STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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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 conducted an annual and follow-up survey on July 12-13, 2023.	D 000		
D 254	10A NCAC 13F .0801(b) Resident Assessment 10A NCAC 13F .0801Resident Assessment (b) The facility shall assure an assessment of each resident is completed within 30 days following admission and at least annually thereafter using an assessment instrument established by the Department or an instrument approved by the Department based on it containing at least the same information as required on the established instrument. The assessment to be completed within 30 days following admission and annually thereafter shall be a functional assessment to determine a resident's level of functioning to include psychosocial well-being, cognitive status and physical functioning in activities of daily living. Activities of daily living are bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting and eating. The assessment shall indicate if the resident requires referral to the resident's physician or other licensed health care professional, provider of mental health, developmental disabilities or substance abuse services or community resource. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure that 1 of 3 sampled residents had a care plan completed	D 254		

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D 254	Continued From page 1	D 254		

within 30 days of admission and at least annually thereafter.

The findings are:
Review of Resident #1's current FL2 dated 05/23/23 revealed:
-Diagnoses included epilepsy, muscle weakness, hypertension, aphasia, chronic seizures, dementia, and a history of cerebrovascular accident (CVA).
-He was non-ambulatory.
-He was incontinent of bladder and bowel.
-He required total assistance with activities of daily living (ADLs).

Review of Resident #1's care plan dated 02/22/19 revealed:
-Resident #1 required total assistance with all ADLs.
-There was no subsequent care plan available for review.

Observation of Resident #1 on 07/12/23 at 12:15pm revealed that he required feeding assistance for the lunch meal service.

Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable.

Interview with the Administrator on 07/17/23 at 12:34pm revealed:
-She was not aware that Resident #1's care plan was not updated since 2019.
-She thought Resident #1 had an updated care plan.
-Resident #1 required assistance with all ADLs and was dependent on staff assistance.
-The Administrator was responsible to ensure that resident care plans and assessments were

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D 254	Continued From page 2 completed annually.	D 254		
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 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 a Licensed Health Professional Support (LHPS) assessment was completed at least quarterly for 3 of 3 sampled residents (Resident #1, #2, and #3) with	D 280		

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D 280	Continued From page 3	D 280		

LHPS tasks of use of assistive devices and collecting fingerstick blood samples (#2), and assistance with transfer and use of assistive devices (#1, and #3).

The findings are:

1. Review of Resident #2's current FL2 dated 06/01/22 revealed diagnoses included dementia, type II diabetes, and chronic obstructive pulmonary disease.

Review of Resident #2's LHPS assessments revealed:
-The most recent LHPS assessment was completed 06/04/20.
-Ambulation using assistive devises that required physical assistance and collecting and testing of fingerstick blood samples (FSBS) were listed as marked tasks.
-There was no subsequent LHPS evaluation for review.

Observation of Resident #2 on 07/12/23 and 07/13/23 revealed:
-On 07/13/23 at 7:55am, the Administrator was passing medications and obtained a FSBS check for Resident #3.
-On 07/13/23 at 8:10am, the resident was sitting in the hallway area with her rolling walker; she placed her rolling walker at the door beside the dining room and carefully ambulated unassisted by staff to a table in the dining room.

Based on observations, interviews and record review, it was determined that Resident #2 was not interviewable.

Attempted telephone interview with LHPS nurse on 07/13/23 at 12:00pm unsuccessful.

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D 280	Continued From page 4 Refer to interview with the Administrator on 07/13/23 at 12:45pm. 2. Review of Resident #3's current FL2 dated 06/28/22 revealed: -Diagnoses included schizophrenia, hypertension, urinary incontinence, impaired renal function, cirrhosis, weight loss, hepatitis B and C, and cerebral atrophy. -She was non-ambulatory. -She was incontinent of bladder and bowel. -She required total care for activities of daily living. Review of Resident #3's Licensed Health Professional Support (LHPS) assessments revealed: -The most recent LHPS assessment was completed 06/04/20. -Transferring semi-ambulatory or non-ambulatory residents, ambulation using assistive devices that required physical assistance (assisting with wheelchair), and maintaining accurate intake and output data were listed as marked tasks. -There was no subsequent LHPS evaluation for review. Observation of Resident #3 on 07/12/23 and 07/13/23 revealed: -On 07/12/23 at 11:50am, she was sitting in the hallway area in her wheelchair; staff assisted her by pushing her wheelchair from the common area into the dining room. -On 07/13/23 at 8:00am, she was sitting in the hallway area in her wheelchair; staff assisted her by pushing her wheelchair from the common area into the dining room. Based on observations, interviews and record	D 280		

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review, it was determined that Resident #3 was not interviewable.

Attempted telephone interview with LHPS nurse on 07/13/23 at 12:00pm unsuccessful.

Refer to interview with the Administrator on 07/13/23 at 12:45pm.

3. Review of Resident #1's current FL2 dated 05/23/23 revealed:
-Diagnoses included epilepsy, muscle weakness, hypertension, aphasia, chronic seizures, dementia, and a history of cerebrovascular accident (CVA).
-He was non-ambulatory.
-He was incontinent of bladder and bowel.
-He required total care for activities of daily living.

Review of Resident #1's Licensed Health Professional Support (LHPS) evaluations revealed:
-The most recent LHPS evaluation was completed on 06/04/20.
-He had LHPS tasks including transferring semi-ambulatory or non-ambulatory residents and ambulation using assistive devices that required physical assistance (assisting with wheelchair).
-There was no subsequent LHPS evaluation for review.

Observation of Resident #1 on 07/12/23 at 11:55am revealed he was sitting in the hallway area in his wheelchair; he was propelled by a staff in his wheelchair from the common area into the dining room.

Attempted telephone interview with LHPS nurse on 07/13/23 at 12:00pm unsuccessful.

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D 280	Continued From page 6 Based on observations, interviews and record review, it was determined that Resident #1 was not interviewable. Refer to interview with the Administrator on 07/13/23 at 12:45pm. _____ Interview with the Administrator on 07/13/23 at 12:45pm revealed: -She knew the residents' quarterly LHPS evaluations had not been completed. -The facility used to employ a contracted nurse. -The nurse was responsible to complete the LHPS evaluations for all residents. -She was responsible to make sure the LHPS reviews were completed quarterly and as needed for residents with new tasks. -The LHPS nurse had resigned after June 2020. -She had not been able to hire a replacement nurse. -The current staff was aware of all residents' needs and LHPS tasks to be provided. -The Administrator was responsible to ensure assessments, including LHPS evaluations, were completed per regulations and rules. -She had not been able to conduct record audits on a regular basis due to staffing shortages, but was aware LHPS ebvaluations were not up to date.	D 280		
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	D 358		

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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:
Based on observations, interviews, and record reviews, the facility failed to administer medications as ordered for 1 of 3 sampled residents (#3) related to an anti-anxiety medication and an anti-depressant medication.

The findings are:

Review of Resident #3's current FL-2 dated 06/28/22 revealed diagnoses included schizophrenia, hypertension, urinary incontinence, impaired renal function, cirrhosis, weight loss, hepatitis B and C, and cerebral atrophy.

Review of Resident #3's summary of eye examination from the contracted optometrist dated 02/27/23 revealed:
-Resident #3 had bilateral glaucoma (increased fluid pressure within the eyeball).
-Resident #3 was ordered to continue current eye drops for glaucoma treatment.
-Resident #3 had elevated eyeball fluid pressures.
-There was an order to add brimonidine (used to treat glaucoma) eye drops twice a day to each eye.

Review of Resident #3's medication orders revealed there was no subsequent order to discontinue brimonidine eye drops twice a day to each eye.

Review of Resident #3's May, June and July 2023 (from 07/01/23 to 07/13/23) medication

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administration record (MAR) revealed:
-There was no entry for brimonidine eye drops twice a day to each eye.
-There was no documentation for administration of brimonidine eye drops twice a day to each eye for May, June or July 2023.

Telephone interview with an order entry staff at the contracted pharmacy revealed:
-The pharmacy was responsible for entering medication orders onto the residents' MARs.
-Sometimes residents' prescribing providers sent medication orders directly to the pharmacy and sometimes orders were left at the facility for facility to process.
-The facility was responsible to fax all new orders to the pharmacy for review and processing.
-She was responsible for processing information for the facility and entered most of the residents' orders.
-There was no documentation the pharmacy had received Resident #3's order for brimonidine eye drops twice a day to each eye dated 02/27/23 from the facility or directly from the optometrist.
-The pharmacy had never dispensed brimonidine eye drops for Resident #3.
-The pharmacy would send the eye drops as soon as the order was faxed to the pharmacy.

Telephone interview with an office staff at the contracted optometrist office on 07/13/23 at 9:29am revealed:
-The optometrist provided mobile, on-site, eye care.
-There was as assistant that traveled with the optometrist from facility to facility routinely every 6 months.
-According to documentation, Resident #3 was seen at the facility on 02/27/23 for monitoring glaucoma pressures.

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D 358	Continued From page 9 -Resident #3 was ordered brimonidine eye drops to be added to her existing eye drops for glaucoma. -Copies of the summary of eye examinations were left at the facility or emailed to the facility's contact person within a few days of the visit. -Routinely, the optometrist left medications orders at the facility for new medications or medication changes. -The optometrist was due to revisit the facility on 8/22/23 and she would make a note to recheck Resident #3's pressure and that the medication was not started as ordered until 07/14/23. -If the resident's eyes were not properly treated over long periods of time, elevated eyeball fluid pressure (glaucoma) could lead to damage to the eyeball and affect vision. Interview with the Administrator on 07/13/23 at 10:45am revealed: -She thought the optometrist sent all medication orders electronically to the contracted pharmacy when he was at the facility. -The medication aide (MA) on duty when the optometrist visited the facility was responsible to fax any orders left by the provider to the contracted pharmacy. -She tried to audit residents' orders randomly, but had not audited in several months due to staffing shortages and performing medication aide duties, personal care aide duties, and administrative duties. -She had not seen the order for Resident #3's order for brimonidine eye drops dated 02/27/23 until she printed the eye examination summaries from the provider's visit on 02/27/23 on 07/12/23. -She did not know how the order for brimonidine eye drops dated 02/27/23 got misplaced if the provider left new orders after his visit.	D 358		

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D 358	Continued From page 10 Based on observations, interviews and record review, it was determined that Resident #3 was not interviewable.	D 358		