

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2017  
FORM APPROVED  
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345559</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOMESTEAD HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2106 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103</b>	
(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 164 SS=E	<p>483.10(h)(1)(3)(i); 483.70(i)(2) <b>PERSONAL PRIVACY/CONFIDENTIALITY OF RECORDS</b></p> <p>483.10 (h)(l) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.</p> <p>(h)(3)The resident has a right to secure and confidential personal and medical records.</p> <p>(i) The resident has the right to refuse the release of personal and medical records except as provided at §483.70(i)(2) or other applicable federal or state laws.</p> <p>§483.70 (i) Medical records. (2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation</p>	F 164	<p>Plan of Correction CCN: 345559 Homestead Hills Annual and Complaint Survey 8/20/17 to 8/23/17</p> <p>This document is to maintain compliance with CMS based upon our DHSR Annual and Complaint Survey held August 20<sup>th</sup>, 2017 through August 23<sup>rd</sup>, 2017. This document does not serve as admission of guilt or fault from Homestead Hills.</p> <p>F164</p> <p>Report sheets that were on medication cart for hall 1 were covered and no longer accessible to visitors and other people inside of the facility. Report sheets that were on the treatment cart for hall 1 were covered.</p>	

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

TITLE

LAHA

(X5) DATE

9/27/2017

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.

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F 164	<p>Continued From page 1</p> <p>purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512. This REQUIREMENT is not met as evidenced by:</p> <p>Based on observations and staff interviews, the facility failed to protect residents' medical information on 2 of 3 carts (1 medication cart and 1 treatment cart) on 1 of 2 halls.</p> <p>The findings include:</p> <p>1) On 8/22/17 at 11:02 am, an observation of medication cart on hall 1 revealed 2 report sheets (stating resident health, medical and personal information) on top of the cart accessible to visitors and other people inside the facility who were walking in the hall at the time of the observation.</p> <p>On 8/22/17 at 11:03 am, an interview completed with the Nurse Supervisor and Interim DON (Director of Nursing) who both stated that these papers which included health information for 29 residents should not be on top of the cart. These sheets of paper were immediately placed under a book on top of the medication cart.</p> <p>2) On 8/23/17 at 11:55 am, an observation of the treatment cart on hall 1 revealed nursing report sheets lying on top of medication cart exposing resident confidential protected health information accessible to visitors and other people inside the facility. There was no staff in proximity of the cart.</p> <p>On 8/24/17 at 8:00 pm, in an interview with the Administrator, she stated that her expectation</p>	F 164	<p>A cart audit by DON was completed of both medication carts and the treatment cart on the unit with no signs of PHI uncovered or accessible to visitors or other people inside of the facility.</p> <p>Licensed Nursing Staff was re-educated on HIPAA on August 24<sup>th</sup>, 2017.</p> <p>The 2 medication carts and treatment carts on the unit will be audited 5 times a week per 1 month, 3 times a week per 1 month, and 1 time a week per one month in efforts to ensure compliance of Personal Privacy and Confidentiality of records by DON or Designee. These findings will be shared monthly at the QA</p>	
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F 164	Continued From page 2 was that resident health, medical and personal information be protected and not accessible by visitors or other people inside the building.	F 164	committee meeting over the next 3 months.	
F 166 SS=D	<p>483.10(j)(2)-(4) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES</p> <p>(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.</p> <p>(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.</p> <p>(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:</p> <p>(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman</p>	F 166	<p>Completion Date: 8/25/17</p> <p>F 166</p> <p>Resident 100 no longer resides at the Facility. A new policy is being written in regulatory language to include the resident's right to file grievances anonymously and the right to receive a written response of the investigation, contact information of grievance official and the contact information of independent entities with whom a grievance can be filed.</p> <p>Grievances received after 8/21/17 received a written response.</p>	

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F 166	<p>Continued From page 3 program or protection and advocacy system;</p> <p>(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;</p> <p>(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;</p> <p>(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;</p> <p>(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;</p>	F 166	<p>Nurse Consultant inserviced Administrator and Social Worker on 8/23/17 regarding the November changes from Phase 1.</p> <p>Grievance log will be audited weekly by the Social Worker for ongoing to ensure all grievances received a written follow up meeting the new regulatory guidelines. These guidelines include: written response detailing the investigation, contact information of grievance official, and the contact information of independent entities with whom the grievance can be filed. The results of grievance audits will be shared at the monthly QA meeting from here after. A copy of the new grievance policy will be made available</p>		

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F 166	<p>Continued From page 4</p> <p>(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and</p> <p>(vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.</p> <p>This REQUIREMENT is not met as evidenced by: Based on staff and family interviews and record review, the facility's grievance policy failed to include the resident's right to file grievances anonymously, the contact information of the grievance official including their name, physical and e-mail business address and business phone number, obtain a written decision regarding his or her grievance, the contact information of independent entities with whom grievances may be filed (that is, state agency, quality improvement organization, state survey agency, ombudsman or protection and advocacy system) and failed to ensure that grievance investigation and resolution was provided in writing to 1 of 1 sampled residents (Resident #100) reviewed for grievances.</p> <p>Findings included: 1. The facility policy dated 11/1/12 and titled "Grievance/Concern: Member/Resident/Family" was provided by the Administrator on 8/22/17. A review of the policy revealed that it did not include a resident's right to file grievances anonymously and receive a written response of the</p>	F 166	<p>to new admissions upon admission from 9/18/17 forward. The Social Worker will ensure written responses are completed and sent.</p> <p>Completion Date: 9/18/17</p>		

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F 166	<p>Continued From page 5</p> <p>investigation, the contact information of the grievance official and the contact information of independent entities with whom a grievance can be filed.</p> <p>A review of the "Addendum to Grievance Policy" dated 8/21/17 revealed, "In efforts to comply with Centers for Medicare and Medicaid Services (CMS) Requirements of Participation, the facility will begin offering a written follow up to the resident beginning 8/21/17. This facility was inserviced on 8/21/17 by the Administrator regarding this policy addendum. This means that any grievance filed on or after 8/21/17 would have a written follow up given to the resident in a timely manner."</p> <p>An interview was completed with the Administrator on 8/23/17 at 3:52 PM. She stated the corporate office wrote the facility policies and she thought the required components for grievances wasn't effective until November 2017. She was unaware that the policy did not include anonymity, providing a written response, the name and contact information of the grievance official or the contact information of independent entities. The Administrator was unaware the CMS regulatory language for grievances was updated and effective in November 2016. She said it was her expectation that the updated regulation information pertaining to grievances be included in the grievance policy and that written responses to grievances be provided to residents and/or family members.</p> <p>2. Resident #100 was admitted to the facility on 4/12/17 with diagnoses that included non-Alzheimer's dementia. She discharged on 5/24/17 to an assisted living facility.</p>	F 166			

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F 166	<p>Continued From page 6</p> <p>A review of a grievance filed by Resident #100's family member dated 5/1/17 revealed a concern that Resident #100 was scheduled for a doctor's appointment on the morning of 5/1/17 and the facility forgot to schedule transportation to the appointment.</p> <p>An interview was completed with Resident #100's family member on 8/22/17 at 4:01 PM. The family member stated the facility was able to re-schedule the appointment for later that same day and provided appropriate transportation. He stated the facility responded verbally to his filed grievance but did not issue a written response.</p> <p>An interview was completed with the Administrator on 8/23/17 at 3:52 PM. She stated the corporate office wrote the facility policies and she thought the required components for grievances wasn't effective until November 2017. She was unaware that the policy did not include anonymity, providing a written response, the name and contact information of the grievance official or the contact information of independent entities. The Administrator was unaware the CMS regulatory language for grievances was updated and effective in November 2016. She said it was her expectation that the updated regulation information pertaining to grievances be included in the grievance policy and that written responses to grievances be provided to residents and/or family members.</p>	F 166		
F 167 SS=C	<p>483.10(g)(10)(i)(11) RIGHT TO SURVEY RESULTS - READILY ACCESSIBLE</p> <p>(g)(10) The resident has the right to-</p>	F 167	<p>F 167</p> <p>Informed resident 36 where the survey results were located.</p> <p>Sign was posted in residents living room area as to where the survey results would be located on 8/22/17.</p>	

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F 167	<p>Continued From page 7</p> <p>(i) Examine the results of the most recent survey of the facility conducted by Federal or State surveyors and any plan of correction in effect with respect to the facility; and</p> <p>(g)(11) The facility must--</p> <p>(i) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.</p> <p>(ii) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request; and</p> <p>(iii) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.</p> <p>(iv) The facility shall not make available identifying information about complainants or residents. This REQUIREMENT is not met as evidenced by: Based on observation and resident, family and staff interviews, the facility failed to post the notice of location and availability of the facility's survey results.</p> <p>Findings included: 1. During a tour of the facility on 8/20/17 at 12:00 PM an observation was made that survey results were located in a binder on a table in the entryway to the facility.</p> <p>An observation on 8/20/17 at 12:06 PM revealed</p>	F 167	<p>Admissions office will also have a sign as to where the survey results are located. Admissions office was inserviced on 8/22/17 to add direction to the survey book while signing paperwork with new admissions.</p> <p>Admissions coordinator will report compliance with disclosing to residents and resident families upon admission at the QA committee meeting monthly for the next three months. Administrator designee will randomly audit 5 times for 1 month, 3 times for the following month, and 1 time for the remaining month, new admissions knowledge as to disclosure of the location of the survey results book. These audit findings will also be reported at the QA committee monthly meeting for the next three months.</p>	

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F 167	<p>Continued From page 8</p> <p>there was no notice posted in the facility regarding the availability and location of recent survey results.</p> <p>An observation on 8/21/17 at 10:28 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results.</p> <p>An observation on 8/22/17 at 11:09 AM revealed there was no notice posted in the facility regarding the availability and location of recent survey results.</p> <p>An interview was completed with a family member on 8/22/17 at 1:14 PM. The family member stated she did not know how to access the state survey results in the facility. She was unaware that survey results were available onsite at the facility.</p> <p>An interview was completed with the Administrator on 8/23/17 at 8:53 AM. She stated there was no notice posted in the facility that directed residents and/or families to the location of the survey results but that there should have been a posting available. She reported the survey results were in a book in the entry way between two sets of doors that were accessible 24 hours a day.</p> <p>An interview was completed on 8/23/17 at 4:23 PM with the Executive Director. He stated he expected a sign to be posted informing resident and families of where they could locate the survey results.</p> <p>An interview was completed with Resident #36 on 8/23/17 at 5:54 PM. She stated she had been in</p>	F 167		
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F 167	Continued From page 9 the facility for a month and had no knowledge of the location of the survey results.	F 167	<p style="text-align: center;"><b>F253</b></p> <p>Bedpans in room 520 were replaced, bagged, and labeled. Bedpans in room 522 were replaced, bagged and labeled. Gray wash basin in room 517b was replaced, bagged and labeled. Bedpan in room 517 was replaced, bagged, and labeled. Urine hat and bedpan in room 512 were replaced, bagged, and labeled.</p> <p>All resident rooms were checked for compliance with housekeeping and maintenance services on 8/24/17. Any bedpan, urine hat, or basin that was found to be out of compliance was replaced, bagged, and labeled.</p> <p>Inservice for nursing staff is in process to re-educate NAs as well as licensed nursing staff on the regulation for maintaining sanitary, orderly, and comfortable interior.</p> <p>This includes bagging and labeling urine hats, bedpans, and wash basins as well as the proper storage of the items. They should never be stored on the floor.</p>	
F 253 SS=E	<p>483.10(i)(2) HOUSEKEEPING &amp; MAINTENANCE SERVICES</p> <p>(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to label and store personal care items in semi-private bathrooms occupied with 2 residents for 5 of 24 bathrooms in the facility.</p> <p>Findings include:</p> <p>1a. On 8/21/17 at 10:15 am, an observation of room 520 revealed 2 bedpans unlabeled and unbagged in the semiprivate bathroom. This was a semiprivate room.</p> <p>b. On 8/21/17 at 10:25 am, an observation of room 522 revealed a bedpan and gray wash basin unlabeled and unbagged in the semiprivate bathroom. This was a semiprivate room.</p> <p>c. On 8/21/17 at 10:30 am, an observation of room 517B revealed a gray wash basin unlabeled and unbagged in the semiprivate bathroom. This was a semiprivate room.</p> <p>d. On 8/21/17 at 10:30 am, an observation of</p>	F 253		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345559</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOMESTEAD HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2106 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103</b>		
(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 253	Continued From page 10 room 517 revealed a gray bedpan on the floor unbagged in the semiprivate bathroom. This was a semiprivate room.  e. On 8/21/17 at 10:50 am, an observation of room 512 revealed a urine hat and collection container on the floor, bedpan unbagged and unlabeled in the semiprivate bathroom. This was a semiprivate room.  On 8/21/17 at 3:20 pm, an interview Administrator confirmed that nursing assistants (NAs) were responsible for labeling all items with the residents' names in semi-private rooms. Items such as bed pans and basins were to be labeled and stored in a bag in the residents' bathroom or where the residents preferred for it to be stored.  On 8/22/17 at 9:00 am interview with housekeeping staff (HS) #2 confirmed that NAs were responsible for the handling and storage of personal care items kept in semi-private bathrooms.  On 8/22/17 at 10:20am an interview with HS #1 confirmed that NAs were responsible for the handling and storage of personal care items kept in semi-private bathrooms.	F 253	Room audits will be completed 5 times a week for 1 month, 3 times a week for the next month, and 1 time a week for the last month by the DON Designee. The findings will be reviewed monthly at the QA meeting for the next three months.  Completion Date: 9/18/17		
F 334 SS=D	483.80(d)(1)(2) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS  (d) Influenza and pneumococcal immunizations  (1) Influenza. The facility must develop policies	F 334	F334  Resident's charts for #43, #47 and #53 remain the same.  Current residents and responsible parties as well as new admissions requesting the influenza and pneumonia vaccination will be educated upon admission and annually thereafter by the DON Designee.  Licensed nursing staff and the Admissions coordinator will be inserviced on providing education to		

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F 334	Continued From page 11 and procedures to ensure that-  (i) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;  (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period;  (iii) The resident or the resident's representative has the opportunity to refuse immunization; and  (iv) The resident's medical record includes documentation that indicates, at a minimum, the following:  (A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization; and  (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.  (2) Pneumococcal disease. The facility must develop policies and procedures to ensure that-  (i) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization;	F 334	patients or responsible party prior to administering the influenza or pneumonia vaccination.  A consent book containing the influenza and pneumonia vaccinations will be kept at the facility to provide a paper copy of the consent as well as evidence that the resident or responsible party was given education prior to consenting or declining the influenza or pneumonia vaccination. This will begin  on 9/18/17 for the new admissions arriving on that date or after.  The consent book will be kept for the year to ensure all residents or responsible parties were educated and had the opportunity to consent or decline the influenza or pneumonia vaccination.		

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F 334	<p>Continued From page 12</p> <p>(ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized;</p> <p>(iii) The resident or the resident's representative has the opportunity to refuse immunization; and</p> <p>(iv) The resident's medical record includes documentation that indicates, at a minimum, the following:</p> <p>(A) That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and</p> <p>(B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to maintain signed vaccine education information sheets in the record for 2 of 5 residents (#47 and #53) reviewed for immunizations.</p> <p>The findings included:</p> <p>1a. A review of the facility's Preventative Health Care report revealed that resident #47 received the influenza vaccine on 9/8/16. There were no signed vaccine education information sheets for Resident # 47.</p> <p>b. A review of the facility's Preventative Health</p>	F 334	<p>The consent book will be randomly audited bi-monthly by the Administrator designee to ensure compliance with keeping record of offering and educating on the influenza and pneumonia vaccination. These findings will be discussed monthly at the QA committee meeting for the next three months.</p> <p>Completion Date: 9/18/17</p>	

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F 334	Continued From page 13 Care report revealed that Resident # 53 received the influenza vaccine on 9/8/16. There were no signed vaccine education information sheets for Resident # 53.  On 8/22/17 at 10:23 am, the interim ADON (Assistant Director of Nursing) confirmed that signed vaccine education sheets for vaccines and immunizations were entered in to the electronic medical record (EMR) under the assessment screen after the resident or RP signed them.  On 8/23/17 at 10:20 am, interview with interim ADON revealed that she could not locate signed vaccine education documentation for 2 of 5 residents (Residents # 47 and # 53) that received vaccines and or immunizations. She confirmed that the expectation for the education to be completed before the immunizations and or vaccines were given and that the copies were scanned into the EMR for viewing and verification.	F 334			
F 367 SS=D	483.60(e)(1)(2) THERAPEUTIC DIET PRESCRIBED BY PHYSICIAN  (e) Therapeutic Diets  (e)(1) Therapeutic diets must be prescribed by the attending physician.  (e)(2) The attending physician may delegate to a registered or licensed dietitian the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by State law. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and	F 367	F367  Resident #16's supplement order for Boost Pudding was clarified on 8/22/17.  CDM will complete a review of all resident supplement orders to ensure our residents are receiving supplements according to orders.		

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F 367	<p>Continued From page 14</p> <p>record reviews, the facility failed to serve the nutritional supplement during lunch and dinner as recommended by the RD (Registered Dietician) and ordered by the Physician for 1 of 1 resident (Resident #16) receiving Hospice Services.</p> <p>Findings included:</p> <p>Resident #16 was admitted to the facility on 1/5/16 with diagnoses which included: squamous cell carcinoma of skin, malignant neoplasm of skin, scalp and neck, abnormal weight loss, and diverticulitis of the large intestine.</p> <p>Resident #16 was admitted to Hospice Services on 6/7/16 with the primary diagnosis of senile degeneration of the brain.</p> <p>Review of the clinical records included a Physician's Order dated 11/11/16 revealed Resident #16 was to receive five ounces of vanilla Boost pudding (nutritional supplement) with her lunch and dinner meals every day.</p> <p>The annual Minimum Data Set (MDS) dated 6/10/17 indicated Resident #16 was moderately, cognitively impaired; required supervision with eating; and received hospice services.</p> <p>The Care Plan dated 6/16/17 revealed Resident #16 was a hospice resident who required a mechanically soft diet with nectar thickened liquids; decline and weight loss was expected. One of the interventions to help increase the resident's nutritional status and promote weight maintenance was to add Boost pudding twice a day.</p>	F 367	<p>Licensed Nursing staff will be re-educated on transcribing supplement orders accurately into the Electronic Health Records (EHR) system. A spreadsheet of residents who require supplements will be kept in the diet slip book and maintained by the CDM as a reference guide for nursing staff to ensure residents are receiving supplements as ordered for those that receive at meal time. For those supplements not received at meal times, the supplements appear on the Medication Administration Record (MAR).</p> <p>CDM or DON Designee will conduct an audit 3 times a week at random meal times for one month and 1 time a week for two months to ensure residents are receiving supplements according to orders. The findings will be discussed at the QA meeting monthly for the next three months.</p>	
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F 367	<p>Continued From page 15</p> <p>During a dining observation on 8/21/17 at 11:30 a.m., Resident #16 was in the dining room feeding herself a meal of mechanical soft consistency and drinking nectar thickened beverages. Throughout the meal service, the resident was not offered or served Boost pudding.</p> <p>During an interview on 8/22/17 at 2:49 p.m., Staff Nurse (SN#1) indicated she had worked with Resident #16 for a year and the resident was alert and oriented to self with confusion of time and place. She stated that the resident ate her meals in the dining room and consumed approximately 25-75% of all meals. SN#1 confirmed the resident had orders for Med Pass 2.0 and Boost pudding (nutritional supplements). SN#1 stated she was not sure if the resident received the five ounces of the Boost pudding during lunch and dinner.</p> <p>On 8/22/17 at 5:00 p.m., Resident #16 was observed in the dining room feeding herself a meal of mechanical soft consistency and drinking nectar thickened beverages. Throughout the meal service, the resident was not offered or served Boost pudding.</p> <p>Review of Resident #16's Diet Slip (which was maintained in a notebook on the meal serving line in the dining room) indicated the resident was to receive Boost pudding twice a day. Throughout the meal service observation, the serving staff did not refer to the notebook containing the residents' diet slips to ensure residents received meals as ordered.</p> <p>During an interview on 8/22/17 at 6:17 p.m., the Certified Dietary Manager (CDM) revealed that several months ago the Registered Dietician recommended Resident #16 receive Boost</p>	F 367		



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F 367	<p>Continued From page 15</p> <p>During a dining observation on 8/21/17 at 11:30 a.m., Resident #16 was in the dining room feeding herself a meal of mechanical soft consistency and drinking nectar thickened beverages. Throughout the meal service, the resident was not offered or served Boost pudding.</p> <p>During an interview on 8/22/17 at 2:49 p.m., Staff Nurse (SN#1) indicated she had worked with Resident #16 for a year and the resident was alert and oriented to self with confusion of time and place. She stated that the resident ate her meals in the dining room and consumed approximately 25-75% of all meals. SN#1 confirmed the resident had orders for Med Pass 2.0 and Boost pudding (nutritional supplements). SN#1 stated she was not sure if the resident received the five ounces of the Boost pudding during lunch and dinner.</p> <p>On 8/22/17 at 5:00 p.m., Resident #16 was observed in the dining room feeding herself a meal of mechanical soft consistency and drinking nectar thickened beverages. Throughout the meal service, the resident was not offered or served Boost pudding.</p> <p>Review of Resident #16's Diet Slip (which was maintained in a notebook on the meal serving line in the dining room) indicated the resident was to receive Boost pudding twice a day. Throughout the meal service observation, the serving staff did not refer to the notebook containing the residents' diet slips to ensure residents received meals as ordered.</p> <p>During an interview on 8/22/17 at 6:17 p.m., the Certified Dietary Manager (CDM) revealed that several months ago the Registered Dietician recommended Resident #16 receive Boost</p>	F 367			

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F 367	Continued From page 16 pudding twice a day, with her lunch and dinner meals. She confirmed the resident should have received the Boost pudding with her dinner meal; but, the serving staff did not serve it to her. The CDM stated the Boost pudding was available and the serving staff were aware the pudding was stored in the snack food closet in the dining room.	F 367	F371	
F 371 SS=F	<p>483.60(i)(1)-(3) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY</p> <p>(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities.</p> <p>(i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations.</p> <p>(ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices.</p> <p>(iii) This provision does not preclude residents from consuming foods not procured by the facility.</p> <p>(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety.</p> <p>(i)(3) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility staff failed to store uncooked meats</p>	F 371	<p>The ground beef was thrown away on 8/20/17. Ice cream, cookie dough and chicken tenders were discarded. The kitchen was deep cleaned on 8/24/17. Hair nets were placed at the access point to the kitchen in a visible position. Dietary Aide was inserviced on 8/20/17 immediately after the unsanitary opening of the coffee was brought to the administrator attention. The dishwasher was brought to 120 degrees Fahrenheit and all dishes were rewashed immediately. On 8/23/17 the dishwasher was re-educated by the Assistant Director of Dining Services on washing his hands between handling soiled dishes and clean dishes immediately and all dishes were rewashed.</p>	

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F 371	<p>Continued From page 17</p> <p>separately from cooked meats and vegetables, failed to reseal opened food items in 2 of 2 walk-in refrigerator units; failed to maintain food service equipment clean and free from debris; failed to use proper food handling practices and wear hair coverings in the kitchen; failed to maintain dishwasher at a temperature that would clean and sanitize dishes and utensils.</p> <p>Findings included:</p> <p>1a. During the initial tour of the kitchen on 8/20/17 at 10:55 a.m., an observation of the walk-in cooler revealed a multishelf, open-sided delivery cart containing one large stainless steel pan containing 1-uncooked corn beef brisket, 1-uncooked sleeve of ground beef, and 1-resealed bag of cooked ham. The pan also contained a red fluid beneath the meats. The shelf directly beneath the pan of meats contained 2-six inch deep quarter pans of cooked vegetables covered with cellophane. The dietary cook revealed he had placed the uncooked ground beef on the pan in preparation for cooking for the dinner meal.</p> <p>On 8/20/17 at 11:00 a.m., the Assistant Director of Dining Services removed the pan from the cooler and discarded the meats. He informed the dietary cook that the uncooked brisket and ground beef should not have been placed on the same pan as the cooked meat and should have been placed on a pan on the lowest shelf in the cart.</p> <p>1b. Observations of the refrigeration units on 8/20/17 at 10:55 a.m. revealed opened food items that were not resealed. There were 3-large</p>	F 371	<p>Dietary Cooks were educated on proper storage of cooked and uncooked meat as well as proper storage regarding covering and sealing bags completely when finished with the product. The Director of Dining Services, Director of Housekeeping, Administrator, and Director of Facility Services met on 8/31/17 to discuss the monthly deep cleaning process as well as the daily cleaning duties to ensure the cleanliness expectations are met moving forward. Dietary Staff is being re-educated on wearing hair nets while working in the kitchen. Dietary staff is being re-educated on how to properly open food in a sanitary fashion. Dishwashers are being re-educated on the proper temperatures and protocols for washing dishes.</p>		

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F 371	<p>Continued From page 18</p> <p>uncovered tubs of ice cream, 1-opened plastic bag of cookie dough, and 2-opened bags of chicken tenders.</p> <p>2. During the tour of the kitchen on 8/20/17 at 10:07a.m., the floor throughout the kitchen was slippery, contained brown/black stains, and was littered with food particles and pieces of cardboard. There was a mop in a bucket of gray/brown water next to the convection ovens during meal preparation. The double convection ovens and the deep fryer were covered with thick, brown, greasy stains. The vents in the hood over the stove were covered with black, greasy lint. The plastic covered table top mixer (which the Assistant Director of Dining Services stated was rarely used) was stained with a white powdery substance in various areas. The can opener holder contained a thick black/brown grease. There were 2-multishelved, open-sided delivery carts containing various food items in the walk-in cooler that had dried brown stains and crumbs.</p> <p>3a. On 8/20/17 at 10:44 a.m., one male dietary staff was observed entering and exiting the kitchen without wearing any hair covering. He was observed at the meal service tray-line and removing food items from the walk-in cooler.</p> <p>During an observation on 8/23/17 at 11:32 a.m., two dietary staff entered and exited the kitchen several times without hair covering. Both staff were collecting food items from the walk-in cooler and taking them to the assisted living dining room located next to the kitchen.</p> <p>During an interview on 8/23/17 at 1:40 p.m., The</p>	F 371	<p>Dietary Cooks were educated on proper storage of cooked and uncooked meat as well as proper storage regarding covering and sealing bags completely when finished with the product. The Director of Dining Services, Director of Housekeeping, Administrator, and Director of Facility Services met on 8/31/17 to discuss the monthly deep cleaning process as well as the daily cleaning duties to ensure the cleanliness expectations are met moving forward. Dietary Staff is being re-educated on wearing hair nets while working in the kitchen. Dietary staff is being re-educated on how to properly open food in a sanitary fashion. Dishwashers are being re-educated on the proper temperatures and protocols for washing dishes.</p> <p>The Director of Dining Services or Designee will observe 3 meals a week for one month and 2 meals a week for 2 months in the SNF kitchen to ensure proper protocols for dishwashing as</p>	

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F 371	<p>Continued From page 19</p> <p>Assistant Director of Dining Services revealed the two dietary staff without the hairnets were dietary aides who attended to the residents' requests in the assisted living dining room. He stated that because the two dietary aides had recently began collecting salads and other produce for these residents from the walk-in cooler in the kitchen, the two aides should wear hairnets.</p> <p>3b. During a meal observation in the dining room on 8/20/17 at 11:45 a.m., a dietary aide opened a bag of coffee using her teeth in a tearing motion. The dietary aide poured the contents of the bag into the coffee pot/maker. The residents were served coffee during and at the completion of their meal.</p> <p>4a. During the tour of the kitchen on 8/20/17 at 10:50 a.m., the thermostat of the low temperature dishwashing machine read 110 degrees Fahrenheit which was below the acceptable temperature of 120 degrees Fahrenheit. The dietary worker continued washing dishes in the machine.</p> <p>During a second observation of the kitchen on 8/23/17 at 1:03 p.m, the water temperature of the low temperature dishwashing machine was 118 degrees Fahrenheit. At 1:14 p.m. the water temperature of the dishwashing machine was 114 degrees Fahrenheit. The dietary staff revealed the water temperature of the dishwashing machine was usually 125 degrees Fahrenheit, but sometimes the temperature would range between 115-118 degrees Fahrenheit if the water in the hot water tank was running low. When asked, the dietary staff indicated he would continue to wash the dishes in the machine when water</p>	F 371	<p>well as opening food are being followed. The Director of Dining Services or designee will audit the temperature of dishwashers 5 times a week for 1 month, 3 times a week for the second month, and 1 time a week for the third month to ensure temperature compliance. The Director of Dining Services or Designee will audit 5 times a week for one month, three times a week for two months, and one time a week for three months to ensure food is stored properly in the cooler. The Administrator designee will audit the kitchen cleanliness 5 times a week for one month, 3 times a week for the second month, and 1 time a week for the third month. These findings of all audits will be discussed in the monthly QA meeting for the next 3 months.</p> <p>Completion Date: 9/19/17</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES  
CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345559</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>08/23/2017</b>
NAME OF PROVIDER OR SUPPLIER  <b>HOMESTEAD HILLS</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103</b>		
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F 371	Continued From page 20 temperature was below 120 degrees Fahrenheit.  During an interview on 8/23/17 at 1:30 p.m., The Assistant Director of Dining Services stated that when the water temperature of the dishwashing machine was low, the water in the water tank was low and the dietary staff were not to continue washing dishes until the water tank filled up. He informed the dietary staff that all of the dishes would have to be rewashed.  4b. During the observation of the dishwashing machine on 8/23/17 at 1:03 p.m, the dietary staff revealed he was the only staff working in the area of the dishwashing machine. The dietary staff was observed scraping food particles from the soiled dishes, placing the rack of soiled dishes into the dishwashing machine and removing the rack of clean dishes from the machine without washing his hands. When asked to describe the procedure for washing dishes in dishwashing machine, the dietary staff included that after placing a rack of dirty dishes into the machine, he would step over to the other side of the dishwashing machine and remove the clean dishes from the machine.  During an interview on 8/23/17 at 1:30 p.m., The Assistant Director of Dining Services stated that the dietary staff should have washed his hands before crossing from the dirty side of the dishwashing machine to the clean side to remove the clean dishes from the dishwashing machine to avoid cross contamination. He informed the dietary staff that all of the dishes would have to be rewashed.	F 371	<b>F372</b>  Dumpster Lid was closed.  2 Dumpsters used by the facility were checked and both dumpster lids were closed.  Staff was inserviced on 9/7/17 at the "All Staff Meeting" on dumpster compliance with keeping the lid and doors closed.  Administrator Designee will monitor the dumpster 3 times a week for 3 months at random to ensure compliance with keeping the dumpster closed. These findings will be reviewed at the QA committee meeting over the next 3 months.  Completion Date: 9/7/17		
F 372 SS=D	483.60(i)(4) DISPOSE GARBAGE & REFUSE PROPERLY	F 372			

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F 372	Continued From page 21  (i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to ensure 1of 1 garbage dumpster properly concealed the waste within.  Findings included:  During an observation of the dumpster area behind the facility on 8/20/17 at 11:15 a.m. accompanied by the Assistant Director of Dining Services, the top lid of the garbage dumpster was open exposing bags of garbage within. There was an unpleasant odor surrounding the area. The Assistant Director indicated the top lid was open due to the fullness of the dumpster and opening the dumpster's side doors would cause the garbage to fall out. He revealed that the trash in the dumpster was scheduled to be picked up twice a week, Mondays and Thursdays.	F 372	F464  Dining Room was rearranged on 8/23/17 to better suit the spacing needs of the residents.  A picture of the proper arrangement of dining room tables is to be framed and hung in the dining room to remind all staff who use the space as to the proper arrangement of the dining room tables.  Inservicing will be completed with nursing, housekeeping, dietary, and the life enrichment leader for skilled nursing as to the proper arrangement of the dining room tables.  Administrator Designee will audit the dining room arrangement 3 times a week for one month and 1 time a week for two months to ensure the facility is meeting		
F 464 SS=D	483.90(h)(1)-(4) REQUIREMENTS FOR DINING & ACTIVITY ROOMS  (h) Dining and Resident Activities  The facility must provide one or more rooms designated for resident dining and activities.  These rooms must--  (1) Be well lighted;  (2) Be well ventilated;  (3) Be adequately furnished; and	F 464			

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F 464	<p>Continued From page 22</p> <p>(4) Have sufficient space to accommodate all activities. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to provide sufficient space to accommodate residents in wheelchairs in 1 of 1 dining room.</p> <p>Findings included:</p> <p>During a meal observation on 8/20/17 at 11:45 a.m., nineteen residents were eating lunch in the dining room. Several of the residents were sitting at the tables in wheelchairs. Some of the residents consumed their meals at a slower rate than the other residents. When some of the residents finished eating and attempted to leave the dining room, there was not enough space between the tables for wheelchair mobility. The staff in the dining room were observed moving residents in wheelchairs (who were still eating) away from the tables to allow the other residents to propel their wheelchairs between the tables, uninhibited. The staff returned the residents who were removed back to the tables so they could continue with their meals.</p> <p>During an observation of the dining room during the dinner meal on 8/22/17 at 5:00 p.m., there was not enough space between the tables for wheelchair mobility. Residents who completed their meals sooner than other residents had difficulty maneuvering their wheelchairs between the tables occupied by other residents in wheelchairs. The staff were observed moving residents (who were still eating) away from the</p>	F 464	<p>the spacing needs of the residents. The findings will be discussed at the QA committee meeting monthly over the next three months.</p> <p>Completion Date: 9/19/17</p>		



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F 464	<p>Continued From page 23</p> <p>tables so that residents (who had finished their meals) were able to maneuver their wheelchairs between the tables and exit the dining room. The staff returned the residents who were removed back to the tables so they could continue with their meals.</p> <p>During an interview on 8/22/17 at 6:17 p.m., the Certified Dietary Manager acknowledged there was insufficient space between the tables in the dining room for wheelchair mobility.</p> <p>During an interview on 8/23/17 at 4:48 p.m., the Administrator revealed the sitting capacity of the dining room was forty-nine and there were ten tables with each table able to seat four residents. She indicated a different dining room set-up would be arranged, immediately.</p>	F 464			