

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345559	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/25/2024
NAME OF PROVIDER OR SUPPLIER Homestead Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Homestead Hills Drive Winston Salem, NC 27103	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide timely, quality laboratory services/tests to meet the needs of residents.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 42007</p> <p>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)</p> <p>The findings included:</p> <p>1. Resident #4 was admitted to the facility 1/3/24 with diagnoses type 2 diabetes mellitus, cognitive impairment, and lymphoma.</p> <p>Resident #4's admission Minimum Data Set (MDS) dated [DATE] revealed he was severely cognitively impaired and Resident #4 took insulin injections.</p> <p>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.</p> <p>Attempts to reach Nurse #5 were unsuccessful.</p> <p>Further review of Resident #4's medical record revealed there were no lab results for the 1/3/2024 order.</p> <p>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.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0770</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>2. Resident #7 was admitted to the facility on [DATE] with diagnoses dementia, type 2 diabetes mellitus, vitamin d deficiency and chronic kidney disease.</p> <p>Resident #7's quarterly MDS dated [DATE] revealed she was severely cognitively impaired.</p> <p>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.</p> <p>Further record review showed there was no evidence of the lab being drawn.</p> <p>Attempts to reach Nurse #5 were unsuccessful.</p> <p>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.</p> <p>During an 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 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.</p>		