STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS	2105 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) COMPLETION DATE
F 272 SS=D	483.20(b)(1) COMPREHENSIVE ASSESSMENTS The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. A facility must make a comprehensive assessment of a resident's needs, using the resident assessment instrument (RAI) specified by the State. The assessment must include at least the following: Identification and demographic information; Customary routine; Cognitive patterns; Communication; Vision; Mood and behavior patterns; Psychosocial well-being; Physical functioning and structural problems; Continence; Disease diagnosis and health conditions; Dental and nutritional status; Skin conditions; Activity pursuit; Medications; Special treatments and procedures; Discharge potential; Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS); and Documentation of participation in assessment.	F 272		8/18/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 08/15/2016

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients . (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS	2105 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) COMPLETION DATE
F 272	Continued From page 1 This REQUIREMENT is not met as evidenced by: F272 Based on observation, interview ' s and record reviews the facility failed to accurately assess 1 of 3 residents reviewed for range of motion. (Resident #71). Findings included: Resident #71 was admitted on 4/30/15, with the diagnoses of right hemiplegia and hemiparesis following a cerebral infarction affecting right dominant side. Review of the occupation therapy evaluation dated 5/1/15, revealed impairment to the right and left upper extremities. Review of the Minimum Data Set (MDS) dated 2/13/16, revealed Resident #71 required total assistance with activity of daily living (ADL ' s) and had no impairment to upper or lower extremities. The most recent Minimum Data Set (MDS) dated 5/14/16, revealed Resident #71 required total assistance with ADL ' s and had no impairment to upper or lower extremities. An observation on 7/20/16 at 3:34pm, Nurse # 2 revealed Resident #71 right wrist were stiff and the right thumb was under the right index finger to the palm of the hand. Four fingers were curled to the palm. Resident #71 was asked to open his hand. He was not able to open his hand. The nurse manually opened the fingers and thumb. She indicated his right hand was contracted. During interview on 7/21/16 at 10:07am, MDS Nurse revealed Resident #71 had impaired extremities. She indicated his MDS assessments were coded wrong. During interview on 7/21/16 at 1:17pm, Director of Nursing indicated Resident #71 was admitted with impairment to the right side and that the	F 272	This Plan of Correction constitutes written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists. This Plan of Correction is submitted to meet requirements established by state and federal law. F-272 1. For Resident # 71 the MDS Coordinator submitted corrected assessments with Assessment Reference Dates of (indicate all ARD□s that were corrected) The corrected assessments appropriately indicated the resident had functional limitations to the right and left upper extremities. This was completed on 7/21/16 2. For residents having the potential to be affected by the same deficient practice The Director of Nursing or her designee will assess all current residents for functional limitations of extremities by 08/18/16. The MDS Coordinator will audit to ensure their MDS has been coded correctly on their Comprehensive Assessments regarding impaired extremities. If discrepancies are found inaccurate MDS assessments will be corrected by 8/18/16 3. The systemic changes to ensure that deficient practice will not occur; the MDS Coordinator will be reeducated by our Clinical Nurse Consultant for accuracy on	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345559	A. BUILDING _____ B. WING _____	C 07/21/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS	2105 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) COMPLETION DATE
F 272	Continued From page 2 correct MDS coding was impairment to one side.	F 272	her MDS Coding of The in-service for the MDS Coordinator will be conducted by August 17, 2016 by the Clinical Nurse Consultant. 4. The Weekly Skin Observation form will be amended to include an area to indicate any reduced/limited function of upper or lower extremities. This change will be implemented by 8/12/2016 and licensed staff will be in-serviced regarding the change by the DON or designee by 8/17/2016. Comprehensive Assessments and Weekly Skin Observation forms will be audited weekly for discrepancies related to functional limitations of upper and lower extremities. This audit will be conducted by the Residents at Risk committee for four weeks and then bi-monthly for two months, and/or a pattern of compliance is achieved. The results will be noted and reviewed in the monthly Quality Assurance Committee.	