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 _____	06/20/2018

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 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status. (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication	F 636		7/18/18

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

Electronically Signed | 07/11/2018

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F 636	Continued From page 1 with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility failed to complete a comprehensive admission assessment within 14 days of admission for 1 of 16 sampled residents. (Resident #30). The findings included: Resident #30 was admitted to the facility on 11/16/17 with diagnoses of cerebral infarction muscle weakness, lack of coordination, Alzheimer's disease, and HTN (Hypertension). During a review of Resident #30's most recent MDS (minimum data set) was coded as a quarterly assessment and dated 2/10/18. The MDS assessed the resident as having impaired	F 636	1. After an internal root cause analysis was completed, it was determined that an effective process for ensuring the completion of comprehensive admission assessments was not in place. 2. The comprehensive admission assessment for Resident #30 was completed on 7/11/18. Resident #30 is no longer a resident of the facility. 3. Director of Clinical Services and/or designee has re-educated the MDS Coordinator on the Resident Assessment Instrument guidelines regarding completing a comprehensive admission assessment within 14 days of admission	

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F 636	Continued From page 2 cognition, incontinence of bowel and bladder, requiring assistance with all personal care and use of antidepressant medications. During a review of Resident #30's electronic medical record revealed there had been a comprehensive MDS started with an ARD (Assessment Reference Date- the last day of the MDS look back period) dated 11/23/17. The assessment was not completed after admission or during the resident's stay. On 6/20/18 at 6:20pm an interview was conducted with the Director of Nursing. She confirmed the comprehensive admission assessment dated 11/23/17 was incomplete and not finished. The Director of Nursing stated that it was her expectation for comprehensive assessments to be completed within 14 days of admission.	F 636	of a resident on June 20, 2018. Director of Clinical Services and/or designee will monitor the MDS assessment schedules in EMR daily during PPS meeting for completion of Comprehensive assessments daily 5 times a week. Monitoring will be ongoing. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	
F 637 SS=D	Comprehensive Assessment After Signifcant Chg CFR(s): 483.20(b)(2)(ii) §483.20(b)(2)(ii) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status, and requires interdisciplinary review or revision of the	F 637		7/18/18

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F 637	Continued From page 3 care plan, or both.) This REQUIREMENT is not met as evidenced by: Based on observation, record review and staff interview, the facility failed to complete a SCSA (significant change in status assessment) for a resident readmitted to the facility with a fracture to the left hip with no surgical intervention resulting in decline in ADL's and pain for 1 of 16 residents. (Resident #16) Resident #16 was admitted to the facility on 8/22/17 with a cumulative diagnosis of benign neoplasm of meninges and headache and readmitted to facility on 11/13/17 with diagnosis of fracture of head of left femur. A review of Resident #16's admission MDS (minimum data set) dated 8/29/17, revealed she was cognitively intact, required supervision for locomotion and limited assistance of one staff member for bed mobility, transfers, dressing, personal hygiene or locomotion and eating and required no pain medications. A review of Resident #16's electronic medical record revealed a Significant Change Assessment with ARD (Assessment Reference Date- last day of the MDS look back period) of 11/20/17 not completed. Sections A, B, C, G, H, J, M, N, O, P, V were incomplete. A review of Resident #16's quarterly MDS dated 2/10/18 indicated she was cognitively intact, required extensive assistance of 2 staff for bed mobility, transfer, dressing and was dependent on 2 staff members for toileting, personal hygiene and bathing and received daily pain medications.	F 637	1. After an internal root cause analysis was completed, it was determined that an effective process for completing the significant change status assessment was not in place. 2. The significant status assessment for Resident #16 was completed on July 11, 2018. 3. Director of Clinical Services and/or designee has re-educated the MDS Coordinator on the Resident Assessment Instrument guidelines regarding completing the significant change status assessment within 14 days of the significant change on June 20, 2018. Director of Clinical Services and/or designee will Educate Clinical management team on criteria for a significant change on July 12, 2018. Director of Clinical Services and/or designee will perform Quality Improvement Monitoring of significant change status assessments. IDT/Clinical Management team to audit residents for Significant change weekly in Clinical Management Team Meeting as an on-going process. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not	

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F 637	Continued From page 4 A review of Resident #16's quarterly MDS dated 5/7/18 indicated she was cognitively intact, required extensive assistance of 2 staff for bed mobility, dressing, toileting, personal hygiene and dependent on 2 staff for bathing and received pain medications daily. A review of a physician progress notes dated 11/14/17 revealed Resident #16 suffered a fall 11/19/17 resulting in left hip fracture. The note further stated that the resident and family opted not to have surgical intervention. On 6/20/18 at 9:15am an interview was conducted with the Director of Nursing and MDS coordinator. The Director of Nursing and MDS Coordinator agreed that a significant change assessment should have been done for Resident #16. Both confirmed the Significant Change in Status MDS dated 11/20/17 was incomplete and not finished. On 6/20/18 at 4:00pm an interview was conducted with the Director of Nursing. She stated that it was her expectation that MDS assessments be completed and submitted in a timely manner and that either a significant change or comprehensive MDS should have been completed for Resident #16 after 11/13/17 due to noted physical decline and increased pain.	F 637	limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	
F 640 SS=E	Encoding/Transmitting Resident Assessments CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data processing requirement- §483.20(f)(1) Encoding data. Within 7 days after a facility completes a resident's assessment, a facility must encode the following information for	F 640		7/18/18

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F 640	Continued From page 5	F 640		

each resident in the facility:
(i) Admission assessment.
(ii) Annual assessment updates.
(iii) Significant change in status assessments.
(iv) Quarterly review assessments.
(v) A subset of items upon a resident's transfer, reentry, discharge, and death.
(vi) Background (face-sheet) information, if there is no admission assessment.

§483.20(f)(2) Transmitting data. Within 7 days after a facility completes a resident's assessment, a facility must be capable of transmitting to the CMS System information for each resident contained in the MDS in a format that conforms to standard record layouts and data dictionaries, and that passes standardized edits defined by CMS and the State.

§483.20(f)(3) Transmittal requirements. Within 14 days after a facility completes a resident's assessment, a facility must electronically transmit encoded, accurate, and complete MDS data to the CMS System, including the following:
(i)Admission assessment.
(ii) Annual assessment.
(iii) Significant change in status assessment.
(iv) Significant correction of prior full assessment.
(v) Significant correction of prior quarterly assessment.
(vi) Quarterly review.
(vii) A subset of items upon a resident's transfer, reentry, discharge, and death.
(viii) Background (face-sheet) information, for an initial transmission of MDS data on resident that does not have an admission assessment.

§483.20(f)(4) Data format. The facility must

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F 640	Continued From page 6 transmit data in the format specified by CMS or, for a State which has an alternate RAI approved by CMS, in the format specified by the State and approved by CMS. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to complete and transmit Discharge Tracking MDS (Minimum Data Set) assessments within the required time frame for 5 of 6 residents (Resident #1, #2, #3, # 4, and # 5) selected to be reviewed for submission of Resident Assessments within the required time frame. Findings included: 1. Resident # 1 was admitted to the facility on 12/22/17 with diagnoses that included Cardiomyopathy, Heart Failure and Chronic Obstructive Pulmonary Disease. A review of Resident # 1's most recent completed MDS was dated 12/31/17. The assessment was coded as an admission assessment. A review of Resident # 1's face sheet had resident as being discharged on 1/12/2018. During an interview on 6/20/18 at 5:30 pm with the MDS coordinator, she indicated the resident had expired in the facility on 1/12/18. She further added an assessment had been started but not completed. She explained that the nurse that was doing the assessment was no longer employed by the facility and she could not speak to why the assessment was not completed. She stated one should have been completed on 1/12/18 and that she would complete and	F 640	1. After an internal root cause analysis was completed, it was determined that an effective process for completing and transmitting the Discharge Tracking MDS assessments within the required time frame was not in place. 2. The Discharge Tracking MDS assessments for Residents #1, #2, #3, #4, #5, have all been completed and submitted. 3. Director of Clinical Services and/or designee has re-educated the MDS Coordinator on the Resident Assessment Instrument guidelines regarding the timely completion and submission of the Discharge Tracking MDS assessment for residents. Director of Clinical Services and/or designee will review MDS assessment schedule 5X weekly in PPS meeting ongoing. MDS Coordinator will bring transmission report to clinical management meeting weekly to ensure completeness and transmission of discharges in order to verify all discharge tracking MDS have been submitted to CMS. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the	

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F 640	Continued From page 7 transmit the assessment. 2. Resident #2 was admitted to the facility on 12/27/17 with diagnoses that included Osteoarthritis and a Right Fernur Fracture. A review of Resident # 2's most recent completed MDS was dated 1/3/18. The assessment was coded as an admission assessment. A review of Resident # 2's face sheet had resident as being discharged on 1/18/2018. During an interview on 6/20/18 at 5:30 pm with the MDS coordinator, she indicated the resident was discharged on 1/18/18. She further added an assessment had been started but not completed. She stated a discharge tracking assessment should have been completed on 1/18/18 and that she would complete and transmit the assessment. 3. Resident #3 was admitted to the facility on 12/11/17 with diagnoses that included Type 2 Diabetes Mellitus and a Right Fernur Fracture. A review of Resident # 3's most recent completed MDS was dated 12/23/17. The assessment was coded as a PPS unscheduled assessment. A review of Resident # 3's face sheet had resident as being discharged on 1/5/2018. During an interview on 6/20/18 at 5:30 pm with the MDS coordinator, she indicated the resident went home with home health 1/5/18. She further added an assessment had been started but not	F 640	Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	

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F 640	Continued From page 8	F 640		

completed. She stated a discharge tracking assessment should have been completed on 1/5/18 and that she would complete and transmit the assessment.

4. Resident #4 was admitted to the facility on 12/20/17 with a diagnosis of Chronic Obstructive Pulmonary disease with acute exacerbation.

A review of Resident # 4's most recent completed MDS was dated 1/1/18. The assessment was coded as a PPS 14-day assessment.

A review of Resident # 4's face sheet had resident as being discharged on 1/7/2018.

During an interview on 6/20/18 at 5:30 pm with the MDS coordinator, she indicated the resident was discharged to the hospital on 1/7/18. She further added an assessment had been started but not completed. She stated a discharge tracking assessment should have been completed on 1/7/18 and that she would complete and transmit the assessment.

5. Resident #5 was admitted to the facility on 12/20/17 with diagnoses that included Congestive Heart Failure and Cellulitis of the left lower extremity.

A review of Resident # 5's most recent completed MDS was dated 1/1/18. The assessment was coded as a PPS 14-day assessment.

A review of Resident # 5's face sheet had resident as being discharged on 1/14/2018.

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F 640	Continued From page 9 During an interview on 6/20/18 at 5:30 pm with the MDS coordinator, she indicated the resident was discharged to the hospital on 1/14/18. She further added an assessment had been started but not completed. She stated a discharge tracking assessment should have been completed on 1/14/18 and that she would complete and transmit the assessment. During an interview with the DON (Director of Nursing), who was also present during the interview with the MDS coordinator, on 6/20/18 at 5:50 pm, the DON stated she expected all required MDS assessments be completed and transmitted within the required time frame.	F 640		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).	F 656		7/18/18

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F 656	Continued From page 10 (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff interviews, the facility failed to develop a comprehensive care plan for 2 of 16 (Resident #12 and Resident #30) sampled residents and failed to develop an individualized care plan for pain after a fracture for 1 of 16 (Resident #16) sampled residents. The findings included: 1) Resident #12 was admitted to the facility on 4/20/18 with diagnoses that included: dementia with behavioral disturbance, hypothyroidism, COPD (chronic obstructive pulmonary disease), osteoarthritis, low back pain, chronic pain, glaucoma, generalized anxiety disorder and wedge compression fracture of lumbar vertebrae.	F 656	1. An internal root cause analysis was completed, it was determined that an effective process for ensuring the development of comprehensive and individualized care plans was not in place. 2. The comprehensive care plan for Resident #12 and #30 have been completed. The individualized care plan for Resident #16 has been completed. Resident #12 has been discharged. Resident #30 expired in May 2018. 3. Director of Clinical Services and/or designee has re-educated the MDS Coordinator on the Resident Assessment Instrument guidelines regarding the development of comprehensive and individualized care plans. Director of	

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F 656	Continued From page 11 The admission MDS (minimum data set) dated 4/29/18 indicated Resident #12 had impaired cognition. There were no mood or behavior issues noted. Resident #12 was marked as receiving antipsychotic, antianxiety, antidepressant and opioid medications 7 of 7 days during the MDS review period. The MDS had the resident's diagnoses coded as arthritis, dementia and anxiety disorder. Review of the resident's electronic medical record revealed there was no comprehensive care plan developed within seven days after the admission MDS had been signed as completed. During an interview 6/20/18 at 9:05am, with the Director of Nursing and MDS Coordinator, both validated that a comprehensive care plan had not been developed after the admission MDS dated 4/29/18 had been completed. The Director of Nursing stated that it was her expectation that comprehensive care plans be completed within the required time frame. 2) Resident #30 was admitted to the facility on 11/16/17 and expired on 5/4/18 with diagnoses that included: cerebral infarction due to unspecified occlusion or stenosis of right cerebellar artery, muscle weakness, lack of coordination, Alzheimer's disease with late onset, major depressive disorder, and HTN (hypertension). During a review of Resident #30's most recent MDS was coded as a quarterly assessment and dated 2/10/18. The MDS had documentation of	F 656	Clinical Services and/or designee will perform Quality Improvement Monitoring of comprehensive and individualized care plans to ensure the development and completion of care plans 5X weekly during PPS meeting as an ongoing process. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	

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the resident being assessed as having impaired cognition, incontinence of bowel and bladder, requiring assistance with all personal care and use of antidepressant medication.

During a review of Resident #30's electronic medical record revealed there had not been a comprehensive MDS completed after admission or during the resident's stay.

Review of Resident #30's electronic medical record revealed there was no comprehensive care plan developed within time frame of admission to facility.

During an interview on 6/20/18 at 6:20pm, with the Director of Nursing and MDS coordinator, both validated that a comprehensive care plan had not been developed. The Director of Nursing stated that it was her expectation that comprehensive care plans be completed within the required time frame.

3) Resident #16 was admitted to facility 8/22/17 with a cumulative diagnosis of benign neoplasm of meninges and headache and readmitted to facility 11/13/17 with diagnosis of fracture of head of left femur.

During a review of Resident #16's admission MDS dated 8/29/17, revealed she was cognitively intact and required no pain medications.

A review of Resident #16's electronic medical record revealed a care plan dated 8/29/17 was in place for headaches.

A review of Resident #16's quarterly MDS dated

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2/10/18 indicated she received daily pain medications for hip fracture and osteoporosis.

A review of Resident #16's quarterly MDS dated 5/7/18 indicated she received pain medications daily for hip fracture and headache.

A review of Resident #16's most recent care plan dated 5/16/18 revealed she was care planned for visual function, psychotropic medication use, nutrition and hydration, at risk for pressure ulcers, at risk for falls, and required assistance from staff for personal care, however; pain was not care planned.

A review of Resident #16's current physician orders revealed the following orders related to pain:
A) An order dated 8/22/17 read: Extra Strength Tylenol 500mg (milligrams). Give 1000mg every 8 hours as needed for pain
B) An order dated 5/1/18 read: Ibuprofen 600mg. Give one tablet every 8 hours as needed for pain
C) An order dated 5/3/18 read: Fentanyl patch 12micrograms per hour every 3 days for pain
D) An order dated 12/11/17 read: Morphine Concentrate 20mg/ml (milliliter) oral syringe. Give 0.5ml po (by mouth) every 2 hours as needed for dyspnea (difficult or labored breathing), tachycardia (rapid heart rate) and pain.

A review of a physician progress notes dated 11/14/17 revealed Resident #16 suffered a fall 11/19/17 resulting in a left hip fracture. The resident and family opted not to have surgical intervention.

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A review of a physician progress notes dated 6/14/18 indicated she was never completely pain free on current pain medication regimen.

An interview was conducted with resident on 6/19/18 at 2:00pm. Resident #16 was noted to be lying in her bed watching TV. She stated that she rarely gets out of bed due to severe pain to left hip with any type of movement. She explained that the staff used a mechanical lift to get her out of bed to a wheelchair when she wanted a shower or to go to the beauty shop. Resident #16 stated that she preferred bed baths and her toileting needs taken care of in the bed. When asked to rate her pain on scale of 1-10, at the time of interview she stated, "right now it's 7-8".

An interview was conducted on 6/19/18 at 2:30 pm with NA #1 (nursing assistant). She stated that the resident could use the upright bed rail to aide in turning from side to side with personal care and that the resident guided the NA's on how to move her due to pain in left hip. NA #1 stated that Resident #16's personal care is rendered in the bed with 2 staff members.

An interview was conducted on 6/20/18 at 8:30am with RN #1 (Registered Nurse). RN stated that Resident #16 was alert and oriented and could request pain medication as needed. RN #1 stated that resident's pain was normally a 9-10 (on a scale of 1-10) when pain medication was requested and attempts to reposition were attempted prior to medication. Stated that resident preferred to remain in bed due to hip pain with movement but staff would transfer her to the wheelchair by mechanical lift for the beauty shop and shower when requested. The RN stated that the resident guided staff on how to

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F 656	Continued From page 15 move her for comfort "she doesn't like us to move that leg because it causes a lot of pain". During an interview on 6/20/18 at 4:00pm, the Director of Nursing stated that it was her expectation that all care plans be person centered, comprehensive and that the care plan for Resident #16 should have included a care plan for pain.	F 656		
F 757 SS=D	Drug Regimen is Free from Unnecessary Drugs CFR(s): 483.45(d)(1)-(6) §483.45(d) Unnecessary Drugs-General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used- §483.45(d)(1) In excessive dose (including duplicate drug therapy); or §483.45(d)(2) For excessive duration; or §483.45(d)(3) Without adequate monitoring; or §483.45(d)(4) Without adequate indications for its use; or §483.45(d)(5) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or §483.45(d)(6) Any combinations of the reasons stated in paragraphs (d)(1) through (5) of this section. This REQUIREMENT is not met as evidenced by: Based on record reviews and staff interviews, the facility failed to obtain a PT/INR (prothrombin	F 757	1. An internal root cause analysis was completed, it was determined that an	7/18/18

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F 757	Continued From page 16 time/international normalized ratio [a test used to help detect and diagnose a bleeding disorder or excessive clotting disorder and is used to monitor how well the blood thinning medication is working]) as ordered while receiving an anti-coagulant (a blood-thinning medication) for 1 of 6 residents (Resident #23) reviewed for unnecessary medication use. Findings included: Resident #23 was admitted to the facility on 5/23/18 with diagnoses that included COPD (Chronic Obstructive Pulmonary Disease) with acute exacerbation, A-Fib (Atrial Fibrillation and long term (current) use of anticoagulants. During a review of the residents most recent MDS revealed the assessment was coded as an admission assessment with an ARD (Assessment Reference Date) of 5/30/18. The resident had been assessed as being cognitively intact. The assessment had documentation of resident receiving anticoagulant medication for 6 of the 7 days of the look-back period. The active diagnoses were marked on the assessment as: A-Fib, COPD, and Diabetes Mellitus. A review of the physician orders revealed the following orders: An order dated 6/8/18 that read: Warfarin 5 mg by mouth three times a week. Monday, Wednesday, and Friday. Another order was dated 6/11/18 that read: Coumadin 3 mg by mouth four times a week. Sunday, Tuesday, Thursday, and Saturday. An order dated 6/15/18 to obtain a PT/INR on	F 757	effective process for ensuring all labs are completed as scheduled, and coumadin monitoring was not in place. 2. Resident #23 discharged from the facility on June 19, 2018. Per physician order, resident was to follow up with Coumadin Clinic. 3. Director of Clinical Services and/or designee have re-educated Nurses on the new process of ensuring all labs are completed for residents on Coumadin. Director of Clinical Services and/or designee will perform Quality Improvement Monitoring on all PT/INR lab orders for residents to ensure they are complete 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks. Coumadin Tracker to be used to monitor PT INR schedules and Coumadin dosing. Lab tracker to be completed on all labs to track compliance with lab draws and insure return of lab results. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	

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6/18/18.

An order dated 6/19/18 to obtain a PT/INR on 6/19/18 STAT.

A review of the nursing notes written 6/18/18-6/20/18 revealed no documentation related to the collection or disposition of the PT/INR ordered for the resident on 6/18/18. A review of the lab results available in the electronic medical record revealed no lab results for 6/18/18.

During an interview with RN #1 on 6/20/18 at 4:30 pm, the nurse stated a PT/INR was ordered for resident #23 to be done on 6/18/18. She explained that the lab did not obtain the ordered blood draw on 6/18/18. She further added she noticed it had been missed the morning of 6/19/18 and notified the physician and the physician gave an order to draw the lab STAT. Additionally, the nurse stated the blood was collected and sent to the lab on 6/19/18, but that the lab had called back to inform the facility there was not enough blood to complete the test. The nurse then stated she notified the physician that the lab couldn't be completed and instructions were given to her to educate the family to take the resident to the Coumadin Clinic to have the blood drawn since the resident was being discharged. When asked if a lab requisition or if any of the information was documented anywhere to be reviewed and she indicated there was no documentation or a lab requisition.

An interview was conducted with the DON on 6/20/18 at 6:15 pm. The DON stated she was aware the PT/INR was not drawn on 6/18/18. The DON explained the lab was missed on

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F 757	Continued From page 18 6/18/18 and was ordered again to be done the following day (6/19/18). She indicated the blood was drawn on 6/19/18 and sent to the lab. She added that the blood that was sent to lab on 6/19/18 and that the lab called to report there was not enough blood in the collection tube to run the test. The DON stated the physician was informed and new orders were given to educate the family and have the resident's blood work done at the Coumadin clinic as this was the resident's discharge date. At 7:45 pm on 6/20/18 the DON provided a printed copy of a nursing note written on 6/20/18 at 7:39 pm which read: "Late entry. LAB PT/INR was not drawn on Monday, writer spoke to MD. Ordered draw STAT on Tues. STAT lab was drawn by lab was unable to do the test. MD was informed, stated she is going home, let clinic draw lab. Son was told to have test done."	F 757		
F 758 SS=D	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used	F 758		7/18/18

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F 758	Continued From page 19 psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff interview, Pharmacist, and Physician's interview the facility failed to give rationale for extended use of as needed (PRN) psychotropic medications to 2 of 5 residents reviewed for unnecessary medication (Resident #14 and Resident #12).	F 758	1. An internal root cause analysis was completed, it was determined that an effective process for ensure all continuing psychotropic medications include rationale for extended use of as needed (PRN) medications was not in place.	

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F 758	Continued From page 20 Findings included: 1.Resident #14 was admitted on 10/10/17 with a cumulative diagnoses that included dementia and depression with anxiety disorder. The Minimum Data Set (MDS) dated 4/28/18 indicated that the resident was moderately cognitively impaired and received 7 out of 7 days of antidepressant from the look back period. There was no coded behavior or rejection of care from the MDS. Review of the physician's order indicated an order for Ativan 0.25mg on 2/22/18 to be given twice daily as needed for 14 days. Another order was written on 3/12/18 for Ativan 0.25mg to be given twice daily as needed for 14 days. There was no rationale written for the continued use of Ativan. There was another order written on 4/14/18 for Ativan 0.5mg twice daily as needed (increased in dose) with no stop date and no rationale for the continuation of the medication. The Ativan 0.5mg order for Resident #14 was still actively in place with no stop date. A telephone interview with the Pharmacist on 6/20/18 at 3:34 PM she stated that the physician visits the facility weekly and should have written rationale for the use of the psychotropic meds but was unsure where it's located. An interview with the Director of Nursing (DON) on 6/20/18 at 4:12 PM stated she looked at the physician's notes and showed a copy of the indication for the medication but there was no specific rationale for the continued use of PRN psychotropic medication. She further stated that	F 758	2. On June 21, 2018, provider completed assessment on Resident #14, restarted medication order X30 days and added providers progress note on rationale for the continuing use of the psychotropic medication. On June 21, 2018, provider completed assessment on Resident #12, restarted medication order X14 days and added providers progress note on rationale for the continuing use of the psychotropic medication. Residents #12 and #14 are longer residing in the facility. 3. Director of Clinical Services and/or designee have re-educated staff and providers on new guidelines for PRN psychotropic medications. The Director of Clinical Services and/or designee will perform Quality Improvement Monitoring for new PRN Psychotropic medications 5 times a week for 4 weeks, 3 times a week for 4 weeks, then weekly for 4 weeks, ensuring that proper indication and duration are documented. DON or designee will track PRN psychotropic orders and coordinate with provider weekly to review residents on PRN psychotropic medication for appropriate indication and length of medication regimen. Pharmacist to review resident charts monthly for documentation of indication and continuation of psychotropic medications. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to	

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F 758	Continued From page 21 she expected the PRN psychotropic medication use should be time limited as regulated. A telephone interview with the physician was conducted on 6/20/18 at 5:28 PM. The Physician stated that he missed documenting the rationale for continued use and he can let his Nurse Practitioner write the rationale. He further stated that he will make sure all PRN psychotropics will be assessed and have rationale for use when he comes for his next visit. 2. Resident #12 was admitted to the facility on 4/20/18 with cumulative diagnoses that included dementia with behavioral disturbance and generalized anxiety disorder. During a review of Resident #12's most recent MDS was coded as an admission assessment and was dated 4/29/18. The MDS indicated Resident #12 had impaired cognition and received antianxiety medications 7 of 7 days during the MDS look back period. During a review of the physician orders for Resident #12 revealed a physician order dated 5/3/18 that read: Give Lorazepam 0.5mg by mouth once a day. Another physician order dated 5/21/18 read: Give Lorazepam 0.5mg twice a day PRN (as needed) for anxiety/agitation. The order did not include a stop date or duration for the PRN Lorazepam. A review of the monthly pharmacy medication reviews revealed there were no pharmacy recommendation made regarding a stop date or a request for the duration of the prn Lorazepam	F 758	be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	

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F 758	Continued From page 22 ordered on 5/21/18. An interview was conducted on 6/20/18 at 11:50am with Director of Nursing. She was unable to locate a pharmacy recommendation or physician documentation regarding a stop date for Lorazepam that was ordered PRN. She stated that it was her expectation for all PRN psychotropic medications be time limited in duration per the regulation. A telephone interview was conducted with in house physician on 6/20/18 at 5:40pm. The physician stated he felt it was an oversight and he could either call in an order or have the nurse practitioner (if still on site) discontinue the prn dose of Lorazepam. He further stated that he would be reassessing Resident #12 and either discontinue the prn dose of Lorazepam or ensure a rationale for continued use was present.	F 758		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.	F 761		7/18/18

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F 761	Continued From page 23 §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview, and record review, the facility failed to dispose/discard expired medications in 1 of 1 medication storage rooms observed for medication storage. Findings included: A review of the facility policy titled, "Storage of Medications" with a revision date of April 2007, and provided by the Director of Nursing (DON) read in part: All expired medications should be returned to dispensing pharmacy or destroyed. An observation of the facility medication storage room was conducted on 6/20/18 at 8:55am. During the observation, there were three bags of 250ml IV (Intravenous) Vancomycin, noted to have a labeled sticker with a handwritten expiration date of 6/19/18 in the medication refrigerator. During an interview with the (DON) Director of Nursing on 6/20/18 at 9:00 am, the DON validated the bags were expired. She stated the bags of Vancomycin were for a resident that had been discharged and should have been sent back to the pharmacy the day of discharge.	F 761	1. An internal root cause analysis was completed, it was determined that an effective process for monitoring for expiration and discarding or returning of medications for residents that have been discharged from the facility was not in place. 2. On June 20, 2018 the three bags of Vancomycin were removed from the medication room refrigerator and have been destroyed. 3. Director of Clinical Services and/or designee have re-educated staff of the removal of medications for residents that have been discharged. Night nurse to return discharged resident□s medications nightly. Night nurse to audit medication room weekly for medications expiring in the next week and remove medications from med room. Pharmacist to audit medication room monthly for medications expiring in the next month and remove medications from the med room. The Director of Clinical Services and/or designee will perform quality improvement monitoring of the medication room to ensure medications have been removed	

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 _____	06/20/2018

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS	2105 HOMESTEAD HILLS DRIVE WINSTON SALEM, NC 27103

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F 761	Continued From page 24	F 761	after a resident has been discharged from the facility. The Director of Clinical Services and/or designee will monitor medications 5 times a week for 4 weeks, 3 times a week for 4 weeks, weekly for 4 weeks, then ongoing. 4. The Care Services Administrator to be responsible for implementing this plan. The Care Services Administrator introduced the plan of correction to the QAPI Committee on 7-10-18. The results of the Quality Improvement Monitoring to be reported to the QAPI Committee by the Director of Clinical Services. QAPI Committee meeting consists of but not limited to: Medical Director, Care Services Administrator, Director of Clinical Services, Activities, Social Services, Maintenance, Dietary, Housekeeping, MDS Nurse and a minimum of one direct caregiver.	