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 _____	R 12/18/2024

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 conducted an annual and a follow-up survey on 12/17/24 and 12/18/24.	D 000		
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 1 of 3 sampled residents (Resident #2) had a current FL2 completed annually. The findings are:	D 235		

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D 235	Continued From page 1 Review of Resident #2's previous FL2 dated 05/10/23 revealed diagnoses included dementia, type 2 diabetes, and schizophrenia. Review of Resident #2's record revealed that Resident #2 did not have an updated FL2 completed since 05/10/23. Based on observations, interviews, and record review, it was determined Resident #2 was not interviewable. Interview with the Supervisor on 12/18/24 at 10:18am revealed: -She did not know Resident #2's FL2 was not updated since May 2023. -The Administrator normally updated all the residents' FL2s. Telephone interview with the Administrator on 12/18/24 at 2:00pm revealed: -She was not aware that Resident #2's FL2 was not updated since May 2023. -She had transported Resident #2 to a doctor's appointment in November 2024 and thought Resident #2's FL2 was updated at the appointment. -She was responsible to ensure that resident FL2s were completed annually.	D 235		
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	D 254		

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D 254	Continued From page 2 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 interviews and record reviews, the facility failed to ensure that 1 of 3 sampled residents (#2) had a care plan completed within 30 days of admission and at least annually thereafter. The findings are: Review of Resident #2's current FL2 dated 05/23/23 revealed: -Diagnoses included dementia, type 2 diabetes, and schizophrenia. -She was ambulatory.	D 254		

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D 254	Continued From page 3 -She was continent of bowel and bladder. Review of Resident #2's care plan dated 05/10/23 revealed: -Resident #2 was independent with all activities of daily living (ADLs). -There was no subsequent care plan available for review. Based on observations, interviews and record review, it was determined Resident #2 was not interviewable. Interview with the Supervisor on 12/18/24 at 10:18am revealed: -She did not know Resident #2 did not have an updated care plan available for review. -She did not know residents must have care plans updated annually. -The Administrator updated the residents' care plans. Telephone interview with the Administrator on 12/18/24 at 2:00pm revealed: -She was not aware Resident #2's care plan was not updated since May 2023. -She thought Resident #2 had an updated care plan available for review. -She had transported Resident #2 to a doctor's appointment in November 2024 and thought Resident #2's care plan was updated at the appointment. -She was responsible to ensure that resident care plans and assessments were completed annually.	D 254		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration	D 358		

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D 358	Continued From page 4 (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: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 3 sampled residents (#2) with an order for a laxative. The findings are: Review of Resident #2's previous FL2 dated 05/10/23 revealed diagnoses included dementia, type 2 diabetes, and schizophrenia. Review of Resident #2's physician appointment after visit summary (AVS) medication lists dated 05/15/24 and 11/27/24 revealed there was an order for polyethylene glycol (a laxative used to prevent constipation) 17 grams daily. Review of Resident #2's October 2024 medication administration record (MAR) revealed: -There was no entry for polyethylene glycol 17 grams. -There was no documentation polyethylene glycol 17 grams was administered from 10/01/24 to 10/31/24. Review of Resident #2's November 2024 MAR revealed: -There was no entry for polyethylene glycol 17 grams. -There was no documentation polyethylene glycol	D 358		

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D 358	Continued From page 5 17 grams was administered from 11/01/24 to 11/30/24. Review of Resident #2's December 2024 MAR from 12/01/24 to 12/17/24 revealed: -There was no entry for polyethylene glycol 17 grams. -There was no documentation polyethylene glycol 17 grams was administered from 12/01/24 to 12/17/24. Observation of Resident #2's medications on hand on 12/17/24 at 2:20pm revealed there was no polyethylene glycol 17 grams available for administration on the medication cart. Telephone interview with the facility's contracted pharmacy on 12/17/24 at 2:40pm revealed: -There was no order on file for Resident #2 for polyethylene glycol 17 grams one capsule daily. -Polyethylene glycol was never an order for Resident #2 in the pharmacy's electronic system for medications and had never been dispensed. Attempted telephone interview with Resident #2's primary care provider (PCP) on 12/18/24 at 9:48am unsuccessful. Based on observations, interviews and record reviews, it was determined Resident #2 was not interviewable. Interview with the Supervisor on 12/17/24 at 2:25pm revealed: -She was a medication aide (MA) and administered medications to Resident #2. -Polyethylene glycol was not on the medication cart for Resident #2. -She did not know Resident #2 had an order for polyethylene glycol and she had not administered	D 358		

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D 358	Continued From page 6 polyethylene glycol to Resident #2. Telephone interview with the Administrator on 12/18/24 at 2:00pm revealed: -She did not know Resident #2 had an order for polyethylene glycol 17 grams daily since May 2024. -She did not know how Resident #2's order for polyethylene glycol was missed. -The facility sometimes faxed new orders to the pharmacy and Resident #2's provider's office usually electronically prescribed new medications directly to the facility's contracted pharmacy. -The Supervisor was responsible to administer medications as ordered.	D 358		