Division of Health Service Regulation

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034023	A. BUILDING: _____ B. WING _____	R 08/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 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) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted a follow-up survey on 08/04/26 through 08/05/26.	D 000	1. For Residents #3 and #5 identified during the survey without a current annual FL-2, the facility immediately contacted the licensed provider and ensured an updated FL-2 was completed and placed in each resident's record. 2. A 100% audit of all current resident records was conducted to identify any additional expired or missing annual FL-2 forms. Any negative findings were corrected immediately, and provider follow-up was initiated as indicated. 3. The Administrator or designee will re-educate Resident Care Director and Special Care Coordinator on the requirement that each resident have an FL-2 completed by a licensed physician or physician extender prior to admission and annually thereafter. Resident Care Director and Special Care Coordinator will also be educated on timely provider notification, tracking of due dates, and maintaining completed FL-2 forms in the resident record. 4. To prevent recurrence, the Resident Care Director or designee will verify that 100% of current residents have an annual FL-2 assessment scheduled in PCC with the appropriate annual review date. PCC will be used to monitor upcoming and overdue FL-2 assessments and alert responsible staff when an annual review is due. The Resident Care Director or designee will review the PCC annual-review status monthly for twelve (12) weeks or until 100% compliant. The Administrator will review the findings monthly through the facility's Quality Assurance Performance Improvement process for three months. Any expired, missing, or incorrectly scheduled FL-2 assessment will be addressed immediately, with staff re-education provided as needed with Resident Care Director and Special Care Coordinator. 5. Date of compliance 9/11/26	
D 235	10A NCAC 13F .0703 (b & c) Tuberculosis Test, Medical Exam & Immunizatio 10A NCAC 13F .0703 Tuberculosis Test, Medical Examination And Immunizations (b) Each resident shall have a medical examination completed by a licensed physician or physician extender prior to admission to the facility and annually thereafter. For the purposes of this Rule, "physician extender" means a licensed physician assistant or licensed nurse practitioner. The medical examination completed prior to admission shall be used by the facility to determine if the facility can meet the needs of the resident. (c) The medical examination shall be completed no more than 90 days prior to the resident's admission to the facility, except in the case of emergency admission. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to ensure 2 of 5 sampled residents (#3 and #5) had an FL2 completed annually. The findings are: 1. Review of Resident #3's FL2 dated 08/04/26	D 235		

Division of Health Service Regulation
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: CSA — (X6) DATE: 9/1/26

Reviewed and Acknowledged by S.A. on 09/08/26

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D 235	Continued From page 1 revealed diagnoses included dementia and Parkinsonism. Review of Resident #3's Resident Register revealed an admission date of 09/01/21. Review of Resident #3's record revealed: -There was an FL2 dated 11/08/23 provided by facility staff. -Resident #3 did not have an FL2 available for review which was completed between 11/09/23 and 08/03/26. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:36pm revealed she did not know Resident #3 did not have an updated FL2 completed annually between 11/09/23 and 08/03/26. Interview with the Resident Care Director (RCD) on 08/05/26 at 2:47pm revealed she did not know Resident #3 did not have an updated FL2 completed annually between 11/09/23 and 08/03/26. Interview with the Administrator on 08/05/26 at 3:00pm revealed she did not know Resident #3 did not have an updated FL2 completed annually between 11/09/23 and 08/03/26 prior to 08/04/26. Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the RCD on 08/05/26 at 2:48pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm. 2. Review of Resident #5's FL2 dated 07/30/25	D 235		

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D 235	Continued From page 2 revealed diagnoses included Alzheimer's disease and osteoarthritis. Review of Resident #5's Resident Register revealed an admission date of 02/23/24. Review of Resident #5's record revealed: -There was an FL2 dated 07/30/25. -There was no FL2 available for review which was completed before or on 07/30/26. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:40pm revealed she was not aware Resident #5 did not have an updated FL2 completed before or on 07/30/26. Interview with the Resident Care Director (RCD) on 08/05/26 at 3:15pm revealed: -She was not aware Resident #5 did not have an updated FL2 completed before or on 07/30/26. -She did not complete Resident #5's FL2 because the day it expired she was at a staff conference. -She filled out FL2's the day they expired or a day or two in advance. Interview with the Administrator on 08/05/26 at 3:07pm revealed she was not aware Resident #5 did not have an updated FL2 completed before or on 07/30/26. Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the RCD on 08/05/26 at 2:48pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm.	D 235		

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D 235	Continued From page 3 Interview with the RCC on 08/05/26 at 2:37pm revealed: -She knew residents must have an FL2 completed annually. -She filled out new FL2s when a new resident was admitted to the facility. -The RCD ensured FL2s were completed annually for all residents. Interview with the RCD on 08/05/26 at 2:48pm revealed: -She knew residents must have an FL2 completed annually. -She ensured the residents' FL2s were completed annually and signed by a provider. -The facility's electronic system normally notified facility staff when resident documents were due to be updated, including FL2s. -Resident records were audited and the last audit was completed in April 2026. Interview with the Administrator on 08/05/26 at 3:01pm revealed: -She knew residents must have an FL2 completed annually. -The RCD was responsible to ensure residents had an updated FL2 completed annually.	D 235		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure referral and follow-up to meet the health care needs for 1 of 5	D 273		

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D 273	Continued From page 4 sample residents (#1) who had an order for daily weights. The findings are: Review of Resident #1's current FL2 dated 04/12/26 with revealed: -Diagnoses included type 2 diabetes, chronic kidney disorder, and carotid stenosis. -There was an order to weigh Resident #1 daily after emptying her bladder, notify the primary care provider (PCP) for a weight gain of 2 pounds overnight or 5 pounds in 1 week. Review of Resident #1's electronic medication administration record (eMAR) for June 2026 revealed: -There was an entry to weigh Resident #1 daily and notify PCP for a weight gain of 2 pounds overnight or 5 pounds in 1 week. -There was documentation that the daily weights were not completed 15 of 30 opportunities. -There were no exceptions documented on the eMAR of why the weights were not taken. Review of Resident #1's eMAR for July 2026 revealed: -There was an entry to weigh Resident #1 daily and notify the PCP for a weight gain of 3 pounds overnight or 5 pounds in 1 week. -There was documentation that the daily weights were not completed 8 of 31 opportunities. -There were no exceptions documented on the eMAR of why the weights were not taken. Review of Resident #1's eMAR for August 2026 from 08/01/26 - 08/04/26 revealed: -There was an entry to weigh Resident #1 daily and notify the PCP for a weight gain of 3 pounds overnight or 5 pounds in 1 week.	D 273	1. For Resident #1 identified during the survey with missed ordered daily weights, reviewed the current physician order and eMAR, and notified the care provider of the missed weights and incomplete documentation. 2. A 100% audit was completed for all residents with physician orders for daily weights to identify any additional residents at risk for the same deficient practice. Any missed task, absent exception documentation, or required provider notification was corrected immediately. 3. The Administrator or designee will educate Medication Techs and resident care staff on following physician orders, completing ordered weights and monitoring tasks at the scheduled time, documenting the result or resident refusal on the eMAR, notifying the supervisor, and completing physician and responsible-party notification as indicated. 4. To prevent recurrence, the Resident Care Director or designee will review the eMAR five (5) times weekly for four weeks, then weekly for eight additional weeks, for all residents with daily weights. The review will verify task completion, documentation of refusals or exceptions, and required follow-up. Any missed task or notification will be corrected immediately and staff will be re-educated as needed. The Administrator will review audit findings through the Quality Assurance process for 3 months. 5. Date of compliance 9/11/26	

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D 273	Continued From page 5 -There was documentation that the daily weights were not completed 1 of 4 opportunities. -There were no exceptions documented on the eMAR of why the weights were not taken. Review of Resident #1's progress notes for June, July, and August 2026 on 08/04/26 revealed there was no documentation the PCP was notified that the daily weights were not completed 15 times in June, 8 times in July, or 1 time in August 2026. Interview with Resident #1 on 08/05/26 at 2:45pm revealed: -She was not aware she had an order for daily weights. -No staff had ever asked her to weigh daily, only on the first of the month. -She had not refused to allow staff to obtain her weight. Interview with a medication aide (MA) on 08/05/26 at 2:17pm revealed: -The MAs were responsible for weighing Resident #1 daily. -Weights were taken on third shift. -Other MAs reported to her that Resident #1 refused to be weighed often. -If a resident refused to be weighed, documentation should reflect that on the eMAR and the PCP should be notified. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:42pm revealed: -The MAs were responsible for weighing Resident #1. -She was not aware that some of the ordered daily weights were not completed. -She expected the MAs to follow the physician's order and if a resident refused, she expected documentation to reflect that, and the PCP would	D 273		

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D 273	Continued From page 6 be notified. Interview with the Resident Care Director (RCD) on 08/05/26 at 3:11pm revealed: -The MAs were responsible for weighing Resident #1 as ordered by the PCP. -The RCC was responsible for completing monthly chart audits. -She expected the MAs to follow the physician's order and if a resident refused, she expected documentation to reflect that, and the PCP would be notified. Interview with the Administrator on 08/05/26 at 3:07pm revealed: -She was not aware that some of Resident #1's ordered daily weights were not completed -She expected the MAs to follow the physician's order and if a resident refused, she expected documentation to reflect that, and the PCP would be notified. Attempted telephone interview with Resident #1's PCP on 08/05/26 at 1:28pm was unsuccessful.	D 273		
D 280	10A NCAC 13F .0903(c) Licensed Health Professional Support 10A NCAC 13F .0903 Licensed Health Professional Support (c) The facility shall assure that participation by a registered nurse, occupational therapist or physical therapist in the on-site review and evaluation of the residents' health status, care plan and care provided, as required in Paragraph (a) of this Rule, is completed within the first 30 days of admission or within 30 days from the date a resident develops the need for the task and at least quarterly thereafter, and includes the	D 280		

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D 280	Continued From page 7 following: (1) performing a physical assessment of the resident as related to the resident's diagnosis or current condition requiring one or more of the tasks specified in Paragraph (a) of this Rule; (2) evaluating the resident's progress to care being provided; (3) recommending changes in the care of the resident as needed based on the physical assessment and evaluation of the progress of the resident; and (4) documenting the activities in Subparagraphs (1) through (3) of this Paragraph. This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure quarterly Licensed Professional Health Support evaluations (LHPS) were completed by an LHPS nurse for 1 of 5 sampled residents (#4) related to evaluating tasks for thrombo-embolic deterrent (TED) hose and including obtaining as needed finger stick blood sugar (FSBS). The findings are: Review of Resident #4's current FL2 dated 02/16/26 revealed: -Diagnoses included Type 2 diabetes mellitus, stage 3 chronic kidney disease, carotid artery disease, hypertension, and hyperlipidemia. -He was constantly disoriented. -He was incontinent of both bowel and bladder. Review of Resident #4's Resident Register	D 280	1. For Resident #4 identified during the survey with an incomplete quarterly LHPS evaluation, the facility immediately notified the LHPS nurse and ensured a complete evaluation was completed for staff-assisted application and removal of TED hose and as-needed finger-stick blood sugar monitoring. The completed evaluation was placed in the resident record. 2. A 100% audit of all residents requiring LHPS oversight was conducted to identify any overdue LHPS or reviewed for accurate resident information. Any negative findings were corrected immediately in coordination with the LHPS nurse. 3. The Administrator or designee will re-educate Registered Nurse completing the LHPS on identifying all tasks requiring LHPS oversight and on the requirement that the LHPS evaluation be completed within the first 30 days of admission or within 30 days of the resident developing the need for the task, and at least quarterly thereafter. Education will include verification that each applicable task is listed and the required assessment, evaluation, recommendations, and documentation are complete. 4. To prevent recurrence, the Resident Care Director or designee will maintain an LHPS tracking log identifying each resident, all applicable LHPS tasks, the date of the most recent evaluation, and the next due date. A 100% audit will be completed 2 times monthly for three months or until 100% compliant. The Administrator will review results through the facility's Quality Assurance process for 3 months. Any incomplete or overdue evaluation will be corrected immediately, and responsible staff will be re-educated as needed. 5. Date of compliance 9/11/26	

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D 280	Continued From page 8 revealed he was admitted to the facility on 05/15/25. Review of Resident #4's care plan dated 02/25/26 revealed: -He required limited staff assistance with toileting, bathing, dressing, and grooming, and transferring. -Resident #4 was ambulatory but he used a walker. -He was incontinent of bowel and bladder daily. -He was totally dependent on staff for obtaining FSBS. a. Review of Resident #4's physician order dated 02/04/26 revealed an order to apply TED hose to both legs in the morning and remove at night. Review of Resident #4's LHPS evaluation records revealed the last quarterly LHPS evaluation available for review was dated 05/14/26 and Resident #4 was marked only for dressing changes. Review of Resident #4's June 2026 electronic medication administration record (eMAR) revealed: -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening. -There was documentation on the eMAR from 06/01/26 through 06/30/26 that TED hose was applied and removed. Review of Resident #4's July 2026 eMAR revealed: -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening. -There was documentation on the eMAR from 07/01/26 through 07/31/26 that TED hose was applied and removed.	D 280		

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D 280	Continued From page 9 Review of Resident #4's August 2026 eMAR from 08/01/26 to 08/03/26 revealed: -There was an entry on the eMAR to apply ted hose in the morning and remove in the evening. -There was documentation on the eMAR from 08/01/26 through 08/03/26 that TED hose was applied and removed. Observation of Resident #4 on 08/05/26 at 11:00am revealed he was wearing his TED hose and there was no swelling of his legs. Interview with Resident #4 on 08/05/26 at 11:00am revealed: -He required assistance from the facility staff to apply and remove his TED hose. -He was physically unable to apply and remove the TED hose on his own. Interview with the LHPS nurse on 08/05/26 at 11:50am revealed: -She was aware Resident #4 required assistance for applying and removing his TED hose and he should have a corresponding LHPS assessment. -She was not aware until today (08/05/26) that Resident #4 did not have an LHPS for his TED hose and no staff from the facility had communicated with her. -The facility was responsible for letting her know when a task was missed on a LHPS assessment. Interview with a personal care aide (PCA) on 08/05/26 at 1:45pm revealed: -Resident #4 required the PCAs and the medication aides (MA) to apply and remove his TED hose. -She applied Resident #4's TED Hose on 1st shift from time-to-time but 2nd shift usually removed Resident #4's TED hose at night.	D 280		

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D 280	Continued From page 10 Interview with a MA on 08/05/26 at 10:35am revealed: -Resident #4 required the MAs to apply and remove his TED hose. -She applied Resident #4's TED hose most of the time when she had worked on 1st shift. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:35pm revealed: -Resident #4 required assistance to apply and remove his TED hose from the PCAs and the MAs. -She was not aware an LHPS evaluation had not been completed for TED hose related to Resident #4. Interview with the Resident Care Director (RCD) on 08/05/26 at 2:45pm revealed: -She was aware Resident #4 required assistance to apply and remove his TED hose, -She was not aware an LHPS evaluation was not completed for Resident #4 related to TED hose and it must have been overlooked between her correspondence with the LHPS Nurse. Interview with the Administrator on 08/05/26 at 2:57pm revealed she was not aware an LHPS was not completed for Resident #4's TED hose. Refer to the interview with the RCC on 08/05/26 at 2:35pm. Refer to the interview with the RCD on 08/05/26 at 2:45pm. Refer to the interview with the Administrator on 08/05/26 at 2:57pm. b. Review of Resident #4's physician order dated	D 280		

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D 280	Continued From page 11 02/04/26 revealed an order to check FSBS as needed for BS monitoring. Review of Resident #4's LHPS evaluation records revealed the last quarterly LHPS evaluation available for review was dated 05/14/26 and Resident #4 was marked only for dressing changes. Review of Resident #4's June 2026 eMAR revealed: -There was an entry to check FSBS as needed. -There were no FSBS values documented on the eMAR from 06/01/26 through 06/30/26. Review of Resident #4's July 2026 eMAR revealed: -There was an entry to check FSBS as needed. -There were no FSBS values documented on the eMAR from 07/01/26 through 07/31/26. Review of Resident #4's August 2026 eMAR from 08/01/26 to 08/03/26 revealed: -There was an entry to check FSBS as needed. -There were no FSBS values documented on the eMAR from 08/01/26 through 08/04/26. Interview with Resident #4 on 08/05/26 at 11:00am revealed: -He required assistance from the facility staff for his FSBS when he needed his levels read. -He could not recall the last time he needed assistance for his FSBS but had not experienced any issues recently. Interview with the LHPS nurse on 08/05/26 at 11:50am revealed: -She was aware Resident #4 required as needed FSBS and he should have a corresponding LHPS assessment.	D 280		

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(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) COMPLETE DATE
D 280	Continued From page 12 -She was not aware until today (08/05/26) that Resident #4 did not have an LHPS for his as need FSBS and no staff from the facility had communicated with her. -The facility was responsible for letting her know when a task was missed on a LHPS assessment. Interview with a medication aide (MA) on 08/05/26 at 10:35am revealed: -She was aware Resident #4 required FSBS checks from the MAs on as needed basis. -She checked Resident #4's FSBS when she had worked on 1st shift but she could not recall the last time Resident #4's FSBS needed to be checked. Interview with the RCC on 08/05/26 at 2:35pm revealed: -Resident #4 required as needed FSBS checks from the MAs. -She was not aware a quarterly LHPS evaluation had not been completed for FSBS checks related to Resident #4. Interview with the RCD on 08/05/26 at 2:45pm revealed: -She was aware Resident #4 required as needed FSBS checks. -She was not aware an LHPS was completed for Resident #4 related to FSBS checks and it must have been overlooked between her correspondence with the LHPS Nurse. Interview with the Administrator on 08/05/26 at 2:57pm revealed she was not aware an LHPS was not completed for Resident #4's FSBS checks. Refer to the interview with the RCC on 08/05/26 at 2:35pm.	D 280		

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D 280	Continued From page 13 Refer to the interview with the RCD on 08/05/26 at 2:45pm. Refer to the interview with the Administrator on 08/05/26 at 2:57pm. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:35pm revealed: -She was aware LHPS assessments were required to be completed within a certain time frame but she was unaware of how often. -The LHPS Nurse was responsible for completing resident LHPS evaluations and the Resident Care Director (RCD) was responsible for auditing the LHPS documentation upon the completion of the LHPS Nurse assessment. Interview with the RCD on 08/05/26 at 2:45pm revealed: -The LHPS Nurse was responsible for completing resident LHPS evaluations and she was responsible for auditing the LHPS documentation upon the completion of the LHPS Nurse assessment. -She was aware LHPS evaluations should be completed quarterly for any identified resident task. -She was required to complete chart audits monthly. Interview with the Administrator on 08/05/26 at 2:57pm revealed: -It was the responsibility of the RCD for auditing the LHPS documentation upon the completion of the LHPS Nurse assessment. -She expected LHPS tasks to be documented on the LHPS evaluation and for the LHPS to be completed as per within a timely manner as part of regulation.	D 280		

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D 358	10A NCAC 13F .1004 (a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: FOLLOW-UP TO TYPE B VIOLATION. The Type B Violation was abated. Non-compliance continues. Based on observations, interviews, and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 residents observed during the morning medication pass including errors with an angiotensin-converting enzyme (ACE) inhibitor that was not available for administration and three medications that were crushed that could not be crushed (#6). The findings are: The medication error rate was 16% as evidenced by the observation of 4 errors out of 25 opportunities during the 8:00am medication pass on 08/05/26. Review of Resident #6's current FL2 dated 07/17/26 revealed diagnoses included chronic kidney disease and hypertension. a. Review of Resident #6's FL2 dated 07/17/26	D 358	1. For Resident #6 identified during the survey, the facility immediately reviewed all current medication orders, the eMAR, pharmacy profile, medication labels, special administration instructions, and medication supply. The prescribing practitioner and contracted pharmacy were notified that aspirin EC, ferrous sulfate, and rosuvastatin were crushed and that ramipril was unavailable and not administered. The resident was assessed for adverse effects, clinical follow-up was completed as indicated, and ramipril was reordered and obtained for administration. 2. A 100% audit of all resident medication profiles, eMARs, medications on hand, and pharmacy instructions was completed to identify medications that must not be crushed, medications requiring special administration, low medication supply, or unavailable medications. Any discrepancies were corrected immediately, and physician or pharmacy clarification was obtained as needed. 3. The Administrator or designee will educate all care services staff who handle and administer medications on the Six Rights of Medication Administration, reviewing the physician order, eMAR, pharmacy label, and do-not-crush or special administration guidance before administering medications. Staff will also be educated on medication reordering procedures, including reordering within the facility-established time frame before the supply is exhausted and immediately reporting unavailable medications to the supervisor, pharmacy, and prescribing practitioner as indicated.	

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D 358	Continued From page 15 revealed there was an order for aspirin EC (enteric coated) tablet delayed release (used to treat inflammation) 81mg take 1 tablet twice daily. Observation of the morning medication pass on 08/05/26 at 8:43am revealed: -The medication aide (MA) removed Resident #6's medication cards from the medication cart. -The MA crushed 15 of Resident #6's oral medications and mixed with chocolate pudding except for one capsule which was opened and sprinkled. -The MA administered 16 oral medications mixed with chocolate pudding to Resident #6, including aspirin. Review of Resident #6's August 2026 electronic medication administration record (eMAR) for 08/05/26 revealed: -There was an entry for aspirin EC tablet 81mg take 1 tablet twice daily scheduled for administration at 8:00am and 8:00pm. -Aspirin was documented as administered on the eMAR on 08/05/26 at 8:00am. Observation of the medications on hand for Resident #6 on 08/05/26 at 8:42am revealed there was a medication card of aspirin 81mg dispensed on 07/22/26 with 22 of 30 aspirin tablets available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/05/26 at 1:38pm revealed: -Resident #6 had an active order on file for aspirin EC 81mg take 1 tablet twice daily. -Resident #6's aspirin was dispensed on 07/22/26 for a quantity of 48 tablets which was a 24-day supply.	D 358	4. To prevent recurrence, the Resident Care Director or designee will complete medication-pass observations audits will be conducted three times weekly for 2 weeks, twice weekly for 4 weeks, and weekly for 6 weeks for a total of 12 weeks or longer until 100% compliant and tracked via audit tool. MAR-to-cart audits will also be completed two times monthly to verify medication availability, accurate transcription, and consistency among physician orders, medications on hand, pharmacy instructions, and eMAR documentation. Audit findings will be reviewed through the facility's Quality Assurance Performance Improvement process for 3 months. Any negative finding will be corrected immediately, with physician or pharmacy notification, competency validation, and staff re-education completed as indicated. 5. Date of compliance 9/11/26	

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D 358	Continued From page 16 Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/05/26 at 1:52pm revealed aspirin EC tablets should not be crushed because aspirin EC tablets had a special enteric coating which caused the tablets to be absorbed in the intestines instead of the stomach. Interview with Resident #6 on 08/05/26 at 1:33pm revealed: -Staff administered her medications and she did not know which medications she was administered. -Staff always crushed her medications and mixed them in pudding or applesauce. Interview with Resident #6's primary care provider (PCP) on 08/05/26 at 10:30am revealed: -Resident #6's aspirin EC could not be crushed. -If aspirin EC was crushed and administered, it would cause decreased effectiveness of the medication and could cause possible stomach lining irritation. Interview with the MA observed during the medication pass on 08/05/26 at 2:38pm revealed she did not know Resident #6's aspirin EC could not be crushed at the time of the morning medication pass on 08/05/26. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:36pm revealed she did not know Resident #6's aspirin EC was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when aspirin EC cannot be crushed. Interview with the Resident Care Director (RCD) on 08/05/26 at 2:47pm revealed she did not know Resident #6's aspirin EC was crushed and administered to Resident #6 during the morning	D 358		

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D 358	Continued From page 17 medication pass on 08/05/26 when aspirin EC cannot be crushed. Interview with the Administrator on 08/05/26 at 3:00pm revealed she did not know Resident #6's aspirin EC was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when aspirin EC cannot be crushed. Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm. b. Review of Resident #6's FL2 dated 07/17/26 revealed there was an order for ferrous sulfate 325mg (65mg iron) tablet (used to prevent anemia) take 1 tablet daily. Observation of the morning medication pass on 08/05/26 at 8:43am revealed: -The medication aide (MA) removed Resident #6's medication cards from the medication cart. -The MA crushed 15 of Resident #6's oral medications and mixed with chocolate pudding except for one capsule which was opened and sprinkled. -The MA administered 16 oral medications mixed with chocolate pudding to Resident #6, including ferrous sulfate. Review of Resident #6's August 2026 electronic medication administration record (eMAR) for 08/05/26 revealed: -There was an entry for ferrous sulfate 325mg take 1 tablet daily scheduled for administration at 8:00am. -Ferrous sulfate was documented as administered on the eMAR on 08/05/26 at	D 358		

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D 358	Continued From page 18 8:00am. Observation of the medications on hand for Resident #6 on 08/05/26 at 8:42am revealed there was a medication card of ferrous sulfate dispensed on 07/21/26 with 8 of 23 tablets available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/05/26 at 1:38pm revealed: -Resident #6 had an active order on file for ferrous sulfate 325mg take 1 tablet daily. -Resident #6's ferrous sulfate was dispensed on 07/21/26 for a quantity of 23 tablets which was a 23-day supply. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/05/26 at 1:52pm revealed ferrous sulfate tablets should not be crushed because ferrous sulfate tablets could irritate the stomach lining when crushed and administered. Interview with Resident #6 on 08/05/26 at 1:33pm revealed: -Staff administered her medications and she did not know which medications she was administered. -Staff always crushed her medications and mixed them in pudding or applesauce. Interview with Resident #6's primary care provider (PCP) on 08/05/26 at 10:30am revealed: -Resident #6's ferrous sulfate could not be crushed. -If ferrous sulfate was crushed and administered, it would cause decreased effectiveness of the medication and could cause possible stomach lining irritation.	D 358		

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D 358	Continued From page 19 Interview with the MA observed during the medication pass on 08/05/26 at 2:38pm revealed she did not know Resident #6's ferrous sulfate could not be crushed at the time of the morning medication pass on 08/05/26. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:36pm revealed she did not know Resident #6's ferrous sulfate was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when ferrous sulfate cannot be crushed. Interview with the Resident Care Director (RCD) on 08/05/26 at 2:47pm revealed she did not know Resident #6's ferrous sulfate was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when ferrous sulfate cannot be crushed. Interview with the Administrator on 08/05/26 at 3:00pm revealed she did not know Resident #6's ferrous sulfate was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when ferrous sulfate cannot be crushed. Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm. c. Review of Resident #6's FL2 dated 07/17/26 revealed there was an order for rosuvastatin calcium (used to treat high cholesterol) 20mg take 1 tablet daily. Observation of the morning medication pass on	D 358		

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D 358	Continued From page 20 08/05/26 at 8:43am revealed: -The medication aide (MA) removed Resident #6's medication cards from the medication cart. -The MA crushed 15 of Resident #6's oral medications and mixed with chocolate pudding except for one capsule which was opened and sprinkled. -The MA administered 16 oral medications mixed with chocolate pudding to Resident #6, including rosuvastatin calcium. Review of Resident #6's August 2026 electronic medication administration record (eMAR) for 08/05/26 revealed: -There was an entry for rosuvastatin calcium tablet 20mg take 1 tablet daily scheduled for administration at 8:00am. -Rosuvastatin calcium was documented as administered on the eMAR on 08/05/26 at 8:00am. Observation of the medications on hand for Resident #6 on 08/05/26 at 8:42am revealed there was a medication card of rosuvastatin calcium dispensed on 07/20/26 with 13 of 24 rosuvastatin calcium tablets available for administration. Telephone interview with a representative from Resident #6's pharmacy on 08/05/26 at 1:38pm revealed: -Resident #6 had an active order on file for rosuvastatin calcium 20mg take 1 tablet twice daily. -Resident #6's rosuvastatin calcium was dispensed on 07/20/26 for a quantity of 24 tablets which was a 24-day supply. Telephone interview with a pharmacist from the facility's contracted pharmacy on 08/05/26 at	D 358		

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D 358	Continued From page 21 1:52pm revealed rosuvastatin calcium tablets should not be crushed because the manufacturer recommended rosuvastatin calcium tablets should be swallowed whole. Interview with Resident #6 on 08/05/26 at 1:33pm revealed: -Staff administered her medications and she did not know which medications she was administered. -Staff always crushed her medications and mixed them in pudding or applesauce. Interview with Resident #6's primary care provider (PCP) on 08/05/26 at 10:30am revealed: -Resident #6's rosuvastatin calcium could not be crushed. -If rosuvastatin calcium was crushed and administered, it would cause decreased effectiveness of the medication and could cause possible stomach lining irritation. Interview with the MA observed during the medication pass on 08/05/26 at 2:38pm revealed she did not know Resident #6's rosuvastatin calcium could not be crushed at the time of the morning medication pass on 08/05/26. Interview with the Resident Care Coordinator (RCC) on 08/05/26 at 2:36pm revealed she did not know Resident #6's rosuvastatin calcium was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when rosuvastatin calcium cannot be crushed. Interview with the Resident Care Director (RCD) on 08/05/26 at 2:47pm revealed she did not know Resident #6's rosuvastatin calcium was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when	D 358		

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D 358	Continued From page 22 rosuvastatin calcium cannot be crushed. Interview with the Administrator on 08/05/26 at 3:00pm revealed she did not know Resident #6's rosuvastatin calcium was crushed and administered to Resident #6 during the morning medication pass on 08/05/26 when rosuvastatin calcium cannot be crushed. Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm. d. Review of Resident #6's FL2 dated 07/17/26 revealed there was an order for ramipril (used to treat hypertension) 10mg take 1 capsule twice daily. Observation of the morning medication pass on 08/05/26 at 8:43am revealed: -The MA removed Resident #6's medication cards from the medication cart. -Ramipril was not available for administration and was not administered to Resident #6. -The MA crushed 15 of Resident #6's oral medications and mixed with chocolate pudding except for one capsule which was opened and sprinkled. -The MA administered 16 oral medications mixed with chocolate pudding to Resident #6. Review of Resident #6's August 2026 electronic medication administration record (eMAR) for 08/05/26 revealed: -There was an entry for ramipril 10mg capsule take 1 capsule twice daily scheduled for administration at 8:00am and 8:00pm. -Ramipril was documented as "other" on the	D 358		

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D 358	Continued From page 23 eMAR and was not documented as administered to Resident #6 on 08/05/26 at 8:00am. Observation of the medications on hand for Resident #6 on 08/05/26 at 8:42am revealed there was not any ramipril available for administration on the medication cart. Interview with Resident #6 on 08/05/26 at 1:33pm revealed staff administered her medications and she did not know which medications she was administered. Interview with Resident #6's primary care provider (PCP) on 08/05/26 at 10:30am revealed: -She did not know Resident #6 was not administered ramipril during the morning medication pass on 08/05/26 and was not sure about the availability of Resident #6's medications. -She expected the facility to have Resident #6's medications refilled and available for administration when they were due, including ramipril. Interview with the MA observed during the medication pass on 08/05/26 at 2:15pm revealed: -Resident #6's ramipril was not available for administration during the morning medication pass on 08/05/26. -Resident #6's ramipril was ordered twice daily. -She called the pharmacy about reordering Resident #6's ramipril on 08/04/26. -MAs and the RCC reordered medications from the pharmacy. Interview with the RCC on 08/05/26 at 2:36pm revealed: -Resident #6's ramipril was reordered from the pharmacy on 08/04/26.	D 358		

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D 358	Continued From page 24 -She thought Resident #6's ramipril was supposed to be dispensed from the pharmacy last night on 08/04/26. -Resident #6's ramipril was not yet dispensed from the pharmacy and available for administration on 08/05/26. -MAs reordered medications when a resident's medications were low or had run out. Interview with the RCD on 08/05/26 at 2:47pm revealed: -She did not know Resident #6's ramipril was not available to administer during the morning medication pass on 08/05/26. -MAs reordered medications from the pharmacy. -She expected the MAs to reorder resident medications within a 7-day window before the medications ran out. Interview with the Administrator on 08/05/26 at 3:00pm revealed: -She did not know Resident #6's ramipril was not available to administer during the morning medication pass on 08/05/26. -MAs were responsible to reorder medications. -The pharmacy normally dispensed medications to the facility on a monthly cycle fill. -She thought Resident #6 ran out of ramipril because Resident #6 had recently moved from a different facility and had not yet started the pharmacy's monthly medication cycle fill. -She expected the MAs to reorder medications when a resident's medication was "low in general." Refer to the interview with the RCC on 08/05/26 at 2:37pm. Refer to the interview with the Administrator on 08/05/26 at 3:01pm.	D 358		

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOMESTEAD HILLS ASSISTED LIVING	2101 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) COMPLETE DATE
D 358	Continued From page 25 Interview with the RCC on 08/05/26 at 2:37pm revealed MAs normally reordered medications and she helped the MAs to reorder medications if the MAs did not receive a response from the pharmacy when reordering residents' medications. Interview with the Administrator on 08/05/26 at 3:01pm revealed MAs were responsible to administer medications as ordered.	D 358		