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
	HAL034019	A. BUILDING _____ B. WING _____	08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
C R T - GOLDEN LAMB REST HOME	1515 GOLDEN LAMB COURT WINSTON SALEM, NC 27105

(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 and the Forsyth County Department of Social Services conducted an annual and follow-up survey and complaint investigation on August 7-8, 2019.	D 000		
D 270	10A NCAC 13F .0901(b) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (b) Staff shall provide supervision of residents in accordance with each resident's assessed needs, care plan and current symptoms. This Rule is not met as evidenced by: Based on record reviews and interviews, the facility failed to provide supervision to 1 of 3 sampled residents (#1) in accordance with his current behaviors and assessed needs. The findings are: Review of Resident #1's current FL-2 dated 06/21/19 revealed: -Diagnoses included: mild retardation and schizophrenia paranoid type. -Resident #1 was intermittently disoriented. -Resident #1 was ambulatory. Review of Resident #1's care plan dated 06/25/19 revealed: -Resident #1 was receiving mental health	D 270	It is the policy of the CRT Golden Lamb that we provide supervision of all residents ~~dece~~ according to their needs, care plan and symtoms. The administrator met with all staff to remind	

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Darlene Kaltz
TITLE: Administrator
(X6) DATE: 9/16/19

STATE FORM 6899 ENDY11 If continuation sheet 1 of 14

Reviewed and Accepted with Revisions - SS
10/7/19

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D 270	Continued From page 1 services and medications. -Resident #1 was somewhat disoriented. -Resident #1 was forgetful and needed reminders. -Resident #1 required supervision with bathing, dressing, and grooming. Review of the facility's admission packet in Resident #1's record revealed: -The admission packet contained an agreement on page 5 titled confused and wandering resident agreement releasing the facility from liability if the resident left the facility and was injured. -Resident #1 did not sign page 5 but he did sign page 15 which indicated the information was reviewed and received. -There was no date beside Resident #1's signature. Review of the facility's sign in and sign out log revealed: -There were two sheets of paper available on a table in the facility lobby dated 08/07/19. -The heading for one of the sheets of paper was visitors and the other was residents. Review of Resident #1's emergency management service (EMS) record dated 11/25/18 revealed: -Resident #1 was transported to a local hospital on 11/25/18 at 5:40 pm. -Resident #1 was transported on 11/25/18 due to an injury to the back of his head caused by a blunt object. -There was documentation that Resident #1 reported to the Paramedics that he was assaulted by two men who approached him at the local convenient store on 11/25/18. Review of Resident #1's local hospital records revealed:	D 270	them to help the nursing department monitor the residents as to we do our best at all times. The facility nurse will contact the residents physician if further assessments are needed. Staff will still monitor the residents every 2 hours. ~~If a resident is unauthorized to leave the facility during the monitor check, it will be documented for future reference.~~ (Remove Amended 10/7/19 SS) This will be monitored by all Med Aides and the Administrator every 4 hours. (Amended 10/7/19 SS) Staff will check the sign in/sign out book to determine a resident's location if the resident is not in the building. This was completed on August 26, 2019.	

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D 270	Continued From page 2 -Resident #1 was treated at the local emergency room (ER) on 11/25/18 at 6:21 pm for head injury to the back of the head caused by a blunt object. -There was documentation by the ER physician that Resident #1 was assaulted on the street with a blunt object to the back of the head resulting in a laceration and possible concussion. Interview with Resident #1 on 08/07/19 at 1:44 pm revealed: -He recalled going to the store. -He got along with people at the store and in the neighborhood. -He knew about the sign in/sign out book. -He fell on the pavement on 11/25/18. Attempted interview with Resident #1's physician on 08/07/19 at 1:19 pm was unsuccessful. Interview with a resident on 08/07/19 at 3:49 pm revealed: -The resident remembered Resident #1 and the last time he saw him was on 08/06/19. -Resident #1 walked to a local store frequently. Interview with another resident on 08/07/19 at 6:15 pm revealed: -The resident knew Resident #1 and walked with him to a local convenient store frequently. -Resident #1 fell one time that he could recall while walking to the store, in April 2019. -He did not know if Resident #1 hurt himself or not in April 2019. -He did not know if Resident #1 was injured in November 2018 or not. -There was a sign in/sign out book, but he did not know if Resident #1 signed it. Interview with a third resident on 08/07/19 at 6:30 pm revealed:	D 270		

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-She knew Resident #1 best and he talked with her all the time.
-Resident #1 told her that he was hit with a tree limb in November 2018.
-She remembered when Resident #1 was injured in November 2018 and she told him he could not have received the injury from a tree limb.
-She thought he was injured by a person or persons while walking up to the store.
-She told Resident #1 many times to stay away from the local convenient store.
-The staff asked her almost daily where Resident #1 was located.
-Resident #1 did not always sign in and out so the staff would look for him and asked her where he was located.
-She told the staff she did not always know where he was located, and she did not work for the facility.
-She had heard the Assistant Administrator tell Resident #1 he had to sign in and out and to stay away from the local convenient store.

Interview with a Paramedic on 08/08/19 at 8:48 am revealed:
-He was one of the three Paramedics who responded to the facility on 11/25/18.
-When they arrived at the facility, Resident #1 was sitting in the hallway in a chair.
-Resident #1 reported to the Paramedics that he fell off of a log walking to the local convenient store.
-When the Paramedics loaded Resident #1 into the ambulance, he changed his story and told them he had left the facility, walked up to the local convenient store where he was approached by two men who wanted him to buy drugs.
-He refused to buy drugs and the two men assaulted him.
-Resident #1 had an injury to the back of his head

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and initially the Paramedics were concerned about a possible skull fracture.
-Resident #1 was transported to a local hospital ER.
-The facility staff did not know Resident #1 was at the local convenient store because staff at the facility made the comment.
-This was not the first time EMS had responded because another resident was assaulted at the same local convenient store.

Attempted interview with the local convenient store worker on 08/08/19 at 10:41 am was unsuccessful.

Interview with a night shift Personal Care Aide (PCA) on 08/08/19 at 9:21 am revealed:
-She was familiar with Resident #1 and he went to a local convenient store frequently.
-Resident #1 attended a day program and was awakened each morning to allow time for him to get bathed, dressed and fed prior to leaving for the day program.
-Resident #1 also attended bible study at a local church directly across the street from the facility.
-Resident #1 sometimes did not return to the facility until 9:00 pm or 9:30 pm, but the time was dependent upon the ending time of the bible study.
-She did not recall Resident #1 having an injury to the back of the head but she did remember he hurt his ribs in April 2019.
-She did not know how he had hurt his ribs.
-When she made rounds every two hours if she was not able to locate a resident she reported to the supervisor/MA on duty.
-She did not know if Resident #1 signed in and out but she would see him when he returned to the facility.
-Resident #1 did not go to the local convenient

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store at night; no resident left the facility during her shift, 7:00 pm to 7:00 am.
-Resident #1 went out to smoke in the morning until breakfast once he was bathed and dressed.

Attempted interview with a day shift PCA on 08/08/19 at 9:18 am was unsuccessful.

Interview with a day shift Medication Aide (MA) on 08/08/19 at 8:33 am revealed:
-She worked first shift from 7:00 am to 3:30 pm and she only worked part time about three days a week.
-Resident #1 had to be directed to do things and then he would forget so he had to be told again, such as dressing.
-Resident #1 left his room often without a shirt or pants and he would have to be prompted to return to his room and put a shirt and pants on.
-She knew Resident #1 was not at the facility on 11/2/5/18 when she left work, but she was not able to tell where every resident was at every point of the shift.
-She was called by the Assistant Administrator on 11/25/18 about Resident #1 but she did not know what happened to Resident #1 to cause his injury.
-She told the Assistant Administrator that Resident #1 was not at the facility and was at the store.
-Resident #1 told her later, she did not know when, that he was "jumped by someone at the store".
-She did not know what Resident #1 was doing at the store.
-When staff made rounds, if they did not see Resident #1 in the facility, staff checked the porch for him and asked other residents about his location.
-She did not check the sign in/sign out log to see if Resident #1 had signed out.

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-She was not able to "keep up with all the residents" and take care of the residents in the facility.
-Resident #1 went to a day program from 8:30 am until 2:30 pm.
-The staff on duty were in charge of knowing where the residents were located at each two-hour round.

Attempted interview with a night shift MA on 08/07/19 at 10:00 pm and 08/08/19 at 7:50 am was unsuccessful.

Interview with the Assistant Administrator on 08/08/19 at 11:13 am revealed:
-Resident #1 was fast and he would go out to smoke and then be at the local convenient store.
-Resident #1 needed reminding to do activities like finish dressing or when bathing.
-He knew Resident #1 had an intellectual disability, but he could not force him to do things.
-There had been incidents when the day program transportation had left him because he was not at the facility for pick-up.
-Resident #1 would stand in the shower and stare up at the shower faucet.
-Resident #1 would stand over in the gravel parking lot and stare up at the sky.
-He told Resident #1 many times to sign in and out.
-He told Resident #1 to stay away from the local convenient store because it was an urban area and a lot happened at the store.
-He knew Resident #1 attended bible study at churches in the area.
-He had spoken with attendees of the bible study and told them Resident #1 needed to be back at the facility at a certain time and needed to be watched because it was dark outside when the bible study ended.

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D 270	Continued From page 7 -He had not spoken with the mental health provider about Resident #1's behavior of going to the store repeatedly. -He had not spoken with Resident #1's physician about Resident #1's behavior of going to the store repeatedly. -Many people had spoken with Resident #1 to tell him not to go to the store, even the Pastor of the church spoke with Resident #1. -He thought residents had the right to refuse and he could not keep Resident #1 inside of the facility. -Resident #1 was his own responsible person and he could not keep him from going to the store. -He did not change how Resident #1 was supervised after the 11/25/18 head injury. -Staff continued to perform every two hour rounds. -Resident #1 continued to attend the day program and go the local convenient store after the 11/25/18 head injury. -He kept telling Resident #1 not to go to the local convenient store. -The staff were busy caring for other residents and were not able to always watch Resident #1. -He had not met with the staff to determine a plan to supervise Resident #1. -The staff on duty were responsible for ensuring residents were supervised. Interview with the Administrator on 08/08/19 at 12:45 pm revealed: -Resident #1 went to churches in the area and walked to the local convenient store. -She expected residents to sign themselves in and out and if they did not it was unauthorized. -She thought this was in the facility policy concerning signing in and out of the facility. -Resident #1 had mental health issues and did things that were different, such as he walked	D 270		

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D 270	Continued From page 8 rapidly. -She knew Resident #1 was injured in November 2018 and she told him after the injury it was not good for him to go to the store. -She felt Resident #1 did not listen when she told him to not go to the store. -She had not spoken with Resident #1's mental health provider or physician about concerns with him going to the local convenient store. -She did not transport Resident #1 to his appointments. -She and the staff continued to tell Resident #1 to not go to the store. -Staff monitored the residents by making rounds every 2 hours and sometimes all the residents were in the facility and sometimes they were not.	D 270		
D 310	10A NCAC 13F .0904(e)(4) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (e) Therapeutic Diets in Adult Care Homes. (4) All therapeutic diets, including nutritional supplements and thickened liquids, shall be served as ordered by the resident's physician. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to assure therapeutic diets were served as ordered for 1 of 5 sampled resident (Resident #4) with diet orders for a mechanical soft (MS) diet. The findings are: Review of Resident #4's current FL2 dated 07/31/19 revealed: -Diagnoses included dementia, hypertension, atrial fibrillation and deconditioning balance	D 310	It is the policy of the CRT Golden Lamb that residents with therapeutic diets shall be served as order by the residents physician. The dietary supervisor will provide additional training so each staff (dietary) is familiar with the therapeutic diets monthly. (amended SS 10/7/19) This will be monitored daily (amended SS 10/7/19)	

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D 310	Continued From page 9 difficulty. -There was an order for a MS diet. Review of the therapeutic diet list posted in the kitchen (no date documented) revealed Resident #4 was to be served a MS diet. Review of the facility's therapeutic diet menu for the lunch meal for Wednesday, 08/07/19 revealed residents ordered a MS diet were to be served ground beef tips in gravy, noodles, seasoned broccoli, cornbread, peaches and beverage. Observation of the lunch meal service on 08/07/19 from 12:00pm to 1:00pm revealed: -Resident #4 was not served his meal until 12:30pm, after the other residents that were getting feeding assistance had eaten. -Resident #4 was served chopped beef with noodles, broccoli, sweet potatoes, tea, and water. -Resident #4 received feeding assistance from a Personal Care Aide (PCA). -Resident #4 had no dentures and had to chew his food 54 to 57 times before swallowing. -The resident consumed 98% of the meal without difficulty. Interview with the Cook on 08/07/19 at 1:10pm revealed: -He knew Resident #4's food had to be altered. -The staff serving the meal took Resident #4's food out of the kitchen before he altered the meal. -When reminded Resident #4 got his food last, the cook stated, "I don't know what happened." Interview with the PCA that provided feeding assistance to Resident #4 on 08/07/19 at 1:15pm revealed: -Resident #4 was not able to feed himself.	D 310	by the dietary supervisor or desisnee Jamelodd SS 10/7/19 This was completed on August 20, 2019	

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-Resident #4 had no teeth and it took a long time for the resident to chew his food.
-Resident #4 was always served chopped meats or cut-up meats with his meals.
-If the meat was not cut-up small enough it took the resident longer to chew the meat.
-Resident #4 did not have dentures and had difficulty chewing foods.
-Resident #4 previously had gotten choked off foods like meat, because they was difficult to break down due to the resident not having any teeth.
-Resident #4 had not gotten choked in several months.

Interview with the Administrator on 08/07/19 at 1:25pm revealed:
-She knew that Resident #4's foods had to altered.
-She thought the MS diet was chopped meat.
-The Cook was supposed to review the meal when preparing meals.
-The Cook had the menus in the kitchen and should have known if the menu called for Resident #4's meats to be grounded.
-She observed the meals but did not realize Resident #4's MS diet required meats to be ground.

Interview with Resident #4's Primary Care Provider (PCP) on 08/08/19 at 10:42am revealed:
-Resident #4 had dementia and no dentures.
-Resident #4 was ordered a MS diet for safety precautions to make swallowing easy.

Based on record review, observation, and interview it was determined that Resident #4 was not interviewable.

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D 451	Continued From page 11	D 451		
D 451	10A NCAC 13F .1212(a) Reporting of Accidents and Incidents 10A NCAC 13F .1212 Reporting of Accidents and Incidents (a) An adult care home shall notify the county department of social services of any accident or incident resulting in resident death or any accident or incident resulting in injury to a resident requiring referral for emergency medical evaluation, hospitalization, or medical treatment other than first aid. This Rule is not met as evidenced by: Based on record reviews and interviews the facility failed to notify the county department of social services for 1 of 3 sampled residents (#1) that required notification because of one hospitalizations. The findings are: Review of Resident #1's current FL-2 dated 06/21/19 revealed diagnoses included schizophrenia paranoid type and mild mental retardation. Review of Resident #1's emergency medical services (EMS) report dated 11/25/18 revealed: -Resident #1 was responded to on 11/25/18 at 5:40 pm for a complaint of a fall. -Resident #1 was transported to the local hospital for treatment due to assault with blunt object at a place of business and head injury.	D 451	It is the policy of the CRT Golden Lamb to the we will notify the County DSS of any accident or incident resulting in injury to a resident requiring medical evaluation, medical treatment or hospitalization The administrator met with all supervisors, persons in charge of the facility in her absence to ensure they	

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D 451	Continued From page 12 Review of Resident #1's hospital report dated 11/25/18 revealed he was admitted to the hospital for treatment of laceration of the scalp, and concussion without loss of consciousness at 6:21 pm on 11/25/18. Interview with Resident #1 on 08/07/19 at 1:44 pm revealed he was injured in November 2018, went to the hospital, but he did not state the reason. Interview with the Forsyth Department of Social Services (DSS) Adult Home Specialist (AHS) on 08/08/19 at 8:15 am revealed an incident report was not received for the 11/25/18 incident. Interview with the Assistant Administrator on 08/08/19 at 8:27 am revealed: -He was unsure if he had completed an incident report when Resident #1 injured the back of his head in November 2018. -The reason he did not complete an incident report for Resident #1 was because the 11/25/18 injury did not occur on the facility premises. -He did not know he needed to complete an incident report for any accident or incident that resulted in an injury to the resident with referral to EMS and the hospital. Interview with the Administration on 08/08/19 at 12:02 pm revealed: -She did not know if an incident report was completed concerning the incident on 11/25/18. -The MAs were supposed to complete an incident report when residents had an accident or incident. -The MAs were supposed to fax the incident report to the county Department of Social Services (DSS). -She made a book that remained at the nurse's	D 451	were properly prepared for such incidents/accidents. An incident form is located at the nurse's station with a fax number, who to fax it to and the time period it is to be faxed. This was complete on August 19, 2019. The administrator will monitor the reports.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL034019	A. BUILDING _____ B. WING _____	08/08/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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D 451	Continued From page 13 station with blank incident reports and the fax number to send the incident reports to DSS. -She told all the MAs about the book and the incident reports. -She did not know if all the MAs understood when a incident report needed to be completed.	D 451		