

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

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 07/01/2026
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)		
F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that residents are free from significant medication errors. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record reviews, and staff, Nurse Practitioner (NP), Pharmacist, and Medical Director interviews, the facility failed to have effective systems in place to prevent a significant medication error. Resident #4 was severely cognitively impaired and had a diagnosis of sinus bradycardia (slow heart rate). On 3/11/2026 the Medication Aide (MA) administered morning medications to Resident #4 which included extended-release propranolol (a betablocker used to treat hypertension which slows the heart rate, reduces the force of heart contractions, and lowers blood pressure), quetiapine (antipsychotic medication that can cause sudden drops in blood pressure) and donepezil. Donepezil can slow the heart rate and affect the sinoatrial (SA) node and atrioventricular (AV) nodes, potentially leading to bradycardia or heart block which is a disruption in the electrical signals that regulate heartbeat. (The SA node set the heart's rate and rhythm, and the AV node regulates the timing of ventricular contractions). The Medication Aide returned to the medication cart and prepared Resident #47's medications and proceeded to administer these to Resident #4. The medications included metoprolol succinate extended release (a betablocker used to treat hypertension that slows the heart rate and lowers blood pressure), tamsulosin (an alpha-blocker used to treat symptoms of enlarged prostate which can cause low blood pressure), and amlodipine (a calcium channel blocker used to treat hypertension and chest pain that lowers blood pressure by causing blood vessels to relax and widen throughout the body), and donepezil. Approximately 30 minutes later the Medication Aide realized he had administered medications prescribed for Resident #47 to Resident #4 and reported this to the nurse immediately. Resident #4 was assessed by the nurse and NP, was lethargic, and his heart rate was in the 40's range and dropped into the high 30's with a blood pressure (BP) reading of 90/60. (The normal range for heart rate is 60 to 100 beats per minute (bpm)). Emergency Medical Services (EMS) was contacted and transported Resident #4 to the hospital for evaluation and treatment. The physician documented the principal problem was severe symptomatic bradycardia and hypotension (low blood pressure) secondary to an unintentional medication overdose with betablockers and amlodipine. The resident received epinephrine drip (a continuous intravenous infusion used to support blood pressure, heart function and bronchodilation in critical situations) and atropine (anticholinergic medication used to treat bradycardia) for his low heart rate. Blood pressures improved and his heart rate was in the mid 40's. The plan was to continue the epinephrine drip and transfer the resident to the Critical Care Unit (CCU) for monitoring. Initial management included epinephrine infusion and atropine with limited response which suggested a high degree heart block (a high-degree heart block is a serious form of AV block where the electrical signals from the atria to the ventricles are significantly impaired). Resident #4's hospital electrocardiogram (ECG) results (An ECG checks the heartbeat and electrical signals in the heart and can help diagnose heart attacks and irregular heartbeats, called arrhythmias) showed progression from sinus bradycardia with a (continued on next page)		

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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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	hospital electrocardiogram ECG results showed progression from sinus bradycardia with a second-degree AV block to a complete heart block. On 3/13/26 Resident #4 was implanted with dual-chamber pacemaker. The resident's clinical status improved, and he was discharged back to the facility on 3/16/26. Pharmacist interview on 06/25/2026 at 4:46 PM revealed metoprolol 25mg ER would release slower throughout the day, but due to Resident#4 receiving his scheduled betablockers, and then getting his roommates (Resident #47) betablocker and alpha betablocker, this would be the cause of Resident #4's drop in heartrate and BP. She further stated the combination including other medications which can lower BP, including tamsulosin, would have been the cause of Resident #4's change in condition. Interview with the Medical Director 06/25/2026 at 11:35 AM revealed she recalled being informed by the NP about Resident #4 receiving another resident's medications in addition to his scheduled medications. The Medical Director indicated metoprolol succinate 25mg was an extended-release meaning and it entered the resident's body system slowly and not acutely (immediate releasing). The Medical Director indicated the medication error could have caused Resident #4's heartrate to decrease into the 30's to 40's and stated any blood pressure pill can cause a decreased heart rate and BP. She stated due to Resident #4's age and comorbidities, his symptoms of low BP and low heartrate could have happened at any time and did not feel this medication error contributed to Resident #4's symptoms of low blood pressure and low heartrate. Interview with the Administrator on 6/25/2026 at 4:30 PM, revealed she became aware of the medication error involving Resident #4 after the Medication Aide #1 informed Nurse #1. The root cause of this incident was a medication administration error related to Medication Aide #1's failure to properly verify Resident #4 identity according to established protocols. The Administrator was notified of the Immediate Jeopardy (IJ) on 06/25/2026 at 5:45pm. The facility completed a Plan of Correction (POC) to include reeducation of medication administration, identifying the correct resident, facility medication policies, observation individual med pass of all staff who pass medications to ensure proper protocol was followed when identifying a resident. The Administrator provided the following corrective action plan with a compliance date of 3/19/2026. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On March 11, 2026, at approximately 8:20 AM, during a routine medication pass, Medication Aide #1 administered Resident #4 his prescribed medications which included Quetiapine 25 mg, Donepezil 10 mg, Metformin ER 500 mg, Propranolol ER 60 mg, Citalopram 10 mg. Medication Aide #1 returned to the medication cart and prepared Resident #47's medications which included Donepezil 5 mg, Tamsulosin 0.4 mg, Eliquis 5 mg, Memantine HCL 5 mg, Metoprolol Succinate ER 25 mg, and Amlodipine 5 mg and administered them to Resident #4 in error. Medication Aide #1 realized the error and reported this to the nurse approximately 15 to 30 minutes upon discovery of the error and the Director of Nursing (DON) and the Nurse Practitioner were notified. Resident #4 was promptly assessed by the DON and a nurse, which included vital signs revealing Resident #4's pulse to be 36 (bradycardic) and O2 saturation 94%. Resident #4 was found to be lethargic and in no acute distress, sitting up in his wheelchair. Which prompted floor staff to notify the Nurse Practitioner to provide a more comprehensive assessment immediately. The Nurse Practitioner (NP) assessed the resident and found him to be bradycardic and hypotensive. The NP determined the resident needed to be sent to the hospital ED for an evaluation. Resident #4 was transported to the hospital at 10:00 AM on March 11, 2026. Hospital diagnoses included severe bradycardia, sinus bradycardia, and hypotension. Hospital ECGs demonstrated progression from sinus bradycardia with second-degree AV (Mobitz 1) block to marked sinus with first-degree AV block, and ultimately to complete heart block. Review of the hospital records indicated Resident #4 had a pacemaker placed during the hospitalization on March 13, 2026, and did (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	not receive any new medication orders. Resident #4 returned to facility on March 16, 2026, where he resumed and continued hospice services at prior baseline. The root cause of this incident was a medication administration error related to failure to properly verify resident identity according to established protocols. On March 11th, 2026 immediately after identifying medication error occurred Medication Aide #1 was removed from medication administration duties pending investigation and retraining. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practices. There were no medication discrepancies identified for trend review, and no medication errors had been noted within the last six months. Because a medication administration error has the potential to affect all residents, the facility conducted a review focused on the performance of the nursing staff and Medication Aide through medication pass evaluations where staff demonstrate the 7 rights of medication administration. Between March 13, 2026 and March 18, 2026 the Assistant Director of Nursing and designee completed medication administration evaluations on all licensed nurses and medication aides ensuring that all licensed nurses and medication aides demonstrated competency in applying the 7 Rights during medication administration. All Licensed Nurses and Medication Aides who were responsible for medication administration including Medication Aide #1 were evaluated by using the facility's Medication Pass Evaluation Form, which includes four required areas of competency. The four competency areas included: (1) proper medication preparation and resident identification according to the Rights of Medication Administration prior to medication administration; (2) adherence to the Rights of Medication Administration, including the right resident, medication, dose, route, and time; (3) compliance with medication-specific instructions and documentation requirements, including medication parameters, administration instructions, medication crushing procedures when applicable, documentation immediately following medication administration, and controlled substance documentation; and (4) appropriate communication and timely reporting of any medication errors or concerns to the supervisor were included in medication pass evaluation observation competency to ensure medication errors were recognized and reported timely. These competencies of resources listed above are available in the agency education binder which is required to review before any worked shifts. The medication pass evaluations included direct observation of an actual medication pass to ensure medications were administered safely and in accordance with physician orders and facility policy. During this evaluation process, no concerns were identified with staff adherence to resident identification procedures, medication-specific parameters, or crushing requirements. Staff demonstrated appropriate knowledge of reporting expectations. All licensed nurses and medication aides hired after March 18, 2026 received this same education and competency evaluation during orientation, provided by the Director of Nursing or designee, to ensure consistent understanding of medication administration expectations from the beginning of employment and ongoing compliance. Overall responsibility for ensuring completion of education, competency validation, and ongoing compliance remains with the Director of Nursing and the Assistant Director of Nursing. On March 11, 2026 and March 12, 2026 the Director of Nursing (DON) completed Medication Administration Record (MAR) audits for all current residents to ensure all resident admission, discharges, and medication order changes via provider orders were accurate. The MAR audits included review of the census sheet for March 11, 2026 and March 12, 2026, verification of any missed medications or medications not administered, and a full audit comparing all medications on the MAR to the physician order summary to ensure accuracy and consistency of orders and documentation. The DON determined there were no medication administration issues identified. On March 11, 2026, after the facility became aware of the incident all current residents were placed under observation for any changes in (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	health status by Director of Nursing or Designee, to identify any deviations from baseline condition including neurologically via resident interviews or if any unintended harm was done from an adverse event relating to a medication error. Residents were observed for any adverse signs or symptoms related to medication administration, and no concerns were identified. No residents required further medical intervention as a result of these observations. 3. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. To ensure that this deficient practice does not recur, the facility has implemented several systemic changes focused on strengthening staff competency, reinforcing adherence to the 7 Rights of Medication Administration, and establishing ongoing quality monitoring audits. By March 18, 2026, all licensed nurses and medication aides were educated by the DON in person and via the phone on resident rights related to medication administration, with specific emphasis on the 7 Rights of Medication Administration, including the right resident, right medication, right dose, right route, right time, and right documentation. The staff members educated via phone were reeducated in person by the Assistant DON during the medication pass evaluation observation. This education reinforced the importance of accurate resident identification prior to medication administration. Staff were educated to utilize the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident before administering medications. Education also reinforced that resident identification must be verified prior to each medication administration and that staff were expected to follow facility policy regarding resident identification at all times. Education was provided in person to all licensed nurses and medication aides by the Director of Nursing starting on March 11, 2026 and concluding on March 18th, 2026. The 7 rights of medication administration were added to the new hire orientation training via in person education and demonstrated during medication pass evaluation observation. Since the incident, the facility has had one new hire, who received the required education during orientation and was observed completing medication administration competency prior to working independently on the floor. The 7 rights of medication administration was added to the agency staff onboarding binder. Agency nurses are required to review the onboarding binder upon entering the facility for each shift, which includes facility policies and procedures, prior to providing resident care. 4. How will the facility monitor its corrective action to ensure the deficient practice will not recur? A Quality Monitoring Audit was initiated on March 11, 2026 to evaluate compliance with the facility's medication administration policy, including adherence to the 7 rights and resident identification procedure by Director of Nursing and/or designee. The Director of Nursing or Assistant Director of Nursing conducted random audits of medication administration passes with 2 Licensed Nurses or Medication Aides weekly for 12 weeks, to ensure adherence of the 7 rights of medication administration, which included right medication, right resident, right dose, right time, right route, right reason, and right documentation. Quality Monitoring Auditing was conducted on both 1st shift (7:00 a.m. to 7:00 p.m.) and 2nd shift (7:00 p.m. to 7:00 a.m.) to ensure ongoing compliance with medication administration practices and identified concerns were addressed through immediate feedback and reeducation as indicated. The results of the quality monitoring were reported by the Director of Nursing or Designee to the Quality Assurance Performance Improvement Committee meeting for 3 months, no negative findings noted. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Care Service Administrator, Director of Nursing, Assistance Director of Nursing, Social Worker, Activities Director, Health Care Liaison, Medical Director, Maintenance Director, Minimum Data Assessments Nurse, and at least one direct care staff member. Alleged date of immediate jeopardy removal and compliance date: 3/19/26. The validation of the corrective action plan was completed on (continued on next page)		

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F 0760 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	07/01/2026.The facility completed a six-month review of medication records to identify any trends or patterns; no discrepancies, trends, or patterns were identified. Between March 13-16, 2026, the Assistant Director of Nursing conducted comprehensive medication pass evaluations on all staff nurses and Medication Aides. Agency staff received Medication Administration education before each shift and signed verification of training completion. This was confirmed by a review of in-service sign in sheets. Staff interviews further confirmed that nurses, medication aides, and agency staff had completed the required education and were able to verbalize the 7 rights of medication administration, utilizing the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident, and the importance of reporting any medication error. This was further confirmed by a review of in-service sign in sheets. The facility also provided documentation demonstrating that newly hired staff and agency personnel assigned to Medication Administration duties had received current training.A Medication Administration Observation was completed during the validation with no medication errors noted.The facility submitted documentation confirming completion of weekly direct observation medication pass audits for two staff members per week over a 12-week period, in accordance with corrective action plan. The facility also provided documentation and interviews related to the Quality Assurance and Performance Improvement (QAPI) Committee meetings.The immediate jeopardy removal and compliance date of 3/19/26 was validated.		

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Dispose of garbage and refuse properly. Based on observations and staff interviews, the facility failed to maintain the dumpster area free of trash and debris for 1 of 1 dumpster area observed for garbage storage and ensure dumpster doors remained closed for 2 of 2 dumpsters. These practices had the potential to attract pests and rodents. An observation of the dumpster area located outside of the kitchen near the facility was conducted on 6/24/2026 at 3:22PM with the Director of Dining Services. The observation revealed multiple pieces of trash and debris including cardboard pieces, multiple used plastic gloves, and a bag of trash pushed in the back corner with a corner of the bag under one of the dumpsters, which was visible by walking around the two dumpsters that were side by side. Both dumpsters' slide doors were not fully closed. An interview with the Director of Dining Services on 6/24/2026 at 3:25PM, revealed that he thought the trash was stuck under the dumpster and they called the dumpster company about a week ago to see when the dumpster company could come out and lift it up so the facility could clean under it. The Director of Dining Services revealed that the dumpster company came 3 times per week to empty the dumpsters. The Director of Dining Services explained the trash on the ground was not acceptable and it could attract rodents. He stated the Director of Facility Services would know more. On 6/24/2026 at 4:00PM the Director of Facility Services presented an email, dated 6/24/2026, from the dumpster company that stated the dumpster company would come 7/3/2026 to install a trash compactor and they could clean the area at that time. An interview on 6/25/2026 at 9:27AM with the Director of Dining Services, the Director of Facility Services, and the Administrator present confirmed that the dumpster company came 3 times per week to empty the dumpster. The Director of Facility Services explained the dumpster company came at 4:00AM. He stated no one was at the facility at that time except the security guard and he could not do it. An observation of the dumpster area on 6/25/2026 at 9:29AM revealed a new trash bag in addition to the other trash seen on 6/24/2026 was now present along with a bag halfway out of the dumpster, with the dumpsters' sliding doors not fully closed. An interview with Dietary Aide #1 on 6/25/2026 at 9:31AM confirmed that the trash bag on the ground should not have been there. She did not know how the trash got there. The Dietary Aide #1 threw a trash bag directly into the dumpster and then closed the dumpster's sliding door. An observation of the dumpster area with the Director of Dining Services on 6/25/2026 at 9:39AM, confirmed that he saw the new trash on the ground and he picked it up and placed the trash into the dumpster. He then closed the dumpsters' sliding doors. An interview with the Director of Dining Services on 6/25/2026 at 9:40AM confirmed that the sliding doors on the dumpster should have been closed and there should have been no trash on the ground. An observation of the dumpster area on 6/25/2026 at 5:30PM revealed a trash bag on the ground below an open dumpster's sliding door. A phone interview with the dumpster service company on 6/26/2026 at 8:25AM confirmed the dumpster company sends a truck out to the facility 3 times per week during the early morning and usually no later than 7:00AM to empty the dumpster area. The dumpster company also confirmed the company would allow the facility to schedule services in addition to the regular scheduled times.		

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 07/01/2026
NAME OF PROVIDER OR SUPPLIER Homestead Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Homestead Hills Drive Winston-Salem, NC 27103	
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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations, record review, and interviews with the Pharmacist from the dispensing pharmacy and facility staff, the facility failed to: 1) discard expired medications (medication room and upper 500 hall medication cart); 2) label medications when opened and dispose of loose nebulization solutions in the bottom drawer (low 500 hall medication cart); and 3) secure prescription medications in a locked compartment (low 500 hall medication cart). These failures occurred for 1 of 1 medication room and 2 of 2 medication carts reviewed for proper storage and labeling of medications. 1a) An observation of the refrigerator in the medication room accompanied by Nurse #3 conducted on 6/25/2026 at 11:38 AM revealed the following expired medications stored in the medication storage refrigerator with other non-expired medications: Flucelvax (flu immunizations) which expired 6/10/2026 and 6 daptomycin (a strong antibiotic used for certain serious bacterial infections) intravenous bags which expired on 6/13/2026, 6/20/2026, 6/21/2026, 6/22/2026, 6/23/2026, and 6/24/2026. Nurse #3 confirmed expired medications should not be in the refrigerator with the non-expired medications on 6/25/2026 at 11:40 AM. She confirmed that the Director of Nursing (DON) would know how the expired medications were discarded. 1b) An observation of the medication cart on the upper 500 hall was conducted on 6/25/2026 at 12:02 PM accompanied by Nurse #1. The observation revealed an Advair prescription inhaler (used for chronic lung disease) was labeled with an expiration date of 6/22/2026 and was stored in the medication cart with the other inhalers. An interview with Nurse #1 on 6/25/2026 at 12:05 PM confirmed that an expired medication should not be in the upper 500 hall medication cart. Nurse #1 stated that it needed to be discarded and that it would be stored in the medication room until the pharmacy came next and collected it. An interview with the Director of Nursing (DON) on 6/25/2026 at 12:20 PM confirmed that when staff came across expired medication it should be stored in the medication room separate from the other medications. She pointed to a bag on the floor of the expired medications awaiting return to the pharmacy. The DON then pulled all of the daptomycin and flu shots from the refrigerator and she placed them in the bag on the floor of expired medications. The DON confirmed keeping the expired medications with the non-expired medications could result in a resident receiving an expired product. An interview with the facility Administrator on 6/25/2026 at 3:00 PM revealed she expected all staff to follow the facility procedure on medication storage and expired medications should be discarded. 2) Review of the fluticasone furoate/vilanterol's (a medication used to control and prevent breathing difficulties) manufacturer guidelines, last updated in June 2024, for storage stated once open the inhaler must be discarded after 42 days. The manufacturer guidelines for Stiolto (a daily inhaler to help control breathing difficulties), last revised in June 2025, stated to discard 3 months after inserting the cartridge into inhaler. The levalbuterol's (a medication used to treat wheezing, shortness of breath, and coughing) manufacturer guidelines, last updated in October 2023, for storage stated that once the pouch was open it should be used within 2 weeks. Review of the manufacturer guidelines, last revised in October 2023, for ipratropium bromide (a medication used to control and prevent breathing difficulties) stated the nebulizing vials should be protected from light and stored in the foil pouch. An observation accompanied by Nurse #3 was conducted on the medication cart near the lower 500 hall on 6/25/2026 at 11:49 AM. The observation revealed the following medications were not properly labeled with the open date: fluticasone furoate/vilanterol inhaler was opened up with 20 doses left on the counter, Stiolto was opened with 4 doses removed, and a pouch of levalbuterol nebulizing solution (continued on next page)		

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	was opened with 16 of 25 vials remaining. The observation also revealed 4 loose nebulizing solution vials of ipratropium bromide were in the bottom drawer not stored in their foil package. An interview on 6/25/2026 at 11:51 AM with Nurse #3 confirmed that medications that were opened from a pouch or inhaler box that should be labeled with the opened date. Nurse #3 reported that the loose vials should have been discarded and they should not have been stored like that. Nurse #3 retrieved the vials to discard them. An interview with the Director of Nursing (DON) on 6/25/2026 at 12:20 PM confirmed that when staff opened any medications from a pouch or inhaler the staff should label it with the opened date and medications should not be stored in the bottom of the drawer loose and not in their original foil package. The DON also stated that the Pharmacist from the dispensing pharmacy would visit the facility monthly and perform medication cart audits. An interview with the facility Administrator on 6/25/2026 at 3:00 PM revealed she expected all staff to follow the facility procedure on medication labeling and storage. 3) An observation of the medication cart near the lower 500 hall on 6/25/2026 at 10:45 AM revealed the cart had been left unattended and 2 prescription blister packs of medications were not secure and laid on top of the medication cart. There were no staff or residents present in sight of the medication cart. A second observation of the medication cart near the lower 500 hall was conducted on 6/25/2026 at 10:50 AM revealed the medications were still left unattended on top of the medication cart and not secure. There were no staff or residents present or in sight of the medication cart. An interview with Nurse #3 on 6/25/2026 at 10:52 AM revealed that she pulled the medications out of the lower 500 hall medication cart as they were not filed in the correct drawer. Nurse #3 stated she meant to put them back after going to a resident's room to administer medications, but she was pulled away by a family member needing help finding the Social Worker's office. Nurse #3 led the family member to the Social Worker's office which was located down the hall and around two corners. Nurse #3 stated she was pulled in many directions and stated unattended medication carts should have all medications locked up and the computer screen closed to prevent any person from grabbing the medication and taking it. An observation of the medications left on top of the lower 500 hall medication cart unattended on 6/25/2026 at 10:54 AM revealed the medications were a blister card of 14 tablets of amlodipine 2.5mg (a medication used to lower blood pressure) and another blister card of 4 capsules of rifampin 300mg (a medication used to kill certain types of bacteria and can cause clinically significant drug interactions by reducing the effectiveness of many medications). An interview with the Director of Nursing (DON) on 6/25/2026 at 10:55 AM confirmed the facility policy of storing medications was to ensure medications were stored inside the medication cart and locked when the cart was left unattended. The DON stated dementia residents could grab them and take them. The DON also confirmed that the facility does training for medication storage at orientation. The Pharmacist from the dispensing pharmacy confirmed on 06/25/2026 at 11:10 AM she had serviced the facility for 10 years. The Pharmacist expected medications to be secured and locked inside an unattended medication cart. The Pharmacist expected that only the nurse would have the key if the cart was left unattended. She stated the risk of leaving medications unsecured was that anyone can grab them and if ingested could experience adverse side effects. The Pharmacist from the dispensing pharmacy stated that if someone ingested amlodipine there may have been a risk for hypotension and if someone ingested rifampin one dose may not cause harm but if they took them all that may have been a different story. An interview with the facility Administrator on 06/25/2026 at 11:17 AM revealed she expected all staff to follow the facility procedure on medication storage and that medications should not have been left unsecured if a medication cart was unattended.		

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observations and staff interviews, the facility failed to ensure dietary staff with facial hair wore beard covers for 2 of 6 male staff members observed for food preparation and service (Director of Dining Services and the Sous Chef). This practice had the potential to affect food served to residents. An observation of the kitchen was conducted on 6/24/2026 at 11:00AM - 11:40AM of the Director of Dining Services. During this time the Director of Dining Services presented with a full dark beard and mustache, approximately 1/2 to 1 inch in length, preparing and serving food without a beard cover. The Director of Dining Services was observed performing the following tasks in the kitchen: on 6/24/2026 at 11:15AM placed plastic wrap over individual peach bowls off the steam table, on 6/24/2026 at 11:20AM grabbed pork chop tray assisting dietary aide with removing the pork chops from the tray on steam table, placed tongs into pork chops on the steam table on steam table, on 6/24/2026 at 11:25AM placed lid over sweet potatoes on the steam table, handled salads from refrigerator off the steam table, and on 6/24/2026 at 11:30AM performed the temperature checks of all hot food on the steam table. An observation of the kitchen was conducted on 6/24/2026 at 11:00AM - 11:40AM of the Sous Chef. During this time the Sous Chef presented with a chin beard (goatee-style facial hair), approximately 2 to 3 inches in length, preparing food without a beard cover. The Sous Chef was observed performing the following tasks: on 6/24/2026 at 11:21AM moved pork chops from storage bags onto cooking tray, on 6/24/2026 at 11:23AM entered steam table area to grab seasoning and then seasoned pork chops, and on 6/24/2026 at 11:25AM placed pork chop tray into oven. An interview with the Director of Dining Services on 6/24/2026 at 11:35AM, revealed that his expectations about beard covers for males were that per his health regulations if longer than an individual's eye lashes then a beard cover must be worn. The Director of Dining Services said he does not think he needed to wear a beard cover, but the Sous Chef should have one on. The Sous Chef confirmed in an interview on 6/25/2026 at 7:49AM that the Director of Dining Services told him to wear a beard cover. He thought the policy was 2 to 3 inches required a beard cover. The Sous Chef stated he had just forgotten the other day. During an interview on 6/25/2026 at 8:20AM with the facility Administrator, she indicated that she expected staff to follow the regulations for beard covers.		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Based on record review and staff, Nurse Practitioner (NP), and resident interviews, the facility failed to ensure advanced directives (code status) was accurate throughout the medical record for 1 of 1 resident reviewed for advance directives (Resident #9). Resident #9 was admitted into the facility on 9/19/2025. An encounter note dated 3/4/2026 for Resident #9 from NP #2 stated Resident #9 had a Do Not Resuscitate (DNR) code status. A quarterly encounter note dated 3/10/2026 for Resident #9 from the Social Worker stated Resident #9's code status was DNR. Review of 2 advance directive orders for Resident #9 both dated 3/25/2026 by NP #1 showed cancellation of full code status and initiated a DNR status. An encounter note dated 4/10/2026 for Resident #9 from NP #1 stated Resident #9 had a full code status. Resident #9's Medical Order Scope of Treatment (MOST) dated 5/7/2026 and signed by NP #2 had a DNR status. An encounter note dated 6/15/2026 for Resident #9 from NP #1 stated Resident #9 had a full code status. Review of the quarterly Minimum Data Set (MDS) assessment completed on 6/18/2026 revealed that Resident #9 was cognitively intact. Review of the comprehensive care plan revised on 6/18/2026 revealed that Resident #9 had a full code status. Encounter notes for Resident #9 from NP #2 stated Resident #9 had a full code status on the following dates: 3/9/2026 and 5/11/2026. A quarterly encounter note dated 6/22/2026 for Resident #9 from the Social Worker stated Resident #9 was DNR. An interview with Resident #9 on 6/24/2026 at 9:05AM revealed she wanted DNR. An interview with Nurse #2 on 6/24/2026 at 7:41AM confirmed she knew where to find a resident's advance directive in the facility's medical electronic record system and said the staff would also look in their advance directive notebook at the nursing station. She confirmed Resident #9 was currently DNR. An interview with the DON on 6/24/2026 at 7:42AM confirmed she expected that the care plan would match the most recent MOST sheet and the resident representative or resident's wishes. She confirmed if the advance directive was changed, she would update the order and care plan. The DON was unsure why the care plan was not updated to match the advance directive for Resident #9, she stated it probably slipped through the cracks. An interview with the facility Social Worker on 6/24/2026 at 2:43PM confirmed she would help the facility update the MOST. She confirmed her encounter notes for Resident #9 that stated Resident #9 was DNR was accurate. She expected that the encounter notes and care plan should match the MOST, but she was not responsible for updating the care plan. An interview with NP #1 on 6/24/2026 at 2:29PM confirmed the process of when a resident changed their advance directive from full code status to DNR was that the nursing staff would notify her and if she was told then she would notify the Nurse and Social Worker. The facility would need to update the MOST for any change. NP #1 stated she was familiar with Resident #9 and that Resident #9 was currently DNR, and she then confirmed this by looking in the electronic medical record. She stated she would expect her encounter notes and the care plan to match with the electronic medical record information by the resident's picture and what was on the MOST. An interview with NP #2 on 6/24/26 at 2:53PM, confirmed she had an encounter note completed on 5/11/2026 which was after her 5/7/2026 review of the MOST. She stated that the resident representative or resident would have the conversation about the resident's advance directive with the facility. Then the Nurse and Social Worker worked together to carry through with the MOST form. If the nurse was notified by the Resident Representative or resident that a change was wanted, then the nurse would leave a note for the provider to update it, and the provider would confirm with the Resident Representative or resident before updating it. If a DNR status was removed, the paper would have been removed from the binder at the nursing station and if changed from full (continued on next page)		

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	code to DNR then a new MOST was created. She expected the encounter note and the care plan to match what was on the most recent order in the resident's medical records and on the MOST. During an interview on 6/25/2026 at 8:20AM, the facility Administrator confirmed that the care plan should match the resident's advance directive and expects that the care plan should have been updated if changes arose.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to meet professional standards of care when nursing staff administered medications prescribed for Resident #47 to Resident #4 for 1 of 5 residents reviewed for significant medication errors (Resident #4). Findings included: Resident #4 was admitted to the facility on [DATE] with diagnoses that included Alzheimer's disease, Type II diabetes mellitus (DM), depression, hypertension, sinus bradycardia (2/28/25), psychotic disorder with hallucinations due to known physiological condition. A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #4 was severely cognitively impaired. Medication Aide (MA) #1 was interviewed on 06/25/2026 at 7:54 AM and revealed he recalled working with Resident #4 on 03/11/2026 and giving Resident #4 his scheduled morning medications on 03/11/2026 at approximately 8:30 AM in the common area. MA #1 indicated he returned to the medication cart and prepared Resident #47's medication and returned to the common area and without realizing it, administered Resident #47's medications to Resident #4. Approximately 30 minutes later, MA #1 stated he realized he had given Resident #4 medications that should have been administered to Resident #47. He stated he immediately informed Nurse #1 about the medication error. Review of Resident #4's Medication Administration Record (MAR) for March revealed on 3/11/26 Resident #4's morning medications were documented as administered at 8:27 AM by Medication Aide #1. Resident #47 was admitted to the facility on [DATE]. A review of Resident #47's active physician orders for the month of March 2026 included the following medication orders: Eliquis 5 mg (anticoagulant medication) twice a day for atrial fibrillation. Memantine 5 mg -two tablets (10 mg total) twice a day related to unspecified dementia without behavioral disturbance, mood disturbance, and anxiety. Omeprazole 20mg -once daily for gastroesophageal reflux disease. Review of nurse progress note dated 03/11/2026 at 2:26 PM written by Nurse #1 revealed Resident #4 received his scheduled medications on the morning of 03/11/2026 and his roommate's (Resident #47) scheduled medications. Resident #4 received Eliquis 5mg and omeprazole 20mg. An interview was conducted with Nurse #1 on 06/25/2026 at 8:39 AM and revealed the MA on duty (MA #1) came to her on 3/11/26 between 8:30 AM and 9:00 AM and reported he had accidentally given Resident #4 Resident #47's medication in error. Nurse #1 indicated when she first assessed Resident #4, she recalled obtaining and writing down his vital signs and remembered Resident #4's heart rate was in the 60's and his blood pressure (BP) was within normal limits. Interview with the Director of Nursing (DON) on 06/25/2026 at 3:45 PM revealed identity verification prior to administering medication was always the expectation of the facility's nurses and medication aides. The DON stated Medication Aide #1 has never made a medication error while working at the facility and she felt it was human error. Interview with the Administrator on 6/25/2026 at 4:30 PM, revealed she became aware of the medication error involving Resident #4 after the Medication Aide #1 informed Nurse #1. The root cause of this incident was a medication administration error related to Medication Aide #1's failure to properly verify Resident #4 identity according to established protocols. The Administrator provided the following corrective action plan with a compliance date of 3/19/2026. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice. On March 11, 2026, at approximately 8:20 AM, during a routine medication pass, Medication Aide #1 administered Resident #4 his prescribed medications which included Quetiapine 25 mg, Donepezil 10 mg, Metformin ER 500 mg, Propranolol ER 60 mg, Citalopram 10 mg. Medication Aide #1 returned to the medication cart and prepared Resident #47's medications which included Donepezil 5 mg, Tamsulosin 0.4 mg, Omeprazole (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	20 mg, Eliquis 5 mg, Memantine HCL 5 mg, Metoprolol Succinate ER 25 mg, and Amlodipine 5 mg and administered them to Resident #4 in error. Medication Aide #1 realized the error and reported this to the nurse approximately 15 to 30 minutes upon discovery of the error and the Director of Nursing (DON) and the Nurse Practitioner were notified. Resident #4 was promptly assessed by the DON and a nurse, which included vital signs revealing Resident #4's pulse to be 36 (bradycardic) and O2 saturation 94%. Resident #4 was found to be lethargic and in no acute distress, sitting up in his wheelchair. Which prompted floor staff to notify the Nurse Practitioner to provide a more comprehensive assessment immediately. The Nurse Practitioner (NP) assessed the resident and found him to be bradycardic and hypotensive. The NP determined the resident needed to be sent to the hospital ED for an evaluation. Resident #4 was transported to the hospital at 10:00 AM on March 11, 2026. Hospital diagnoses included severe bradycardia, sinus bradycardia, and hypotension. Hospital ECGs demonstrated progression from sinus bradycardia with second-degree AV (Mobitz 1) block to marked sinus with first-degree AV block, and ultimately to complete heart block. Review of the hospital records indicated Resident #4 had a pacemaker placed during the hospitalization on March 13, 2026, and did not receive any new medication orders. Resident #4 returned to facility on March 16, 2026, where he resumed and continued hospice services at prior baseline. The root cause of this incident was a medication administration error related to failure to properly verify resident identity according to established protocols. On March 11th, 2026 immediately after identifying medication error occurred Medication Aide #1 was removed from medication administration duties pending investigation and retraining. 2. Address how the facility will identify other residents having the potential to be affected by the same deficient practices. There were no medication discrepancies identified for trend review, and no medication errors had been noted within the last six months. Because a medication administration error has the potential to affect all residents, the facility conducted a review focused on the performance of the nursing staff and Medication Aide through medication pass evaluations where staff demonstrate the 7 rights of medication administration. Between March 13, 2026 and March 18, 2026 the Assistant Director of Nursing and designee completed medication administration evaluations on all licensed nurses and medication aides ensuring that all licensed nurses and medication aides demonstrated competency in applying the 7 Rights during medication administration. All Licensed Nurses and Medication Aides who were responsible for medication administration including Medication Aide #1 were evaluated by using the facility's Medication Pass Evaluation Form, which includes four required areas of competency. The four competency areas included: (1) proper medication preparation and resident identification according to the Rights of Medication Administration prior to medication administration; (2) adherence to the Rights of Medication Administration, including the right resident, medication, dose, route, and time; (3) compliance with medication-specific instructions and documentation requirements, including medication parameters, administration instructions, medication crushing procedures when applicable, documentation immediately following medication administration, and controlled substance documentation; and (4) appropriate communication and timely reporting of any medication errors or concerns to the supervisor were included in medication pass evaluation observation competency to ensure medication errors were recognized and reported timely. These competencies of resources listed above are available in the agency education binder which is required to review before any worked shifts. The medication pass evaluations included direct observation of an actual medication pass to ensure medications were administered safely and in accordance with physician orders and facility policy. During this evaluation process, no concerns were identified with staff adherence to resident identification procedures, medication-specific parameters, or crushing requirements. Staff (continued on next page)		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	demonstrated appropriate knowledge of reporting expectations. All licensed nurses and medication aides hired after March 18, 2026 received this same education and competency evaluation during orientation, provided by the Director of Nursing or designee, to ensure consistent understanding of medication administration expectations from the beginning of employment and ongoing compliance. Overall responsibility for ensuring completion of education, competency validation, and ongoing compliance remains with the Director of Nursing and the Assistant Director of Nursing. On March 11, 2026 and March 12, 2026 the Director of Nursing (DON) completed Medication Administration Record (MAR) audits for all current residents to ensure all resident admission, discharges, and medication order changes via provider orders were accurate. The MAR audits included review of the census sheet for March 11, 2026 and March 12, 2026, verification of any missed medications or medications not administered, and a full audit comparing all medications on the MAR to the physician order summary to ensure accuracy and consistency of orders and documentation. The DON determined there were no medication administration issues identified. On March 11, 2026, after the facility became aware of the incident all current residents were placed under observation for any changes in health status by Director of Nursing or Designee, to identify any deviations from baseline condition including neurologically via resident interviews or if any unintended harm was done from an adverse event relating to a medication error. Residents were observed for any adverse signs or symptoms related to medication administration, and no concerns were identified. No residents required further medical intervention as a result of these observations. 3. Address what measures will be put into place, or systemic changes made to ensure that the deficient practice will not recur. To ensure that this deficient practice does not recur, the facility has implemented several systemic changes focused on strengthening staff competency, reinforcing adherence to the 7 Rights of Medication Administration, and establishing ongoing quality monitoring audits. By March 18, 2026, all licensed nurses and medication aides were educated by the DON in person and via the phone on resident rights related to medication administration, with specific emphasis on the 7 Rights of Medication Administration, including the right resident, right medication, right dose, right route, right time, and right documentation. The staff members educated via phone were reeducated in person by the Assistant DON during the medication pass evaluation observation. This education reinforced the importance of accurate resident identification prior to medication administration. Staff were educated to utilize the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident before administering medications. Education also reinforced that resident identification must be verified prior to each medication administration and that staff were expected to follow facility policy regarding resident identification at all times. Education was provided in person to all licensed nurses and medication aides by the Director of Nursing starting on March 11, 2026 and concluding on March 18th, 2026. The 7 rights of medication administration were added to the new hire orientation training via in person education and demonstrated during medication pass evaluation observation. Since the incident, the facility has had one new hire, who received the required education during orientation and was observed completing medication administration competency prior to working independently on the floor. The 7 rights of medication administration was added to the agency staff onboarding binder. Agency nurses are required to review the onboarding binder upon entering the facility for each shift, which includes facility policies and procedures, prior to providing resident care. 4. How will the facility monitor its corrective action to ensure the deficient practice will not recur? A Quality Monitoring Audit was initiated on March 11, 2026 to evaluate compliance with the facility's medication administration policy, including adherence to the 7 rights and resident identification procedure by Director of Nursing (continued on next page)		

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 07/01/2026
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.			
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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and/or designee. The Director of Nursing or Assistant Director of Nursing conducted random audits of medication administration passes with 2 Licensed Nurses or Medication Aides weekly for 12 weeks, to ensure adherence of the 7 rights of medication administration, which included right medication, right resident, right dose, right time, right route, right reason, and right documentation. Quality Monitoring Auditing was conducted on both 1st shift (7:00 a.m. to 7:00 p.m.) and 2nd shift (7:00 p.m. to 7:00 a.m.) to ensure ongoing compliance with medication administration practices and identified concerns were addressed through immediate feedback and reeducation as indicated. The results of the quality monitoring were reported by the Director of Nursing or Designee to the Quality Assurance Performance Improvement Committee meeting for 3 months, no negative findings noted. The Quality Assurance Performance Improvement Committee members consist of but not limited to the Care Service Administrator, Director of Nursing, Assistance Director of Nursing, Social Worker, Activities Director, Health Care Liaison, Medical Director, Maintenance Director, Minimum Data Assessments Nurse, and at least one direct care staff member. Alleged date of compliance date: 3/19/26. The validation of the corrective action plan was completed on 07/01/2026. The facility completed a six-month review of medication records to identify any trends or patterns; no discrepancies, trends, or patterns were identified. Between March 13-16, 2026, the Assistant Director of Nursing conducted comprehensive medication pass evaluations on all staff nurses and Medication Aides. Agency staff received Medication Administration education before each shift and signed verification of training completion. This was confirmed by a review of in-service sign in sheets. Staff interviews further confirmed that nurses, medication aides, and agency staff had completed the required education and were able to verbalize the 7 rights of medication administration, utilizing the resident photograph displayed in the electronic Medication Administration Record (eMAR) to properly identify the correct resident, and the importance of reporting any medication error. This was further confirmed by a review of in-service sign in sheets. The facility also provided documentation demonstrating that newly hired staff and agency personnel assigned to Medication Administration duties had received current training. A Medication Administration Observation was completed during the validation with no medication errors noted. The facility submitted documentation confirming completion of weekly direct observation medication pass audits for two staff members per week over a 12-week period, in accordance with corrective action plan. The facility also provided documentation and interviews related to the Quality Assurance and Performance Improvement (QAPI) Committee meetings. The compliance date of 3/19/26 was validated.		

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 07/01/2026
NAME OF PROVIDER OR SUPPLIER Homestead Hills		STREET ADDRESS, CITY, STATE, ZIP CODE 2101 Homestead Hills Drive Winston-Salem, NC 27103	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observations, record reviews, and a Nurse Practitioner (NP) and staff interviews, the facility failed to adhere to the required personal protective equipment (PPE) for Enhanced Barrier Precautions (EBP) for Resident #30, who had an indwelling urinary catheter (a soft tube inserted through the urinary opening into the bladder to drain urine) and unstageable pressure ulcer that required wound care, when Nurse Aide (NA) #4 was observed changing a fecal-soiled incontinent brief without wearing a gown. The deficient practice occurred for 1 of 4 staff members observed for infection control practices (NA #4). A facility policy provided by the Director of Nursing (DON) titled "Enhanced Barrier Precautions" last revised December 2024 indicated the facility would implement EBP utilized to prevent the spread of multi-drug-resistant organisms to residents. The policy stated EBP apply when a resident had an indwelling medical device. The policy would apply to all residents with any of the following indwelling medical devices: central lines, urinary catheters, feeding tubes, and tracheotomies. Examples of high-contact resident care activities listed in the policy included: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting, transferring, providing bed mobility, changing lines, prolonged high-contact with items in the resident's room, device care or use, and wound care. EBP would remain in effect for the duration of the resident's stay or until resolution of the wound or discontinuation of the indwelling medical device. During an observation on 6/23/2026 at 3:02PM, an EBP sign was noted outside on Resident #30's door. The sign indicated that everyone must clean their hands before entering and after leaving room and all healthcare personnel must wear gloves and gowns for the following high-contact resident care activities: dressing, bathing/showering, transferring, changing linens, providing hygiene, changing briefs or assisting with toileting, device care or use, and wound care. NA #4 was observed entering Resident #30's room at 6/23/2026 at 3:10PM. NA #4 entered the room and donned gloves. NA #4 started to change Resident #30's brief. As she changed him, NA #5 entered Resident #30's room to see if NA #4 needed assistance. NA #5 donned gloves. NA #5 did not provide any direct contact to Resident #30. An interview with NA #5 at 6/23/2026 at 3:12PM confirmed that Resident #30 was the resident in the room requiring EBP. An interview with NA #4 at 6/23/2026 at 3:15PM confirmed that Resident #30 was the resident in the room requiring EBP. NA #4 stated it was because he had a catheter. She confirmed that EBP required healthcare personnel to don gloves and a gown when changing briefs. NA #4 stuttered and said, oh yea. She then confirmed she was supposed to wear a gown when changing him. She pointed out where the gowns were located which was right inside upon entering Resident #30's room. She confirmed she completed training on EBP at hire and annual training by signing completion. An interview on 6/24/2026 at 7:42AM with the Director of Nursing (DON), who was also the facility's Infection Preventionist, explained that all residents with an indwelling medical device would have EBP to prevent infections. She stated that all staff should follow the sign on the resident's door. She confirmed that Resident #30 had EBP because of his catheter and wound. An interview with NP #2 on 6/24/26 at 2:53PM, revealed that NP #2 expects staff to follow the sign on the door for EBP residents. She stated that changing a brief would require gloves and gown. During an interview on 6/25/2026 at 8:20AM with the facility Administrator, she indicated that she expects staff to follow the EBP sign.		