not aware that Colace was not administered as ordered for over 30 days.
-She did not know why it had not been entered on to the electronic MAR until 6/30/15.

Interview with a Med Aide on 8/6/15 at 2:40 pm revealed:
-New orders are faxed to the pharmacy and then filed in the chart.
-If orders have been faxed from an outside doctor a copy is placed in the physician visit folder, a copy goes in the chart and a copy is always given to the RCD.
-RCD has a copy of all new orders.
-Med Aide is able to make changes to the electronic MAR but did not change the Colace in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 38	D 358		

Resident #3's MAR.
-She was not aware if resident was constipated or not because the sitter always took her to the bathroom.
-There was no documentation of Resident #3 having bowel movements because the sitter took her to the bathroom.
-Staff did not inquire with the sitter and sitter did not report bowel movements.

Interview with Med Aide on 8/6/15 at 2:55 pm revealed:
-New orders are written by the doctor and RCD always has a copy.
-We fax the order to the pharmacy and they put orders into the eMAR.
-If orders are faxed from a doctor they photocopy the order, one copy gets faxed to the pharmacy gets filed in the residents chart and the other copy goes into the pharmacy tote.
-Med Aide reports she is unsure how to change an order in the electronic MAR.

The ordering physician was unavailable for interview on 8/06/15.

B. Review of Resident #5's current FL-2 dated 2/23/14 revealed:
-Diagnoses included Hyperthyroidism.
-Medications ordered included Levothyroxine 25 mcg daily (used to treat low thyroid functioning).

Review of Resident #5's record revealed:
-A physician's signed order sheet dated 1/15/15 which included Levothyroxine 25 mcg daily.
-A subsequent signed physician's order sheet dated 5/14/15 with "Levothyroxine 25 mcg one tab daily" hand-written at the end of the medication list and included above the physician's signature.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 39	D 358		

-Another signed physician's order sheet dated 7/7/15 which did not include an order for Levothyroxine 25 mcg daily.

Review of Resident #5's electronic Medication Administration Records (eMARs) for January 2015 and February 2015 revealed:
-Levothyroxine 25 mcg, take one tablet daily was transcribed and documented as administered at 6:30 am from 1/1/15 through 2/26/15.
-Included in the transcription information was a stop date of 2/26/15.
-There was no documentation of administration on February 27-28, 2015.
-There was no exception documentation for the missed doses of 2/27/15 or 2/28/15.

Review of Resident #5's March 2015, April 2015, and May 2015 eMARs revealed:
-Levothyroxine 25 mcg, one table daily, was not transcribed to the EMARs.
-There was no documentation Levothyroxine was administered.
-There were no exceptions for Levothyroxine noted.

Review of Resident #5's June 2015 eMAR revealed:
-Levothyroxine 25 mcg, one tablet daily was transcribed to the eMAR and schedule administration at 6:30 am.
-Levothyroxine 25 mcg was documented as administered on 6/30/15 only.
-There were no exceptions of administration for Levothyroxine 25 mcg noted.
-The original start date of the order was documented as 1/11/13.

Review of Resident #5's eMARs from 7/1/15 through 8/4/15 revealed Levothyroxine 25 mcg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 358	Continued From page 40 daily was transcribed to the eMAR with daily administration documented at 6:30 am with no exceptions noted. Observation on 8/4/15 at 4:20 pm of Resident #5's medication available for administration revealed: -A 3/5/15 VA pharmacy dispensing bottle containing 56 of 90 tablets of Levothyroxine 25 mcg with instructions for once daily administration. -A 5/18/15 VA pharmacy dispensing bottle containing 90 of 90 tablets of Levothyroxine 25 mcg with instructions for once daily administration. Interview with the Medication Aide (MA) at 4:30 pm on 8/4/15 revealed: -She worked as a MA on all shifts. -She had administered Levothyroxine 25 mcg to Resident #5 in the past, but not recently. -She thought the medication had been stopped because it had not been on the eMARs. -She had notified the pharmacy the Levothyroxine was not on the eMARs after performing a cart audit one night and found the bottles of Levothyroxine on the cart. -She reported the concern regarding the Levothyroxine administration to management but could not remember who she mentioned it to. -The Levothyroxine 25 mcg showed up on the eMAR again so she thought there was a new order for it. Interview with the facility's pharmacy technician on 8/5/15 at 9:10 am 11:00 am revealed: -The Levothyroxine 25 mcg was dispensed from the VA Pharmacy, and the facility's pharmacy only profiles the drug and transcribed it to the eMAR for administration.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 41 -There was an automatic stop order for all drugs profiled in their system of one year. -The pharmacy encouraged the facility to print and review monthly the report of upcoming resident's drug stop orders so that they can be reviewed to prevent dropping off the eMARs, -The automatic one year stop order for the Levothyroxine was not renewed by 5/26/15, so it was automatically removed from the eMAR and medication pass information. -The facility's pharmacy did dispense 30 tablets of Levothyroxine 25 mcg on 2/19/15 as a one time order. Interview with Resident #5's family member on 8/5/15 at 9:15 am revealed: -All of Resident #5's medications from the VA are on automatic refill status and come to his house. -The facility was "pretty good" about notifying him when the resident needed more medications. -The family member brought the prescriptions to the facility as soon as they arrived, but sometimes the VA was slow in filling the medications. -The family member did authorize the one time medication order from the facility's pharmacy for Levothyroxine. -The family member did bring to the facility the prescription bottle of Levothyroxine when it arrived in early March 2015. -The family member was not aware Resident #5 had not received Levothyroxine in March 2015, April 2015, May 2015 or June 2015. -The family member was not aware Resident #5 had experienced any signs or symptoms of low thyroid functioning. (Signs and symptoms of low thyroid replacement therapy might include feeling run down, tired, confusion, weight gain and hair loss.)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 42 Interview with the Resident Care Director (RCD) on 8/5/15 at 11:10 am revealed: -She was responsible for review of the eMARs for accuracy and month to month comparisons. -Those monthly eMARs with changes or omissions are faxed to the pharmacy. -Both the RCD and the Director of Nursing have administrative rights and can make changes to the eMARs. -Medication Aides have ability to enter orders in the eMAR system, but she checks those orders daily for accuracy. -Cart audits are supposed to be done daily by the Supervisors and MAs to look for out of date medications and cleanliness no documentation was required. -She was unaware Resident #5 was not getting his Levothyroxine daily. -She did not print or review the expiring medication order report on a regular basis. Interview with Resident #5 on 8/5/15 at 2:50 pm revealed: -He recalled a period of time where he was not woken up in the morning to take a "little tiny" pill, but that had started back recently. -He did no know how long he went without the early morning medication. -He did not know for sure what the pill was for. -He relied on the facility to administer medications as ordered by his physician. Review of e-mail communication from the prescribing physician's office on 8/7/15 revealed: -Resident #5 was first prescribed Levothyroxine in 2012 secondary to a Thyroid Stimulating Hormone (TSH) level of 11. (a normal range would be 0.4 to 4.2 mu/l) -The TSH was within normal limits in March of 2015.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 43 -The doctor wanted Resident #5 to take Levothyroxine 25 mcg daily as ordered. Review of a facsimile sent by the RCD at the facility on 8/9/15 revealed Resident #5's TSH test collected and reported on 8/7/15 was 3.12. C. Observation of the medication passes on 08/04/15 at 4:40 pm and the 8:00 am on 08/05/15 and review of the residents' records revealed 2 errors out of 28 observations were identified with one significant error with the unavailability of an anticoagulant, Xarelto. 1. Review of Resident #6's current FL2 dated 04/14/15 revealed diagnoses included Cerebral Vascular Accident (CVA) and esophageal strictures with bleed. Review of Resident #6's facility's Face Sheet used for resident's admissions revealed diagnoses included Diabetes Mellitus II without complication, not stated as uncontrolled. Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 04/15/15. Review of the FL-2 dated 01/14/15 and Physician's Orders dated 06/29/15 revealed: - An order for Fingerstik Blood Sugar checks (FSBS) 4 times a day, before meals and at bedtime. - An order for Novolin 70/30 insulin 44 units every morning and 25 units every evening. (Novolin 70/30 insulin is a mix of long acting and short acting insulin used to treat elevated blood sugar in diabetics.) Observation of medication administration on	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 44 08/04/15 at 4:22 pm revealed: - The evening shift Medication Aide (MA) was instructed to complete preparation of the insulin injection and when preparation was complete, but prior to injecting the resident, to allow the insulin syringe to be examined. - At 4:22 pm, the evening shift medication aide (MA) obtained a FSBS from Resident #6 (FSBS=203). - At 4:30 pm, the MA stated the resident was scheduled to receive 25 units of Novolin 70/30 insulin at 5:00 pm and she would prepare and administer the insulin. - At 4:33 pm, the MA obtained a 1 cc 31 gauge 100 unit insulin syringe and drew up Novolog 70/30 to the 20 unit mark plus 4 hash marks (28 units of insulin) and stated she was ready to administer Resident #6's insulin dose. - Observation of the syringe with insulin prepared by the MA revealed the syringe was calibrated in 10 unit increments and each 10 unit block had 4 hash marks (corresponding to 2 units per hash mark) between the 10 unit increments; the insulin dose was at 20 units plus 4 hash marks representing 28 units of Novolin 70/30 insulin to be administered. - At 4:40 pm, the surveyor intervened to stop the MA from injecting the Novolin 70/30 insulin. - At 4:42 pm, the MA expressed insulin from the syringe to measure half way between the 2nd and 3rd hash mark (approximately 25 units) and administered the insulin injection to Resident #6. Interview on 08/04/15 at 4:45 pm with the MA revealed: - She was extremely nervous during observation of the insulin administration. - She routinely worked evening shift and primarily the hall for Resident #6. - She routinely measured as close as she could	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 45	D 358		

to half way between the 24 and 26 unit hash marks for Resident #6's Novolin 70/30 insulin dose.
- Resident #6 had previously had a 50 unit insulin syringe capable of measuring 25 units accurately, however the pharmacy sent the current 100 unit syringes the last order. (Observation of Resident #6's insulin syringe box revealed labeling for dispensed on 6/15/15 for 100 syringes.)
- The MA had not informed the facility nurse that Resident #6 currently had no insulin syringes calibrated to accurately measure 25 units.

Review of Resident #6's electronic Medication Administration Record (eMAR) for August 1-4, 2015 revealed:
- At 6:30 am FSBS values of 173, 144, 120, and 137 respectively.
- At 8:00 pm FSBS values of 156, 220, and 204 respectively.

Review of Resident #6's eMAR for July 2015 revealed:
- At 6:30 am FSBS values ranged from 82 to 242.
- At 8:00 pm FSBS values ranged from 148 to 400.

Interview on 08/04/15 at 6:00 pm with the Resident Care Director (RCD) revealed:
- Medication Aide staff were responsible to contact the pharmacy provider for the resident's insulin syringes.
- Medication Aide staff should be using insulin syringes calibrated to measure 25 units of insulin accurately for Resident #6.
- Medication Aide staff had not informed her Resident #6 did not have insulin syringes capable of accurately measuring 25 units.
- She would contact the pharmacy to order the correct insulin syringes for Resident #6.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 46 Interview on 08/04/15 at 4:45 pm with Resident #6 revealed: - Staff routinely administer her insulin. - Staff keep up with the amount she is supposed to receive. - She had not had any problems that she was aware of with her insulin. Interview on 08/05/15 at 9:45 am with a day shift MA revealed: - Resident #6 had a Novolin 70/30 insulin Flexpen until late May or June 2015. (Flexpen is a packaging that allows dialing the required units of insulin from the package and administering directly from the pen.) - She routinely worked day shift and the resident received 44 units of Novolin 70/30 insulin in the morning. - The current 1 cc 100 unit syringes were calibrated to measure even number of units of insulin accurately. - She had not had the occasion to need to administer the 25 unit dose of Novolin 70/30. Observation on 08/05/15 at 9:45 am of the medication cart for Resident #6's medications, including insulin syringes, revealed a supply of 50 unit insulin syringes with calibration in one unit increments. Interview on 08/05/15 at 9:45 am with the Facility Nurse revealed: - She was not aware Resident #6 did not have insulin syringes calibrated for accurately administering 25 units of insulin until staff informed her on 08/04/15. - Medication Aide staff or the RCD had not informed her the resident needed a different insulin syringe.	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 47 - She had ready access to insulin syringes calibrated for accurate administration of 25 units of insulin in the adjoining skilled care facility. Interview on 08/06/15 at 5:00 pm with the Administrator revealed: - Medication Aide staff were responsible to administer medication as ordered. - The RCD and facility nurse were responsible to monitor resident's medication for proper administration. 2. Review of Resident #3's current FL-2 dated 05/15/2015 revealed diagnoses included Intracerebral hemorrhage, Atrial Fibrillation, and Hemiplegia affecting dominant side, Cerebral Vascular Accident (CVA). -An order for Xarelto 20mg once daily (used to reduce the risk of stroke and blood clots secondary to Atrial Fibrillation; treats and prevents Deep Vein Thrombosis and Pulmonary Embolism blood clots). Observation of the 8:00 am medication pass on 08/05/15 at 7:40 am revealed: - The Medication Aide (MA) prepared 5 solid dose oral medications (tablets and capsules) and one oral inhalation medication for Resident #6. - The MA advised the surveyor that one medication, Xarelto 20 mg, was not available for administration to Resident #3 because the pharmacy had experienced billing conflicts with the resident's insurance. - The MA stated the facility had not had Resident #6's Xarelto 20 mg for the last couple of months that she had been working the medication cart. - The MA stated she thought the facility was working with the pharmacy to obtain the medication. (She had not notified the resident's physician.)	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 48 Observation of Resident #3's medication on hand on 8/5/15 at 10:15 am revealed a bubble pharmacy card of 30 tablets of Xarelto 20mg dispensed on 8/3/2015 and 1 tablet had been administered. Review of Resident #3's electronic Medication Administration Record (eMAR) for August 2015 revealed: - Xarelto 20 mg daily was transcribed to the eMAR and scheduled for administration at 8:00 am daily. - Xarelto 20 mg was documented for administration on 08/04/15 at 8:00 am. Later interview on 08/05/15 at 10:18 am with the MA revealed: - The MA did not work on 08/04/15. - Medications dispensed by the pharmacy were routinely delivered around 9:00 pm on the day of the labeled dispensed date. - Based on the date dispensed of 08/03/15, Resident #3's Xarelto 20 mg would have been delivered to the facility on 08/03/15 around 9:00 pm. - Resident #3's Xarelto 20 mg was not on the cart the last time she worked prior to today (08/05/15). - The MA stated she overlooked Resident #3's Xarelto 20 mg when she pulled the morning medications on 08/05/15. - The MA stated she would contact the Resident's Physician Assistant for authorization to administer the medication late. Interview with the Resident Care Director (RCD) and Administrator on 8/5/2015 at 5:30 pm revealed: - The MA had informed the RCD that Resident #3 did not receive Xarelto 20mg during the	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 49 medication pass earlier today. - The RCD was aware the pharmacy had experienced delays in providing Resident #3's Xarelto 20 mg due to insurance requirements for prior authorization. - The RCD and Administrator related medication aides were responsible to administer medications as ordered on the eMAR and check the cart each time for all medications. The facility provided a Plan of Protection on 8/06/15 as follows: - Immediately, the facility will in-service staff for medication ordering/medication administration, availability, and carrying out orders. - All MARS will be compared to the physicians's orders and reviewed for accuracy. - Review eMAR exceptions and medication variances report daily for 6 weeks, and then weekly. - Medications orders expiring within 30 days to be run weekly and monitored by the Resident Care Director (RCD). - The RCD will be responsible to monitor the Plan of Protection. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED SEPTEMBER 9, 2015.	D 358		
D 466	10A NCAC 13F .1308(b) Special Care Unit Staffing 10A NCAC 13F .1308 Special Care Unit Staffing (b) There shall be a care coordinator on duty in the unit at least eight hours a day, five days a week. The care coordinator may be counted in the staffing required in Paragraph (a) of this Rule for units of 15 or fewer residents.	D 466		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 466	Continued From page 50	D 466		

This Rule is not met as evidenced by:
Based on observations, interviews, and review of records, the facility failed to ensure a care coordinator was on duty in the Memory Care Unit (MCU) at least eight hours a day, five days a week.

The findings are:

Review of the facility's current license revealed the Memory Care Unit (MCU) was licensed for 18 beds.

Observations in the MCU on 08/04/15 and 08/05/15 revealed:
-The current census in the MCU was 18.
-The day and evening shifts had one medication aide (MA), two personal care aides (PCAs), and one Life Enrichment Director (LED), whose duties were to perform activities with the residents.
-There was no care coordinator scheduled in the MCU.

Interview on 08/06/15 at 4:03 pm with the Administrator revealed:
-There had never been a care coordinator position in the MCU.
-He was not aware of the regulation requiring a care coordinator in the MCU for 8 hours a day, 5 days a week.

Interview on 08/05/15 at 8:30 am with the Resident Care Coordinator (RCC) revealed:
-She was responsible for the day-to-day operations of the facility, on both the assisted living side and the MCU.
-The Registered Nurse from the skilled portion of the facility assisted by performing tasks requiring

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 466	Continued From page 51 an RN. -There was not a care coordinator specifically for the MCU. -The RCC stated she worked full time (40+ hours) and spent approximately 1/3 of her daily shift in the MCU. _____ On 08/06/15, the Administrator submitted a Plan of Protection as follows: -Effective immediately, a Registered Nurse would be assigned to the Memory Care Unit 8 hours daily, 5 days a week. -Recruitment for the Memory Care Coordinator position would begin immediately. -The Executive Director would monitor weekly to ensure ongoing compliance.	D 466		
D 482	10A NCAC 13F .1501(a) Use Of Physical Restraints And Alternatives 10A NCAC 13F .1501Use Of Physical Restraints And Alternatives (a) An adult care home shall assure that a physical restraint, any physical or mechanical device attached to or adjacent to the resident's body that the resident cannot remove easily and which restricts freedom of movement or normal access to one's body, shall be: (1) used only in those circumstances in which the resident has medical symptoms that warrant the use of restraints and not for discipline or convenience purposes; (2) used only with a written order from a physician except in emergencies, according to Paragraph (e) of this Rule; (3) the least restrictive restraint that would provide safety; (4) used only after alternatives that would provide safety to the resident and prevent a potential	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 52	D 482		

decline in the resident's functioning have been tried and documented in the resident's record.
(5) used only after an assessment and care planning process has been completed, except in emergencies, according to Paragraph (d) of this Rule;
(6) applied correctly according to the manufacturer's instructions and the physician's order; and
(7) used in conjunction with alternatives in an effort to reduce restraint use.
Note: Bed rails are restraints when used to keep a resident from voluntarily getting out of bed as opposed to enhancing mobility of the resident while in bed. Examples of restraint alternatives are: providing restorative care to enhance abilities to stand safely and walk, providing a device that monitors attempts to rise from chair or bed, placing the bed lower to the floor, providing frequent staff monitoring with periodic assistance in toileting and ambulation and offering fluids, providing activities, controlling pain, providing an environment with minimal noise and confusion, and providing supportive devices such as wedge cushions.

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews, and record reviews, the facility failed to obtain a physician's order, provide assessment and care planning, and document attempted alternatives to restraints for 1 of 1 sampled residents (Resident #1) prior to the use of restraints (furniture placed against the bed to prevent the resident from exiting the bed).

The findings are:

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 53 Review of Resident #1's current FL-2 dated 01/26/15 revealed: -Diagnoses included dementia, history of falls, and macular degeneration. -The resident was semi-ambulatory and constantly confused. Review of Resident #1's current care plan dated 01/22/15 revealed: -The resident required extensive assistance with ambulation and transfers. -The resident was totally dependent upon staff for toileting. Observation during initial tour on 08/04/15 at 10:00 am revealed: -Resident #1 was lying in bed. -The bed was positioned with one side against the wall. -A wheelchair was locked into position against the top 1/3 of the bed. Observation on 08/05/15 at 7:15 am revealed: -Resident #1 was lying in bed. -The bed was positioned with one side against the wall. -A five-foot sofa was placed with the seating edge against the bed, blocking all but 1 foot of the length of the bed. -A wheelchair was locked into position beside the sofa against the remaining length of the bed. -In order for the resident to exit her bed, she would have to climb over the furniture as it was currently placed. Interviews on 08/05/15 at various times with six day-shift staff (personal care aides, medication aides, and housekeeping staff) revealed: -One staff member stated the furniture was	D 482		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 54	D 482		

placed against the bed at night to prevent the resident from falling.
-Two staff members stated they had noticed the furniture placed against the bed every morning when they arrived, since the resident was readmitted to the facility in June 2015.
-One staff member stated she had seen the furniture placed against the bed "a couple times a week".
-One staff member stated she first noticed the furniture being placed against the bed about a month ago.
-One staff member stated she had noticed the furniture against the bed every day for the "last couple of weeks".
-None of the staff had ever seen the resident attempt to get out of bed around or over the furniture.
-One staff member stated the resident was physically able to get out of bed independently, but "would not be able to make it (far) by herself" without falling.
-One staff member stated she knew the resident was a fall risk and was physically capable of walking where she wanted to, but staff did not allow her to ambulate independently because she was a high risk for falls.
-One staff member stated she reported the issue to the Resident Care Director (RCD).
-Two staff members stated they reported the issue to the Director of Nursing (DON) from the skilled side of the facility.

Interviews on 08/05/15 at various times with three evening shift staff members (personal care aides and medication aides) revealed they had never positioned the furniture against the resident's bed or seen it in that position.

Interviews on 08/05/15 at various times with two

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 55	D 482		

night-shift staff (personal care aide and medication aide) revealed:
-Both staff members had observed the furniture placed against the resident's bed.
-Neither staff person had ever placed the furniture against the resident's bed.
-The furniture was already placed against the bed when they arrived for their shift.
-One staff member stated that's how the furniture "always was" when she arrived for her shift for the past three months, and she thought it was "supposed to be that way" to keep the resident from falling.
-Neither of the staff members knew who positioned the furniture against the bed.
-Both staff thought the furniture was positioned against the bed to prevent the resident from falling or from getting out of bed unattended.
-One staff member stated the resident has had "several falls" in the past.
-One staff member stated "4 or 5 months ago", the resident occasionally got up out of bed without calling for assistance.

Interview on 08/05/15 at 8:45 am with the Director of Nursing (DON) from the facility's skilled building revealed:
-She was not aware staff were moving the resident's furniture against the bed to block her from exiting the bed.
-The facility was "supposed to be restraint free".
-The DON would begin inservices with the staff immediately.

Interview on 08/05/15 at 8:30 am with the Resident Care Director (RCD) revealed:
-She was not aware staff were positioning the furniture against the bed.
-She was aware that placement of furniture against the bed to prevent the resident from

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 56	D 482		

exiting and/or falling out of bed constituted a restraint.
-The facility was restraint free.
-The RCD would immediately remove the furniture from the resident's bedside.

Interview on 08/06/15 at 9:30 am with the resident's family member revealed:
-The resident had just returned to the facility from receiving rehab in a skilled facility due to a fall with hip fracture.
-He was not aware the staff had been placing furniture against the bed.
-He stated most of the resident's falls were at night and he recently requested staff get a hospital bed with rails to prevent the resident from getting out of bed and falling at night.
-He had "no concern" about staff looking after the resident and was confident in staff's care of the resident.
-The family member stated staff repeatedly instructed the resident to call for assistance before trying to get up, but "she forgets".
-The staff had tried to use bed and seat alarms, but the problem was that once the alarm sounds, the resident "has already done something".
-The family member stated he felt facility staff were "very attentive" to the resident.

On 08/06/15, the Administrator submitted a Plan of Protection as follows:
-The restraints (furniture) were immediately removed from Resident #1's bedside.
-Immediate inservicing of the staff was begun regarding what constitutes a restraint and reporting requirements and procedures.
-Training regarding restraint use would be provided for all new staff during orientation and annually thereafter.
-New hire and annual training would be monitored

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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 482	Continued From page 57 for ongoing compliance by the Business Office Manager. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D 482		
D912	G.S. 131D-21(2) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 2. To receive care and services which are adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations. This Rule is not met as evidenced by: Based on observation, record review, and interview, the facility failed to assure all residents received care and services which were adequate, appropriate, and in compliance with relevant federal and state laws and rules and regulations related to staff qualifications, health care, nutrition and food services, Special Care Unit staffing, physical restraints, infection prevention requirements, and medication aide training and competency requirements. The findings are: A. Based on observation, interview and record review, the facility failed to assure 5 of 6 sampled staff (Staff A, C, D, E and F) were competency validated by a registered nurse (RN) by return demonstration prior to staff performing the required tasks such as Fingerstick Blood sugars (FSBS), injections of insulin, application of anti-embolic hose, Oxygen administration and	D912		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D912	Continued From page 58	D912		

administration of nebulizer medication. (Refer to Tag D0161, 10A NCAC 13F .0504(a) Competency Validation for LHPS Tasks (Type B Violation)].

B. Based on interview, record review and observation, the facility failed to assure 4 of 6 Staff (Staff A, C, D and E) received training by a licensed health professional on the care of diabetic residents prior to administering insulin to diabetic residents. (Refer to Tag D0164, 10A NCAC 13F .0505 Training on Care of Diabetic Resident (Type B Violation)].

C. Based on observations, interviews, and record reviews, the facility failed to ensure therapeutic diets (no concentrated sweets and mechanical soft) were served as ordered by the physician for 2 of 5 sampled residents (Residents #10 and #11) in the Memory Care Unit (MCU).[Refer to Tag D0310, 10A NCAC 13F .0904(e)(4) Nutrition and Food Service (Type B Violation)].

D. Based on observations, interviews, and record reviews, the facility failed to obtain a physician's order, provide assessment and care planning, and document attempted alternatives to restraints for 1 of 1 sampled residents (Resident #1) prior to the use of restraints (furniture placed against the bed to prevent the resident from exiting the bed). [Refer to Tag D0482, 10A NCAC 13F .1501(a) Use of Physical Restraints and Alternatives (Type B Violation)].

E. Based on observation, interview and record review, the facility failed to assure adequate and appropriate infection control measures were implemented for blood glucose monitoring regarding the use of shared glucometers for 3 of 4 sampled residents (Residents # 6, #7, #8, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D912	Continued From page 59 #9) with orders for glucose monitoring. [Refer to Tags D0932, G.S.131D-4.4A(b) ACH Infection Prevention Requirements (Type B Violation)]. F. Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control, safe practices for injections and glucose monitoring for 3 of 5 sampled Staff (Staff B, C, and E). [Refer to Tag D0934, G.S.131D-4.5B.(a) ACH Infection Prevention Requirements (Type B Violation)]. G. Based on observation, interview and record review, the facility failed to assure 3 of 5 sampled Staff (Staff A, Staff C, and Staff E), who were hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training and 1 of 5 sampled Staff (Staff A) completed the Medication Clinical Skills Validation, prior to administering medications. [Refer to Tag D0935, G.S. 131D-4.5B(b) ACH Medication Aide: Training and Competency (Type B Violation)].	D912		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure each resident be free of neglect related medication administration. The findings are:	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D914	Continued From page 60 Based on observation, interview, and record review, the facility failed to assure medications were administered as ordered by the licensed prescribing practitioner for 2 of 6 residents (#3 and #6) observed during medication administration which included errors with administration of Novolin 70/30 insulin and Xarelto 20 mg and 2 of 5 sampled residents (#3, and #5) which included errors with medications for blood clotting, constipation, and altered thyroid function. [Refer to Tag D0358, 10A NCAC 13F .1004(a) Medication Administration (Type A2 Violation)].	D914		
D932	G.S. 131D-4.4A (b) ACH Infection Prevention Requirements G.S. 131D-4.4A Adult Care Home Infection Prevention Requirements (b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012: (1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following: a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents. b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules. c. Accessibility of infection control devices and supplies. d. Blood and bodily fluid precautions.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 61 e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens. f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves. (2) Require and monitor compliance with the facility's infection control policy. (3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens. This Rule is not met as evidenced by: TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure adequate and appropriate infection control measures were implemented for blood glucose monitoring regarding the use of shared glucometers for 3 of 4 sampled residents (Residents # 6, #7, #8, and #9) with orders for glucose monitoring. The findings are: Interview with the Resident Care Director on 8/06/15 at 2:30 pm revealed: - The facility had 9 residents receiving fingerstick blood sugar checks.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 62 - None of the nine residents receiving fingerstick Blood sugar checks had a diagonsis of bloode borne infectious disease such as herpatitis or Human Immunodeficiency Virus (HIV). Based on the Center for Disease Control (CDC) guidelines for infection control, the recommendations are that blood glucose monitoring devices (glucometers) should not be shared between residents. If the glucometer is to be used for more than one person, it should be cleaned and disinfected per the manufacturer's instructions. If the manufacturer does not list the disinfection information, the glucometer should not be shared between residents. Review of the facility's written Diabetes-care procedures and techniques revealed: - Assign separate glucometers to individual patients. - If glucometer is shared, the device must be cleaned and disinfected between each patient use. - Use Germicidal disposable wipes. - Follow the manufacturer's instruction. Telephone interview on 8/05/15 at 3:54 pm with a representative of the manufacturer for the Brand B glucometer revealed the glucometer was approved for use on multiple residents if properly disinfected, according to the manufacturer of the disinfectant's direction, with an EPA approved germicidal wipe. Telephone interview on 8/05/15 at 4:15 pm with a representative of the manufacturer for the Brand A glucometer revealed the glucometer was recommended for single use only. (Based on manufacturer's guidelines the Brand A glucometer should not be shared.)	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 63 Telephone interview on 8/05/15 at 3:54 pm with a representative of the manufacturer for the Brand C revealed the glucometer was recommended for single use only. (Based on manufacturer's guidelines the Brand C glucometer should not be shared.) Observation on 8/04/15 at 4:22 pm of the evening shift Medication Aide (MA) revealed: - She was working on a medication cart on the 200 Hall. - The MA identified a resident scheduled to receive a fingerstick blood sugar (FSBS) check. - She removed a glucometer (Brand A) from the second drawer from the bottom of the medication cart, adjacent to medications the resident's bingo medication cards, and stated it was for the resident identified to receive a fingerstick blood sugar (FSBS) check. - The glucometer and the glucometer storage pouch were not labeled with a resident's name. - The MA obtained a FSBS value for the resident, returned the glucometer to the storage pouch, and stored the glucometer on the cart. (No cleaning or disinfecting was observed.) Interview on 08/04/15 at 4:22 pm with the MA revealed: - The 200 Hall cart had 2 glucometers stored on the cart. - Both glucometers, and glucometer storage pouches were not labeled with resident's name. - The glucometers were different brands and she knew which glucometer belonged to each resident because they were kept in seperate drawers on the cart, beside the resident's oral medications. Continued observation on 08/04/15 of the	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 64	D932		

medication cart on 200 Hall revealed:
- A second (Brand B) glucometer stored in the bottom drawer of the cart.
- No EPA approved germicidal/bactericidal-tuberculocidal-Virucidal for Hepatitis B Virus wipes were observed on the cart.

Observation on 8/05/15 at 11:20 am of the medication cart on Hall 300 revealed:
- Two glucometers (one Brand C and one Brand B) were located on the medication cart.
- Neither of the glucometers or glucometer storage pouches were labeled with a resident's name.
- The glucometer storage pouches were located adjacent to the resident's bingo packaged medications.
- No EPA approved wipes (germicidal/bactericidal-tuberculocidal-Virucidal for Hepatitis B Virus) were observed on the cart.

A. Review of Resident #6's current FL2 dated 04/14/15 revealed diagnoses included Cerebral Vascular Accident (CVA) and esophageal strictures with bleed.

Review of Resident #6's facility's Face Sheet used for resident's admissions revealed diagnoses included Diabetes Mellitus II without complication, not stated as uncontrolled.

Review of Resident #6's Resident Register revealed the resident was admitted to the facility on 04/15/15.

Review of Resident #6's Physician's Orders dated 7/07/15 revealed an order for fingerstick blood sugar (FSBS) checks before meals and at bedtime.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 65 Observation of Resident #6's glucometer (Brand A) on 08/05/15 revealed: - Glucometer was stored in the 200 Hall cart. - Black bag for storing the glucometer was not labeled with a resident's name. - Glucometer inside the bag was not labeled with any resident name. Review and comparison of the glucometer's history data for Resident #6's glucometer on 08/05/15 and August 2015 electronic Medication Administration Records (eMARs) revealed: - FSBS values were scheduled for 6:30 am, 11:30 am, 4:30 pm, and 8:00 pm. - Date and time on the glucometer was set correctly. - FSBS values stored in Resident #6's glucometer's history data were inconsistent with values documented on the August 2015 eMAR. - On 8/03, 6 FSBS values were stored in the memory history [7:08 pm (209), 7:00 pm (124), 4:23 pm (128), 11:21 am (374), 6:23 am (120), and 6:16 am (113)]. - On 8/03, 2 of the FSBS values [7:00 pm (124) and 6:16 am (113)] were not documented on the Resident #6's August eMAR and were consistent with values documented on another resident's eMAR for the corresponding day and time. Review and comparison of the glucometer's history data for Resident #6's glucometer on 08/05/15 and July 2015 eMAR revealed: - FSBS values were scheduled for 6:30 am, 11:30 am, 4:30 pm, and 8:00 pm. - Date and time on the glucometer was set correctly. - FSBS values stored in Resident #6's glucometer's history data were inconsistent with	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 66	D932		

values documented on the July 2015 eMAR.
- Reading for 7:00 pm FSBS values documented on Resident #6's eMAR for July 2015 were not located in the glucometer's history data 16 of 31 times with examples as follows: 7/31(188), 7/30(148), 7/29(164), 7/27(168), 7/26(289), 7/07(200), and 7/05(246).
- On 7/13/15 at 8:00 pm a FSBS value of 239 was documented on the eMAR and FSBS at 7:11 pm=130 was recorded in the glucometer's history data.
- On 7/05/15, Resident #6 was missing two FSBS values (documented on Resident #6's eMAR) in the glucometer's history data of 246 at 7:00 pm, and 209 at 11:30 am. (FSBS values corresponding to the same time and value were recorded in another resident's glucometer's history data and not scheduled for the other resident.)

Interview with Resident #6 on 08/06/15 at 10:20 am revealed:
- Staff checked her FSBS several times a day.
- She was not aware if staff used her glucometer all the time to check her FSBS.

Refer to interview on 8/05/15 at 3:00 pm with a first shift Medication Aide.

Refer to interview on 08/05/15 at 5:30 pm with the Administrator.

Refer to interview on 8/05/15 at 5:00 pm with the facility Nurse.

Refer to interview on 8/06/15 at 10:00 am with a Medication Aide.

Refer to interview on 8/06/15 at 10:10 am with a second Medication Aide.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 67 B. Review of Resident #8's current FL2 dated 04/28/15 revealed diagnoses included Diabetes Mellitus II. Review of Resident #8's Resident Register revealed the resident was admitted to the facility on 05/15/13. Review of Resident #8's Physician's Orders dated 7/07/15 revealed an order for fingerstick blood sugar (FSBS) checks twice a day on Monday, Wednesday, and Friday. Observation of Resident #8's glucometer (Brand B) on 08/05/15 revealed: - Glucometer was stored in the 200 Hall cart. - Black bag for storing the glucometer was not labeled with a resident's name. - Glucometer inside the bag was not labeled with any resident name. Review and comparison of the glucometer's history data for Resident #8's glucometer on 08/05/15 and August 2015 electronic Medication Administration Records (eMARs) revealed: - FSBS checks were listed for twice a day on Monday, Wednesday, and Friday and were scheduled for 6:30 am, and 8:00 pm. - Date on the glucometer was set correctly but time was one hour late. - FSBS values stored in Resident #8's glucometer's history data were inconsistent with values documented on the August 2015 eMAR. - 0n 8/05/15, FSBS recorded in the glucometer's history data at 6:20 am (adjusted to 7:20 am) =128 and 128 documented on the eMAR. - On 8/03/15, FSBS value documented on Resident #8's eMAR at 6:30 am was 113, and at	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 68	D932		

8:00 pm was 124; No FSBS values were recorded in Resident #8's glucometer's history data for 8/03/15.

Review and comparison of the glucometer's history data for Resident #8's glucometer on 08/05/15 and July 2015 eMAR revealed:
- FSBS checks were listed for twice a day on Monday, Wednesday, and Friday and were scheduled for 6:30 am, and 8:00 pm.
- Date on the glucometer was set correctly but time was one hour late.
- FSBS values stored in Resident #8's glucometer history data were inconsistent with values documented on the July 2015 eMAR.
- On 7/13/15 at 8:00 pm a FSBS value of 130 was documented on Resident #8's eMAR and FSBS at 7:11 pm of 239 was recorded in the glucometer's history data. (FSBS of 239 corresponded to a FSBS value documented on another resident's eMAR and another resident had a corresponding FSBS value of 130, not 239, recorded in the resident's glucometer's history data for 7:28 pm on 7/13.)
- On Tuesday, 7/05/15, Resident #8 was not scheduled for FSBS and the glucometer's history data revealed FSBS values of 246 at 7:24 pm and 209 recorded at 11:28 am. This corresponded to FSBS values documented on another Resident's eMAR, but missing in the resident's glucometer's history data, for 7:00 pm and 11:30 am.

Interview with Resident #8 on 08/06 at 10:20 am revealed:
- Staff checked her FSBS on Monday, Wednesday and Fridays.
- She was not aware if staff used her glucometer all the time to check her FSBS; she did not pay attention to the glucometer used by staff.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 69 - She thought staff used her glucometer all the time but she was not aware if it was labeled with her name. - On 7/13/15, FSBS of 239 recorded in Resident #8's glucometer history data corresponded to a FSBS value documented on Resident #6 of 239 recorded in the glucometer's history data for 7:28 pm on 7/13.) - On 8/03/15, 2 of the FSBS values [7:00 pm (124) and 6:16 am (113)] recorded in the glucometer history data for Resident #6 that were not documented on the Resident #6's August eMAR were found to be consistent with values documented on Resident #8's eMAR for the corresponding day and time. Refer to interview on 8/05/15 at 3:00 pm with a first shift medication aide. Refer to interview on 08/05/15 at 5:30 pm with the Administrator. Refer to interview on 8/05/15 at 5:00 pm with the facility Nurse. Refer to interview on 8/06/15 at 10:00 am with a Medication Aide. Refer to interview on 8/06/15 at 10:10 am with a second Medication Aide. C. Review of Resident #7's current FL-2 dated 4/28/15 revealed diagnoses diabetes, and hypertension. Review of Resident #7 record revealed Physician's orders dated 6/09/15 ordering for fingerstick blood sugar (FSBS) before meals and at bedtime.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 70 Observation of Resident #7's glucometer (Brand C) on 08/05/15 at 11:40 am revealed: - Glucometer was stored on the medication cart for the 300 Hall. - Black bag for storing the glucometer was not labeled with a resident name. - Glucometer inside the bag was not labeled with a resident name. Review and comparison of the glucometer's history data for Resident #7's glucometer on 08/05/15 and August 2015 and July 2015 electronic Medication Administration Records (eMARs) revealed: - The date on the glucometer was correct but the time was approximately 4 hours early (needed to add 4 hours to the time displayed on the glucometer for actual time.) - On 7/29/15, FSBS values recorded in the glucometer's history data were as follows: at 4:09 pm(adjusted for time) FSBS=120, at 5:09 pm FSBS=102; FSBS documented on the eMAR was 99 at 4:30 pm. - On 7/27/15, FSBS value documented on the eMAR at 8:30 pm was 162; No value was recorded in the glucometer's history data. - On 7/26/15, FSBS value documented on the eMAR at 8:30 pm was 100; Value recorded in the glucometer's history data were 7:21 pm (adjusted) FSBS of 84, and at 9:45 pm (adjusted) FSBS of 123. - On 7/24/15, FSBS value documented on the eMAR at 8:30 pm was 256; No value was recorded in the glucometer's history data. - On 7/16/15, FSBS value documented on the eMAR at 6:30 am was 149; Resident #7's glucometer's history recorded 149 at 6:12 am (adjusted) and an additional FSBS value of 101 recorded at 6:06 am(adjusted) not accounted for	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 71	D932		

on the eMAR.
- On 7/13/15, FSBS value documented on the eMAR at 6:30 am was 119; Resident #7's glucometer's history recorded 119 at 6:15 am(adjusted) and an additional FSBS value of 100 recorded at 6:09 am(adjusted) not accounted for on the eMAR.

Interview with Resident #7 on 08/05/15 at 10:50 am revealed:
- Staff checked her FSBS several times each day.
- She stated did not pay attention to the glucometer staff used to check her FSBS.
- She had never observed the staff cleaning the glucometer.

Refer to interview on 8/05/15 at 3:00 pm with a first shift medication aide.

Refer to interview on 08/05/15 at 5:30 pm with the Administrator.

Refer to interview on 8/05/15 at 5:00 pm with the facility Nurse.

Refer to interview on 8/06/15 at 10:00 am with a Medication Aide.

Refer to interview on 8/06/15 at 10:10 am with a second Medication Aide.

D. Review of Resident #9's current FL-2 dated 5/28/15 revealed:
- Diagnoses included diabetes and hypertension.
- Order for fingerstick blood sugar (FSBS) twice a week on Mondays and Thursdays at 6:00 am.

Observation of Resident #9's glucometer (Brand A) on 08/05/15 at 12:00 pm revealed:
- Glucometer was stored on the medication cart

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 72	D932		

for the 300 Hall.
- Black bag for storing the glucometer was not labeled with a resident name.
- Glucometer inside the bag was not labeled with a resident name.

Review and comparison of the glucometer's history data for Resident #9's glucometer on 08/05/15 and August 2015 and July 2015 electronic Medication Administration Records (eMARs) revealed:
- The date on the glucometer was off by one day (display the previous day) but the time was correct.
- Resident #9's eMARs for July 2015 and August 2015 listed FSBS values scheduled for 6:30 am on Mondays and Thursdays with documentation for FSBS values documented as ordered from 07/2/15 to 8/03/15.
- A total of 8 FSBS values were recorded in Resident #9's Brand A glucometer's history data from 7/01/15 to 8/02/15.
- FSBS values were not recorded in Resident #9's glucometer's history data for 7/13/15 and 7/16/15.

Interview with Resident #9 on 08/05/15 at 10:45 am revealed:
- She had a glucometer that was assigned to her.
- She did not pay attention to the type of glucometer staff used to check her FSBS.
- She had not noticed if the staff clean the glucometer.
- She depended on staff to obtain her FSBS as ordered.

Refer to interview on 8/05/15 at 3:00 pm with a first shift Medication Aide.

Refer to interview on 08/05/15 at 5:30 pm with the Administrator.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 73 Refer to interview on 8/05/15 at 5:00 pm with the facility Nurse. Refer to interview on 8/06/15 at 10:00 am with a Medication Aide. Refer to interview on 8/06/15 at 10:10 am with a second Medication Aide. _____ Interview on 8/05/15 at 3:00 pm with a first shift Medication Aide revealed: - Each resident had a glucometer assigned to the resident. - Staff were trained for the facility policy that glucometers should be used only for the resident assigned to the glucometer. - Glucometers were not supposed to be shared. - She randomly, once or twice month, cleaned a glucometer she used to test a FSBS with an alcohol wipe. - She was not aware of any cleaning/disinfecting wipe that staff were to use for disinfecting glucometers. - She had received training from the nurse with the pharmacy provider for glucometer infection prevention during her medication aide check off. - Residents' glucometers had not been labeled with a resident's name since she had been re-hired in March 2015. - Residents' glucometers on the 200 Hall medication cart were different brands from each other and staff knew which glucometer was each resident. - Residents' glucometers on the 300 Hall medication cart were different brands from each other and staff knew which glucometer was for each resident. - She stated she was not aware of an instance	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 74 when she shared a resident's glucometer. Interview on 08/05/15 at 5:30 pm with the Administrator revealed: - Facility policy was for all residents to have their own glucometer. - Glucometers should not be shared. - He was not aware of a routine cleaning or disinfecting schedule for glucometers because the glucometers should not be shared. - He was not aware staff were sharing glucometers. Interview on 8/05/15 at 5:00 pm with the facility Nurse revealed: - She was not aware staff were sharing glucometers between residents. - The facility policy was for each resident to have a glucometer assigned to the resident and staff were not to use the glucometer for FSBS on another resident. - The facility EPA approved germicidal/bactericidal-tuberculocidal-Virucidal for Hepatitis B Virus were wipes available through the sister skilled nursing facility but she had not provided them to the facility because staff should not be sharing glucometers and therefore would not need to disinfect glucometers. - The facility had conducted an in-service 2 or 3 months ago for glucometer infection prevention and many of the medication aides had attended the in-service. - She and the Resident Care Director were responsible to monitor medication administration, including FSBS monitoring with glucometers, and medication aides. - The facility did not currently have a system in place for routine audits of glucometers and residents' FSBS documentation on the eMARs, but a system would be put in place immediately.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 75 Interview on 8/06/15 at 10:00 am with a Medication Aide revealed: - She filled in on the 200 Hall and 300 Hall medication carts. - The facility policy was for each resident to have their own glucometer. - She was aware the facility policy was to not share glucometers between residents. - She used alcohol swabs to routinely clean residents' glucometers once a week, when she worked, but she was not aware of a routine schedule for cleaning glucometers. - She had not had a training specific to glucometer infection prevention recently. - She thought the facility had an in-service for glucometers about 2 or 3 months ago but she did not attend the in-service. - She stated she did not recall an instance when she had shared a glucometer between residents. Interview on 8/06/15 at 10:10 am with a second Medication Aide revealed: - She was sometimes assigned to the 200 Hall and sometimes to the 300 Hall medication carts. - She was aware the facility policy was to not share glucometers between residents. - The facility policy was for each resident to have their own glucometer. - Alcohol swabs were the only cleaning wipes the facility provided for cleaning glucometers. - The facility had an in-service for glucometers about 2 or 3 months ago that she attended. - She was not aware of a routine cleaning/disinfecting schedule for glucometers. - The glucometers were labeled with resident's names but staff stored them on the cart for the hall the residents resided on, and the glucometers were different brand for each of the 2 residents on each medication cart.	D932		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D932	Continued From page 76 - She stated if she had ever shared a glucometer between residents it would not have been intentional. _____ Review of the facility's Plan of Protection dated 08/05/15 revealed: - Immediately, the facility will audit all resident glucometers' history compared documented FSBS to ensure they have not been shared. - The facility will replace, or if the manufacturer deems it appropriate to be disinfected when approved for use on multiple residents, or disinfected/cleaned per the manufacturer's recommendation. - Prior to the next FSBS, all staff will be in-serviced for the importance of following the facility's policy for glucometers not to be shared. - The Director of Nursing, Resident Care Director or designee will monitor the glucometers daily for 2 weeks, then 3 times a week for 2 weeks, then 2 times a week for 2 weeks, then 1 time a week for 2 weeks. - The facility will monitor for one monthly Quality Assurance meeting. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D932		
D934	G.S. 131D-4.5B. (a) ACH Infection Prevention Requirements G.S. 131D-4.5B Adult Care Home Infection Prevention Requirements (a) By January 1, 2012, the Division of Health Service Regulation shall develop a mandatory,	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D934	Continued From page 77 annual in-service training program for adult care home medication aides on infection control, safe practices for injections and any other procedures during which bleeding typically occurs, and glucose monitoring. Each medication aide who successfully completes the in-service training program shall receive partial credit, in an amount determined by the Department, toward the continuing education requirements for adult care home medication aides established by the Commission pursuant to G.S. 131D-4.5 This Rule is not met as evidenced by: TYPE B VIOLATION Based on interview and record review, the facility failed to assure all medication aides received annual in-service training for infection control, safe practices for injections and glucose monitoring for 3 of 5 sampled Staff (Staff B, C, and E). The findings are: Interview with the Resident Care Director (RCD) and the Director of Nursing (DON) on 8/6/15 at 2:40 pm revealed: -The Human Resources department was responsible for maintaining personnel records. -The RCD and the DON are responsible for scheduling training, both on line and by presenter at the facility. -They were aware of missing training requirement as a result of a recent personnel records audit. -They had not instituted the state mandated Infection control program as yet.	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D934	Continued From page 78 -They were only using the infection control online program provided by their CEU (continuing education units) online provider. A. Review of Staff B's personnel record revealed: -A hire date of 8/21/13 as a Medication Aide (MA)/Nurse Aide. -A Medication Clinical Skills check list completed on 9/5/13. -No documentation of any additional Infection Control Training received since hire. -There was no signed certificate of Infection Control Training. Interview with Staff B on 8/6/15 at 3:15 pm revealed: -She had worked at the facility as a MA for approximately 2 years. -She received basic orientation and training the first week, and thought she had had infection control training at some time, but could not recall when. -She administered insulin and collected Fingerstick Blood Sugar results for a number of diabetics in the facility. Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm. B. Review of Staff C's personnel record revealed: -A hire date of 5/22/14 as a Medication Aide (MA)/Nurse Aide. -A Medication Clinical Skills check list completed on 6/19/14. -There was no signed certificate from the North Carolina State Infection Control Training. -A certificate from an on-line course for one hour continuing education unit on Infection Control. Interview with Staff C on 8/06/15 at 3:45 pm	D934		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D934	Continued From page 79	D934		

revealed:
-She had worked at the facility as a MA for over a year.
-She received training on the facilities computer program and remembered a part on Infection Control.
-She does not remember a class that the nurse did on Infection Control.
-She administered insulin and collected Fingerstick Blood Sugar results for a number of diabetics in the facility.

Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm.

C. Review of Staff E's personnel record revealed:
-She was hired as a Nurse Aide/ Medication Aide on 10/21/13.
-A Medication Clinical Skills check list was completed 12/20/13.
-No documentation of Infection Control Training signed certificate.
-A copy of a 1 hour online course for infection control.

Interview on 08/06/15 at 5:15 pm with Staff E revealed:
-She was hired on 10/21/13 as a Nurse Aide/ Medication Aide.
-She knew she took the online course for Infection Control but did not receive a signed certificate.

Refer to interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm.

Interview with the facility's Director of Nursing on 8/6/15 at 2:40 pm revealed:
-She was responsible for training records and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D934	Continued From page 80 classes for staff. -The management staff had completed a record audit within the last month and identified missing staff requirements. -She was trying to get the missing requirements caught up and was able to complete some training for 3 new staff. -She had not contacted anyone for assistance in completing the required training for care of a diabetic resident. -She thought the 5 hour Medication Aide training class met the requirement for the training for care of a diabetic resident. _____ The Administrator provided a Plan of Protection on 08/06/15 as follows: - Business Office Manager will immediately audit all employee personnel files to identify employees requiring the annual infection control training. - A facility nurse will work with employees for completing the required infection control training immediately. - Infection control training will be completed on all new hire employees. - The Business Office Manager will be responsible to ensure compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D934		
D935	G.S.§ 131D-4.5B(b) ACH Medication Aides; Training and Competency G.S. § 131D-4.5B (b) Adult Care Home Medication Aides; Training and Competency Evaluation Requirements.	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D935	Continued From page 81 (b) Beginning October 1, 2013, an adult care home is prohibited from allowing staff to perform any unsupervised medication aide duties unless that individual has previously worked as a medication aide during the previous 24 months in an adult care home or successfully completed all of the following: (1) A five-hour training program developed by the Department that includes training and instruction in all of the following: a. The key principles of medication administration. b. The federal Centers for Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. (2) A clinical skills evaluation consistent with 10A NCAC 13F .0503 and 10A NCAC 13G .0503. (3) Within 60 days from the date of hire, the individual must have completed the following: a. An additional 10-hour training program developed by the Department that includes training and instruction in all of the following: 1. The key principles of medication administration. 2. The federal Centers of Disease Control and Prevention guidelines on infection control and, if applicable, safe injection practices and procedures for monitoring or testing in which bleeding occurs or the potential for bleeding exists. b. An examination developed and administered by the Division of Health Service Regulation in accordance with subsection (c) of this section. This Rule is not met as evidenced by:	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D935	Continued From page 82 TYPE B VIOLATION Based on observation, interview and record review, the facility failed to assure 3 of 5 sampled Staff (Staff A, Staff C, and Staff E), who were hired after 10/1/13 as Medication Aides (MA), had successfully completed the 15 hour medication administration training and 1 of 5 sampled Staff (Staff A) completed the Medication Clinical Skills Validation, prior to administering medications. The findings are: Interview with the Resident Care Director (RCD) and the Director of Nursing (DON) on 8/6/15 at 2:40 pm revealed: -The Human Resources department was responsible for maintaining personnel records. -The RCD and the DON are responsible for scheduling training, both on line and by presenter at the facility. -They were aware of missing training requirement as a result of a recent personnel records audit. -DON did not offer the 5, 10, 15 hour training until recently. -The DON had recently incorporated the 5 hour medication aide training requirement in to the orientation schedule but only for the newest hires. A. Review of Staff A's personnel and training record revealed: -She was hired 1/27/15 as a Medication Aide (MA). -Staff A was currently listed on the Nurse Aide Registry as a Nurse Aide (NA). -Staff A had successfully passed the Medication Aide Test on 6/3/09. -There was no documentation Staff A completed a Medication Clinical Skills checklist. -There was no documentation Staff A completed	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D935	Continued From page 83 a 5, 10 or 15 hour medication administration program. -There was no documentation a Medication Aide Employment Verification was completed. Interview with Staff A, MA, on 8/6/15 at 3:40 pm revealed: -She worked as a MA or NA on second shift in the Special Care Unit. -She had previously worked at another assisted living facility as a medication aide and an independent living facility before coming to this facility. -She did not recall having a medication class conducted by an RN or pharmacist since hire. B. Review of Staff C's personnel record revealed: -A hire date of 5/22/14 as a Medication Aide/Nurse Aide. -A Medication Clinical Skills check list completed on 6/19/14. -There was not 5 hour and 10 hour Medication Training certificates or a 15 hour Medication Training Certificate. -There was no Medication Aide Employment Verification Form completed. Interview with Staff B on 8/06/15 at 3:45 pm revealed: -She did a lot of training on the computer the first week of employment. -She did a check off with the pharmacy nurse to be able to work on the med cart. -She took some classes with the pharmacy RN "but does not really remember what they were about." -She did not receive a 5 hour certificate for medication training prior to working on the med cart. -She did not have any class with the facility RN or	D935		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	C 08/10/2015

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

(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
D935	Continued From page 84 pharmacist and did not receive a 15 hour training certificate. C. Review of Staff E's personnel record revealed: -She was hired as a Nurse Aide/Medication Aide on 10/21/13. -Staff E had successfully passed the Medication Aide Test on 12/20/13. -A Medication Clinical Skills check list completed on 12/20/13. -She worked on third shift. -There was no documentation Staff E completed a 5, 10 or 15 hour Medication Administration Training program. Interview with Staff E on 08/06/15 at 5:05 pm revealed: -She did not remember being in a training class given by a nurse or a pharmacist. -She worked as a third shift Medication Aide. _____ The facility provided the following Plan of Protection on 8/6/15: -Immediately conduct an audit of the affected Medication Aides. -An RN will conduct 5, 10, 15 hour training for all affected by 8/7/15. -We will obtain Medication Aide verification on all new Medication Aides for 5, 10, or 15 hour within the regulatory required time frames by an RN or pharmacist. -The Business Office Manager will monitor for ongoing compliance. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 24, 2015.	D935		