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 _____	04/25/2024

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

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E 000	Initial Comments An unannounced recertification survey was conducted on 4/22/24 through 4/25/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M22411.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 4/22/24 through 4/25/24, Event ID# M22411.	F 000		
F 770 SS=D	Laboratory Services CFR(s): 483.50(a)(1)(i) §483.50(a) Laboratory Services. §483.50(a)(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. (i) If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories specified in part 493 of this chapter. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to obtain laboratory blood work as ordered for 2 of 5 residents reviewed for unnecessary medications. (Resident #4 and Resident #7) The findings included: 1.Resident #4 was admitted to the facility 1/3/24 with diagnoses type 2 diabetes mellitus, cognitive impairment, and lymphoma. Resident #4's admission Minimum Data Set (MDS) dated 1/9/24 revealed he was severely cognitively impaired and Resident #4 took insulin	F 770	1. How will the facility address the deficient practice - The facility secured all ordered lab work for resident #4 and #7 on 4/24/24. All labs for resident #4 were within acceptable range for that resident. All labs for resident #7 were also within acceptable limits. 2. How will the facility identify other residents potentially effected by the deficient practice - The facility did a six month look back on all ordered labs for all residents. All issues identified were corrected. This issue was sent to the	5/14/24

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

Electronically Signed | 05/14/2024

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 770	Continued From page 1 injections. An order for Resident #4 dated 1/3/2024 for a routine Complete Metabolic Panel (CMP), a Complete Blood Count (CBC) with differential, a Lipid Panel, and a Hemoglobin A1C was marked as completed by Nurse #5. Attempts to reach Nurse #5 were unsuccessful. Further review of Resident #4's medical record revealed there were no lab results for the 1/3/2024 order. During an interview with the Nurse Practitioner on 4/24/24 at 2:09 pm, she stated that when she orders blood work for a resident, she will either enter the order in the electronic chart herself or she will let the staff do it for her. She stated that she ordered blood work for this patient as a baseline upon admission due to his diagnosis of diabetes. She was unaware of the process used by the facility to communicate to the lab that a resident needed blood work drawn. She stated her expectation was she would order the lab work and the staff would ensure that it was done. She was unaware that Resident #4 had not had blood work completed by the lab. During and interview with the Director of Nursing (DON) on 4/25/24 at 10:47 am, she stated that with the current electronic chart system, the nurse will review any orders made by the nurse practitioner or doctor, submit all laboratory orders via paper requisition that the nurse fills out and it is placed in the external lab book at the nurse's station. She stated that the lab technician will come 5 or 6 times a week, draw the ordered lab work based on the requisitions in his/her notebook, and then send the results to the facility	F 770	QAPI committee and will be monitored weekly for a period of 3 months and monthly thereafter by the DON or designee. 3. What measures will be put in place to ensure that the deficient practice will not recur - The facility met with the contract lab company on 4/29 to automate the lab process from paper to electronic. Implementation and training on this new process will be completed by 5/22/24. The DON or designee will monitor this process weekly for a period of 3 months and monthly thereafter to ensure successful implementation. 4. The facility will monitor all corrective actions weekly for 3 months and monthly thereafter. Monitoring will be conducted by the DON or designee in conjunction with the QAPI committee. The facility will be in compliance with all state requirements by 5/22/24.	

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F 770	Continued From page 2	F 770		

via fax when completed. The DON was unaware that two residents had not received their blood work as ordered and was unable to say why the order was marked completed.

2. Resident #7 was admitted to the facility on 6/18/21 with diagnoses dementia, type 2 diabetes mellitus, vitamin d deficiency and chronic kidney disease.

Resident #7's quarterly MDS dated 2/12/24 revealed she was severely cognitively impaired.

An order for Resident #7 dated 3/13/2024 for a routine Hemoglobin A1C, Vitamin D level, and a TSH (Thyroid stimulating hormone), was marked as completed by Nurse #5.

Further record review showed there was no evidence of the lab being drawn.

Attempts to reach Nurse #5 were unsuccessful.

During an interview with the Nurse Practitioner on 4/24/24 at 2:09 pm, she stated that when she orders blood work for a resident, she will either enter the order in the electronic chart herself or she will let the staff do it for her. She stated that she ordered blood work for this patient as a 6 month monitor for her diabetes and vitamin d deficiency diagnoses. She was unaware of the process used by the facility to communicate to the lab that a resident needed blood work drawn. She stated her expectation was she would order the lab work and the staff would ensure that it was done. She was unaware that Resident #7 had not had blood work completed by the lab.

During an interview with the Director of Nursing

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F 770	Continued From page 3 (DON) on 4/25/24 at 10:47 am, she stated that with the current electronic chart system, the nurse will review any orders made by the nurse practitioner or doctor, submit all laboratory orders via paper requisition that the nurse fills out and it is placed in the external lab book at the nurse's station. She stated that the lab technician will come 5 or 6 times a week, draw the ordered lab work based on the requisitions in his/her notebook, and then send the results to the facility via fax when completed. The DON was unaware that two residents had not received their blood work as ordered and was unable to say why the order was marked completed.	F 770		