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 07/30/2026

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 a follow-up survey from 07/28/26 to 07/30/26.	D 000		
D 224	10A NCAC 13F .0702 (b) Discharge Of Residents 10A NCAC 13F .0702 Discharge Of Residents (b) The discharge of a resident initiated by the facility at the direction of the administrator or their designee shall be based on one of the following reasons: (1) the discharge is necessary to protect the welfare of the resident and the facility cannot meet the needs of the resident, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (2) the health of the resident has improved sufficiently so that the resident is no longer in need of the services provided by the facility, as documented by the resident's physician, physician assistant, or nurse practitioner in the resident's record; (3) the safety of the resident or other individuals in the facility is endangered as determined by the facility at the direction of the administrator or their designee in consultation with the resident's physician, physician assistant, or nurse practitioner; (4) the health of the resident or other individuals in the facility is endangered as documented by a physician, physician assistant, or nurse practitioner in the resident's record; or (5) the resident has failed to pay the costs of services and accommodations by the payment due date according to the resident's contract after receiving written notice of warning of discharge for failure to pay.	D 224		

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D 224	Continued From page 1	D 224		

This Rule is not met as evidenced by:
TYPE B VIOLATION

Based on observations, interviews and record reviews, the facility failed to initiate the discharge of 1 of 1 resident (#4) who was recommended for a higher level of care by the primary care provider (PCP).

The findings are:

Review of Resident #4's current FL2 dated 04/03/26 revealed:
-Diagnoses included psychosis-negative of symptoms (NOS), schizophrenia-unspecified type, tardive dyskinesia, and borderline intellectual functioning.
-She was incontinent of bowel and bladder, and semi-ambulatory.
-She was intermittently disoriented and verbally abusive.
-The recommended level of care was a skilled nursing facility (SNF).

Review of Resident #4's FL2 dated 03/09/26 revealed:
-Diagnoses included tardive dyskinesia, schizophrenia, annual wellness visit, and behavior disturbance.
-She was incontinent of bowel and bladder, and semi-ambulatory.
-She was intermittently disoriented and verbally abusive.

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D 224	Continued From page 2 -The recommended level of care was a domiciliary (rest home). Review of Resident #4's FL2 dated 07/24/25 revealed: -Diagnoses included psychosis-negative of symptoms (NOS), schizophrenia-unspecified type, tardive dyskinesia, and borderline intellectual functioning. -She was incontinent of bowel and bladder, and semi-ambulatory. -She was intermittently disoriented and verbally abusive. -The recommended level of care was a domiciliary (rest home). Review of Resident #4's Resident Register revealed an admission date of 06/23/14. Observation of Resident #4 on 07/28/26 at 10:30am revealed: -Resident #4 was seated in a wheelchair near the medication aide/nursing desk in the center of the facility. -She was leaning forward (slumped) with her chest close to her knees and appeared to be resting. Review of Resident #4's care plan date 04/03/26 revealed: -There was no documentation identifying whether the care plan was annual or a significant change in condition. -She required extensive assistance for activities of daily living (ADL) of eating, toileting, ambulation, and transferring. -She was verbally abusive and exhibited disruptive/socially inappropriate behaviors. -She was totally dependent for ADL of bathing, dressing, and grooming.	D 224		

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D 224	Continued From page 3 -She was sometimes disoriented, was incontinent to bladder and bowel, and was ambulatory with a wheelchair. Review of Resident #4's examination or contact by physician's notes revealed: -On 12/16/25, there was documentation for a physician visit with no changes in medications. -On 03/09/26, there was documentation Resident #4 was at the clinic for an FL2 form and tuberculosis test. The PCP spoke with the Administrator at the facility, and the guardian would call (no information who she would call). -There were no other physician encounter notes or physician notes available for review. Review of Resident #4's progress notes revealed: -On 03/09/26 at 7:00am-3:00pm, Resident #4 saw her primary care provider (PCP) for an FL2. -On 03/10/26 at 7:00am-3:00pm, Resident #4 cursed all shift. -On 03/12/26 at 7:00am-3:00pm, Resident #4 had been cursing off and on all shift. -On 03/13/26 at 7:00am-3:00pm, Resident #4 had done a lot of cursing and told a supervisor she wanted to hurt her. On 03/16/26, 03/20/26, 03/26/26, and 03/27/26 at 7:00am-3:00pm, Resident #4 had been cursing staff off and on. -On 04/03/26 at 7:00am-3:00pm, Resident #4 saw her PCP for an updated FL2, care plan, and current medication list. Resident #4 was given level of care for SNF. The guardian was given a copy of all. -On 04/13/26 at 7:00am-3:00pm, Resident #4 had been crying off and on all shift, pulled at her clothes, and told staff and residents to get out of her house. -On 05/03/26 at 12:00pm, Resident #4 had a witnessed fall from her wheelchair to the floor.	D 224		

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D 224	Continued From page 4 She hit her head and was sent out to local emergency department. She returned at 5:15pm with sutures in forehead. -On 05/05/26 (no time indicated or staff identifier), a message was left for Resident #4's guardian by the facility's contracted Licensed Health Profession Services (LHPS) nurse regarding her placement to a SNF and additional notation left by the nurse in the progress notes. -On 05/05/26 at 3:45pm, the contracted LHPS nurse noted Resident #4's guardian was notified, via telephone message, as of 04/03/26 the PCP increased Resident #4's level of care to SNF. The facility did not provide skilled care, only assisted living. The guardian did not answer the telephone when she called. -On 05/06/26 (no time indicated or staff identified), Resident #4's guardian called the facility requesting progress notes to be sent to a skilled nursing and rehabilitation facility. The guardian was told the facility did not really have progress notes. Resident #4's guardian was informed, verbally, she had 30 days to move her. -On 05/12/26 (no time indicated or staff identifier), Resident #4 was transported for suture removal in forehead. -On 05/28/26 at 7:00-3:30pm, Resident #4's guardian called for progress notes, and was told the facility did not have progress notes but she could call back this evening to speak to the Administrator. -On 05/31/26 (no time indicated or staff identifier), the guardian was called and message left. -On 06/02/26 (no time indicated or staff identifier), Spoke with guardian who stated she was waiting on 2 facilities today was documented. -Additional care notes were documented on 06/22/26, 07/16/26, 07/17/26, 07/20/26, and 07/24/26 related to Resident #4 leaning way forward in her wheelchair and staff laying her in	D 224		

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D 224	Continued From page 5	D 224		

her bed, and/or cursing a lot.
-On 07/28/26 at 11:35am the Administrator documented that Resident #4 had an unwitnessed fall from her wheelchair to the floor in her room. She was transported by ambulance to a local emergency department.
-There was no documentation Resident #4's primary care provider (PCP) was notified for increasing inappropriate behaviors of cursing staff or increased leaning forward in her wheelchair.

Review of Resident #4's after visit summary (AVS) from a local emergency department dated 07/28/26 revealed:
-The resident was seen for a fall.
-Her diagnoses were unwitnessed fall and hematoma of forehead.
-Imaging of the head and spine cervical were performed.
-There were no negative outcomes from the imaging noted.

Review of the Resident #4's facilty form created and titled "Immediate Discharge Notice" dated 07/28/26 revealed:
-The reason for immediate discharge was documented as follows: "Resident is being discharged immediately due to: A significant change in conditions requiring a higher level of care. Safety concerns/risk to self.
-The guardian was notified on 07/28/26 by phone with no time of notification documented.
-The Administrator completed the form on 07/28/26.

Review of the Notice to Transfer/Discharge and Adult Care Home Hearing Request Form revealed there were no forms issued for Resident #4 available for review.

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D 224	Continued From page 6 Interview with the Administrator on 07/29/26 at 9:50am revealed: -On 07/28/26 (no time provided), the hospital called to say Resident #4 was stable with no fractures only a bump on her forehead. -She told the hospital case worker the facility was not taking Resident #4 back at the facility. -Resident #4's guardian had been working on placement for Resident #4 to a SNF for 3 months. -Resident #4 was not coming back to the facility. -Resident #4 was discharged from the facility on 07/28/26. Telephone interview with a representative from the local Department of Social Services (DSS) on 07/29/26 at 11:05am revealed: -The facility faxed an incident report for Resident #4 on 07/28/26. -The fax included the first sheet of the Resident #4's AVS from a local ED. -The DSS representative did not know Resident #4's current condition or location. -In April 2026 (not sure of exact date), Resident #4's guardian had contacted the DSS for names of skilled facilities. She had not heard back from the guardian. -The DSS representative assumed the guardian was coordinating moving Resident #4 to a SNF. -On 05/07/26, the DSS representative discussed with the Administrator that Resident #4's FL2 dated 04/03/26 upgraded the resident level of care to SNF and informed her Resident #4 needed to be moved to skilled care. -The Administrator did not request assistance in placing Resident #4 in a SNF from the DSS representative. Telephone interview with a case manager at the local hospital on 07/29/26 at 11:50am revealed: -Resident #4 arrived at the local ED on 07/28/26	D 224		

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D 224	Continued From page 7	D 224		

at 12:08pm and was discharged from the ED at 5:33pm.
-Resident #4 was transported back to the facility by a local ambulance service but the facility refused to accept Resident #4 back at the facility and returned her to the hospital at 6:23pm.
-There was no discharge paperwork from the facility available for Resident #4 on 07/28/26.
-The case manager contacted Resident #4's guardian requesting any discharge paperwork from the facility but was informed there was no available paperwork.
-On 07/29/26 at 9:00am, She requested official discharge paperwork from the facility but did not receive any paperwork from the Administrator by 11:50am.
-She was working with the guardian to seek placement of Resident #4 in a skilled facility.

Telephone interview with Resident #4's guardian on 07/29/26 at 5:00pm revealed:
-She attended the visit with PCP on 04/03/26 when Resident #4 was issued the FL2 with SNF level of care.
-She had been attempting to find a SNF for Resident #4.
-The facility staff called and left messages on her telephone related to need to move Resident #4 but had not assisted her with finding a SNF or provided information as to how to seek assistance in placing the resident in a SNF.
-On 07/28/26 after 6:00pm, the guardian received a telephone call from the case manager at a local hospital informing her that the facility had refused that Resident #4 be able to return to the facility.
-Later on 07/28/26, the Administrator called the guardian to advise her Resident #4 had an immediate discharge and could not return to the facility.
-She had not received discharge paperwork or a

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D 224	Continued From page 8 Notice to Transfer/Discharge nor the Adult Care Home Hearing Request Form from the facility and was not aware of the immediate discharge. Interview with a medication aide (MA) supervisor on 09/30/26 at 9:20am revealed: -Resident #4 had been at the facility for a long time. -She had gone from ambulating independently to no longer able to stand and pivot when transferring from wheelchair to bed or toilet or back to wheelchair. -Staff assisted her with bathing, dressing, toileting, grooming, and monitored her eating to ensure she ate independently. -Resident #4 was leaning over in her wheelchair with chest touching legs often each day now, and cursing staff when the staff attempted to provide care. -She returned Resident #4 to her bed to rest mid-morning and mid-afternoon. Resident #4 was placed from bed to wheelchair for meals where she remained for a few hours between meals. -She transported Resident #4 and met the guardian at Resident #4's PCP visit on 04/03/26 when the PCP changed the resident to SNF level of care. -Resident #4's guardian had been seeking placement for Resident #4 since 04/03/26. She had overheard phone messages, occasionally since 04/03/26, left to the guardian by the Administrator. -She had not seen or heard of any outside facility completing placement assessments at the facility since 04/03/26. -The Administrator was responsible for admitting and discharging residents. -She had no involvement with the Notice to Transfer/Discharge and Adult Care Home Hearing Request Form paperwork.	D 224		

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D 224	Continued From page 9 Interview with the Administrator on 07/29/26 at 3:40pm revealed: -Resident #4 did not have a current mental health provider. -Resident #4's medications to treat mental health disorders were managed by the PCP. -Resident #4 had a visit with her PCP on 04/03/26 and was assessed for skilled level of care. -Resident #4's guardian had attended the PCP visit on 04/03/26. -The Administrator told Resident #4's guardian several times after the FL-2 on 04/03/26 that the resident would need to be moved to a SNF. -The Administrator had not contacted SNF for placing Resident #4 because the guardian was handling the move. -As recently as three months ago, Resident #4 was able to weight-bear and transfer, with some assistance, from wheelchair to bed or toilet. Currently, Resident #4 was not weight-bearing and required full assistance with all transfers. -Resident #4's slumping forward in her wheelchair had become more than once daily. Resident #4 seemed to be tiring daily, so staff routinely assisted her to bed mid-morning and mid-afternoon and returned to her to her wheelchair for meals. -On 07/28/26, Resident #4 was found on the floor beside her wheel chair at 11:50am shortly after she had returned the resident to her wheelchair for attending the lunch meal in the dining room. -She sent Resident #4 out by ambulance to the local ED for evaluation. -Resident #4 had not returned from the ED when she left on 07/28/26 around 5:15pm. -On 07/28/26 at 5:55pm, the Supervisor on duty called her regarding the ambulance returning Resident #4 to the facility at which time the Supervisor was instructed to inform the	D 224		

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ambulance service Resident #4 had been discharged from the facility and could not be left at the facility.
-On 07/28/26 around 6:15pm, a case worker from the local hospital called her wanting to know why the facility refused to accept Resident #4 back to the facility. The Administrator informed the case worker she had sent the current FL2 with level of care indication SNF with the resident when the ambulance picked the resident up after the fall.
-On 07/28/26 at 7:00pm and on 07/29/26 (no time given, She faxed the hospital case worker a copy of the facility generated "Immediate Discharge Notice" dated 07/28/26 and another copy of Resident #4's FL2 dated 04/03/26 with SNF level of care.
-Later on 07/28/26, Resident #4's guardian was contacted by the Administrator and verbal immediate discharge given to the Guardian.
-The facility had no Discharge Policy available for review.
-She had never done a facility-initiated discharge of a resident before Resident #4.
-In the past, discharges were resident originated.
-She was not familiar with Notice to Transfer/Discharge and Adult Care Home Hearing Request Form and the requirements of the 30-day discharge notice procedure and had not completed the forms for Resident #4.

Attempted telephone interviews with Resident #4's PCP on 7/29/26 at 1:40pm and on 07/30/26 at 11:45am were unsuccessful.

_____
The facility failed to initiate the discharge of Resident #4 who had an FL2 with a recommendation for a skilled nursing facility (SNF) on 04/03/26: the resident had declined in physical status and had a fall on 05/03/26 requiring sutures, and a fall without apparent

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D 224	Continued From page 11 injury on 07/28/26. This failure was detrimental to the health, safety and welfare of the resident and constitutes a Type B Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/30/26 for this violation. CORRECTION DATE FOR THE TYPE B VIOLATION SHALL NOT EXCEED SEPTEMBER 13, 2026.	D 224		
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.	D 235		

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D 235	Continued From page 12 This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure 1 of 4 sampled residents (#3) had a current FL2 completed annually. The findings are: Review of Resident #3's current FL2 dated 07/07/22 revealed diagnosis included hyperlipidemia and right shoulder pain. Review of Resident #3's record revealed that Resident #3 did not have an updated FL2 completed since 07/07/22. Based on observations, interviews, and record review, it was determined Resident #3 was not interviewable. Interview with the medication aide/Supervisor (MA/S) on 07/28/26 at 10:29am revealed: -She was not aware Resident #3's FL2 was not updated since 07/07/22. -The Administrator was in charge of updating all the residents' FL2s. Interview with the Administrator on 07/28/26 at 3:05pm revealed: -She was not aware that Resident #3's FL2 was not updated since 07/07/22. -She was responsible for ensuring that resident FL2s were completed annually. -Resident #3 had a medical appointment in early June, and she sent his FL2 with him however the FL2 was never returned to her. -She had a difficult time getting providers to send FL2's back to the facility. -She expected all FL2's to be updated annually.	D 235		

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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 248	Continued From page 13	D 248		
D 248	10A NCAC 13F .0704 (b) Resident Contract, Information On Facility & 10A NCAC 13F .0704 Resident Contract, Information On Facility, And Resident Register (b) The administrator or their management designee and the resident or the resident's representative shall complete and sign the Resident Register initial assessment within 72 hours of the resident's admission to the facility in accordance with G.S. 131D-2.15. The facility shall involve the resident in the completion of the Resident Register unless the resident is cognitively unable to participate. The Resident Register shall consist of the following: (1) resident's identification information including the resident's name, date of birth, sex, admission date, medical insurance, family and emergency contacts, advanced directives, and physician's name and address; (2) resident's current care needs including activities of daily living and services, use of assistive aids, orientation status; (3) resident's preferences including personal habits, food preferences and allergies, community involvement, and activity interests; (4) resident's consent and request for assistance including the release of information, personal funds management, personal lockable space, discharge information, and assistance with personal mail; (5) name of the individual identified by the resident who is to receive a copy of the notice of discharge per G.S. 131D-4.8; and (6) resident's consent including a signature confirming the review and receipt of information contained in the form. The Resident Register is available on the internet website,	D 248		

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D 248	Continued From page 14 https://info.ncdhhs.gov/dhsr/acls/pdf/resregister.pdf at no charge. The facility may use a resident information form other than the Resident Register as long as it contains the same information as the Resident Register. Information on the Resident Register shall be kept updated and maintained in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure a Resident Register was signed and dated within 30 days following admission for 4 of 4 sampled residents (#1, #2, #3 and #4). The findings are: 1. Review of Resident 1's current FL2 dated 07/14/25 revealed diagnoses included dementia, type 2 diabetes, colon polyps, chronic obstructive pulmonary disease, blindness in right eye and schizoaffective disorder. Review of Resident #1's Resident Register revealed: -Resident #1's date of admission was 06/28/14. -The Resident Register was not signed or dated by Resident #1 or their representative. -The Resident Register was signed by the Administrator but not dated by the Administrator or Administrator-in-Charge. Interview with the Administrator on 07/30/26 at 4:45pm revealed:	D 248		

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D 248	Continued From page 15 -At the time Resident #1 was admitted to the facility, the Business Office Manager (BOM) was responsible for ensuring the Resident Registers were completed and signed. -She was not aware Resident #1's Resident Register was not signed Interview with Resident #1 on 07/30/26 at 4:00pm revealed: -She had been a resident at the facility for a long time. -A family member helped with admission into the facility. -The family member did all her admission paperwork. Refer to the interview with a medication aide (MA) supervisor on 07/30/26 at 3:10pm. Refer to the interview with the Administrator on 07/30/26 at 4:45pm. 2. Review of Resident #4's current FL2 dated 04/03/26 revealed diagnoses included psychosis, borderline intellectual functioning hypertension, asthma, tardive dyskinesia and schizophrenia Review of Resident #4's Resident Register revealed: -Resident #4's date of admission was 06/23/14. -Resident #4 had a guardian listed on the Resident Register. -The Resident Register was not signed or dated by Resident #2 or their representative. -The Resident Register was not signed or dated by the Administrator or Administrator-in-Charge. Interview with the Administrator on 04/01/26 at 11:45am revealed: -She was not aware that Resident #2's Resident	D 248		

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D 248	Continued From page 16	D 248		

Register was not signed or dated by the guardian.
-At the time Resident #2 was admitted to the facility, the Business Office Manager (BOM) was responsible for ensuring the Resident Registers were completed and signed.

Refer to the interview with a medication aide (MA) supervisor on 07/30/26 at 3:10pm.

Refer to the interview with the Administrator on 07/30/26 at 4:45pm.
3. Review of Resident #2's current FL2 dated 07/14/26 revealed:
-Diagnoses included hypertension, schizophrenia, and urinary incontinence.
-Resident #2's date of admission was 09/06/06.

Review of Resident #2's record revealed there was no Resident Register available for review.

Interview with the Administrator on 07/28/26 at 3:00pm revealed:
-She was not aware Resident #2's Resident Register was not available for review.
-She was not sure what happened to Resident #2's Resident Register because since Resident #2 had been at the facility for so long she was sure Resident #2 had a Resident Register.

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

Refer to the interview with a medication aide/Supervisor (MA/S) on 07/30/26 at 3:10pm.

Refer to the interview with the Administrator on 07/30/26 at 4:45pm.

4. Review of Resident #3's current FL2 dated

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D 248	Continued From page 17 07/07/22 revealed diagnosis included hyperlipidemia and right shoulder pain. Review of Resident #3's Resident Register revealed: -Resident #3's date of admission was 11/10/16. - Resident #3 had a guardian listed on the Resident Register. -The Resident Register was not dated by Resident #3 or their representative. -The Resident Register was not signed or dated by the Administrator or Administrator-in-Charge. Interview with the Administrator on 07/28/26 at 3:00pm revealed: -She was not aware that Resident #3's Resident Register was not dated by Resident #3 or their representative. -She was not aware Resident #3's Resident Register was not signed or dated by the Administrator or Administrator-in-Charge. Refer to the interview with a medication aide/Supervisor (MA/S) on 07/30/26 at 3:10pm. Refer to the interview with the Administrator on 07/30/26 at 4:45pm. _____ Interview with a medication aide/Supervisor on 07/30/26 at 3:10pm revealed: -She was aware the Resident Register needed to be completed and signed prior to admission. -She was not responsible for auditing charts. -The Administrator was responsible for ensuring all admission paperwork was completed. Interview with the Administrator on 07/30/26 at 4:45pm revealed: -She was currently responsible for ensuring all resident's Resident Registry was completed and	D 248		

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D 248	Continued From page 18 signed on admission because there was no BOM. -She was responsible for completing chart audits. -She had not audited the charts to ensure that the Resident Registers were completed and signed. -There was a problem with obtaining signatures on residents' paperwork because it seemed the family members did not want to sign admission paperwork or any paperwork and assume responsibilities. -Her expectation would be for the Resident Registries to be completed and signed prior to admission.	D 248		
D 253	10A NCAC 13F .0801 (a) (b) Resident Assessment 10A NCAC 13F .0801 Resident Assessment (a) The facility shall complete an assessment of each resident within 30 days following admission and annually thereafter. (b) The facility shall use the assessment instrument and instructional manual established by the Department or an instrument developed by the facility that contains at least the same information as required on the instrument established by the Department. The assessment shall be completed by an individual who has met the requirements of Rule .0508 of this Subchapter. If the facility develops its own assessment instrument, the facility shall ensure that the individual responsible for completing the resident assessment has completed training on how to conduct the assessment using the facility's assessment instrument. The assessment shall be a functional assessment to determine the resident's level of functioning to include psychosocial well-being, cognitive status, and physical functioning in activities of daily living.	D 253		

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D 253	Continued From page 19 The assessment instrument established by the Department shall include the following: (1) resident identification and demographic information; (2) current diagnoses; (3) current medications; (4) the resident's ability to self-administer medications; (5) the resident's ability to perform activities of daily living, including bathing, dressing, personal hygiene, ambulation or locomotion, transferring, toileting, and eating; (6) mental health history; (7) social history, to include family structure, previous employment and education, lifestyle habits and activities, interests related to community involvement, hobbies, religious practices, and cultural background; (8) mood and behaviors; (9) nutritional status, including specialized diet or dietary needs; (10)skin integrity; (11)memory, orientation and cognition; (12)vision and hearing; (13)speech and communication; (14)assistive devices needed; and (15)a list of and contact information for health care providers or services used by the resident. The assessment instrument established by the Department is available on the Division of Health Service Regulation website at https://policies.ncdhhs.gov/divisional/health-benefits-nc-medicaid/forms/dma-3050r-adult-care-home-personal-care-physician/@@display-file/form_file/dma-3050R.pdf at no cost.	D 253		

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This Rule is not met as evidenced by:
Based on record reviews and interviews, the facility failed to ensure that 3 of 4 sampled residents (#1, #2 and #3) were assessed and had a care plan developed annually.

The findings are:

1. Review of Resident #1's current FL2 dated 07/14/25 revealed:
- Diagnoses included dementia, type 2 diabetes, colon polyps, chronic obstructive pulmonary disease, blindness in right eye and schizoaffective disorder.
-The resident was intermittently disoriented.
-The resident was incontinent with bladder.

Review of Resident #1's Resident Register revealed an admission of 06/28/14.

Review of Resident #1's record on 07/28/26 revealed:
-There was an assessment and care plan developed and signed on 05/10/23.
-Resident #1 was verbally abusive and had a history of mental illness.
-Resident #1 required no assistance from staff with bathing, dressing, toileting, and grooming.
-There was no subsequent assessment and care plan available for review.

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D 253	Continued From page 21 Interview with the Administrator on 07/28/26 at 9:50am revealed: -She thought Resident #1 had a more current assessment and care plan. -She reviewed her facility notes for information. -Resident #1 had an appointment with her primary care provider (PCP) in April 2026. -The Administrator sent an assessment and care plan with the resident for the PCP to review and sign. -The PCP must not have returned the assessment and care plan. -She had not audit Resident #1's assessment and care plan to ensure the care plan was current. Interview with a medication aide (MA) supervisor on 07/28/26 at 3:30pm revealed: -The Administrator was responsible for ensuring assessments were completed and care plan developed annually. -She did not assist with the residents' assessments. Telephone interview with a office assistant at Resident #1's PCP clinic revealed: -The facility was responsible for sending residents' needed paperwork to the clinic for processing. -Resident #1 was last seen by the PCP in the clinic on 04/15/26. -The clinic staff place all paperwork requests in front of the PCP for review and completion. -The clinic staff were responsible for scanning the completed documents in the resident's electronic chart at the clinic. -The last documented assessment and care plan in the electronic clinical records was completed 05/10/23. 2. Review of Resident #2's current FL2 dated 07/14/26 revealed:	D 253		

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D 253	Continued From page 22 -Diagnoses included hypertension, schizophrenia, and urinary incontinence. -The resident was constantly disoriented. -The resident was incontinent with bladder and bowel. -Resident #2's date of admission was 09/06/06. Review of Resident #2's record on 07/28/26 revealed: -There was an assessment and care plan developed and signed on 06/27/24. -Resident #2 was totally dependent on staff for bathing, toileting, and grooming. -There was no subsequent assessment and care plan available for review. Telephone interview with an office assistant at Resident #2's primary care provider (PCP) clinic on 07/28/26 at 2:50pm revealed: -The facility was responsible for sending residents' needed paperwork to the clinic for review. -Resident #2 was last seen by the PCP in the clinic on 06/02/26. -There was no documentation in the system showing that an assessment and care plan was completed on the last visit for Resident #2. Interview with a medication aide (MA) supervisor on 07/30/26 at 10:29am revealed: -The Administrator was responsible for ensuring assessments were completed and care plan developed annually. -She did not assist with the residents' assessments. Interview with the Administrator on 07/30/26 at 4:02pm revealed: -She was not aware Resident #2 did not have a more current assessment and care plan.	D 253		

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-She assigned different staff members resident charts to be audited.
-The staff member assigned to audit Resident #2's chart was no longer employed at the facility.
-She sent assessment and care plan forms to Resident #2's PCP appointments but had a hard time getting them back from the provider.
-She expected Resident #2 to have a current assessment and care plan.

3. Review of Resident #3's current FL2 dated 07/07/22 revealed:
-Diagnoses included hyperlipidemia and right shoulder pain.
-Resident #3's date of admission was 11/10/16.

Review of Resident #3's record on 07/28/26 revealed:
-There was an assessment and care plan developed and signed on 07/07/22.
-Resident #3 was independent with eating, bathing, toileting, dressing and grooming.
-There was no subsequent assessment and care plan available for review.

Interview with a medication aide (MA) supervisor on 07/30/26 at 10:29am revealed:
-The Administrator was responsible for ensuring assessments were completed and care plan developed annually.
-She did not assist with the residents' assessments.

Interview with the Administrator on 07/30/26 at 4:02pm revealed:
-She was not aware Resident #3 did not have a more current assessment and care plan.
-She was responsible for auditing Resident #3's chart.
-She sent assessment and care plan forms to

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D 253	Continued From page 24 Resident #3's primary care provider (PCP) appointment in June 2026 but never received it back. -She expected Resident #3 to have a current assessment and care plan. Attempted telephone interview with an office assistant at Resident #2's PCP clinic on 07/30/26 at 11:28am was unsuccessful.	D 253		
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: 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 health care referral and follow-up for 2 of 4 sampled resident related to notifying the eye doctor about an unfilled medication prescription (#2) and notifying the Primary Care Physician (PCP) about changes in behaviors (#4). The findings are: 1. Review of Resident #2's current FL2 dated 07/14/25 revealed diagnoses included glaucoma, hypertension, and schizophrenia. Review of Resident #2's physician orders signed 04/09/26 revealed there was an order for	D 273		

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brinzolamide (a medication used to treat glaucoma) 1% place one drop into both eyes three times a day.

Review of Resident #2's May 2026 medication administration record (MAR) revealed there was no entry or documentation for brinzolamide 1% place one drop into both eyes three times a day.

Review of Resident #2's June 2026 MAR revealed there was no entry or documentation for brinzolamide 1% place one drop into both eyes three times a day.

Review of Resident #2's July 2026 MAR from 07/01/26 to 07/29/26 revealed there was no entry or documentation for brinzolamide 1% place one drop into both eyes three times a day.

Observation of Resident #2's medications on hand on 07/29/26 at 11:39am revealed there was no brinzolamide 1% for Resident #2 available for administration.

Telephone interview with a representative from the facility's contracted pharmacy on 07/29/26 at 9:45am revealed:
-They did have an active order on file for brinzolamide 1% for Resident #2.
-Resident #2's brinzolamide 1% was never picked up by the facility due to the out-of-pocket cost of the medication.

Telephone interview with a representative from Resident #2's eye doctor on 07/30/26 at 8:52am revealed:
-The last time Resident #2 was seen at the eye doctor, she had a severe amount of glaucoma and was sent to the emergency department.
-Resident #2's eye doctor was not aware the

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facility was not administering brinzolamide 1%.
-Resident #2's eye doctor expected the facility to administer Resident #2's brinzolamide 1%, and if there was an issue with cost, they expected the facility to reach out to them for another medication option.

Interview with a medication aide (MA) supervisor on 07/30/26 at 3:00pm revealed:
-She thought Resident #2's brinzolamide 1% was discontinued due to the cost.
-If the mediation was not on Resident #2's MAR she would not have known to follow up on the mediation with the eye doctor.
-She was not in charge of Resident #2's chart audit.

Interview with the Administrator on 07/30/26 at 4:00pm revealed:
-She thought Resident #2's brinzolamide 1% was discontinued due to the cost.
-She assigned different staff members resident charts to be audited.
-The staff member assigned to audit Resident #2's chart was no longer employed at the facility.
-There was no documentation Resident #2's eye doctor had been notified that brinzolamide 1% prescription was not filled due to the cost.
-Staff should have called the provider for an alternative medication.
2. Review of Resident #4's current FL2 dated 04/03/26 revealed:
-Diagnoses included psychosis-negative of symptoms (NOS), schizophrenia-unspecified type, tardive dyskinesia, and borderline intellectual functioning.
-Resident #4 was incontinent of bowel and bladder, and semi-ambulatory.
-Resident #4 was intermittently disoriented and verbally abusive.

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	HAL034019	A. BUILDING: _____ B. WING _____	R 07/30/2026

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 273	Continued From page 27 -The recommended level of care was a skilled nursing facility (SNF). Review of Resident #4's progress notes revealed: -On 04/03/26 at 7:00am-3:00pm, Resident #4 saw her PCP for an updated FL2, care plan, and current medication list. Resident #4 was given level of care for SNF. The guardian was given a copy of all. -On 04/06/26 at 7:00am-3:00pm, the medication aide (MA) supervisor reported she was trying to unlock Resident #4's wheelchair and the resident put her finger in MA/S face pointing, Resident #4 was redirected. -On 04/08/26 at 7:00am-3:00pm, Resident #4 had been cursing hard words all shift. -On 04/13/26 at 7:00am-3:00pm, Resident #4 had been crying off and on all shift, pulled at her clothes, and told staff and residents to get out of her house. -On 04/14/26 (no time documented), Resident #4 had been cursing all shift. -On 04/15/26 (no time documented), Resident #4 had been cursing all shift. -On 06/22/26, 07/16/26, and 07/17/26, additional care notes were documented related to Resident #4 leaning way forward in her wheelchair and staff laid her in her bed, -07/20/26 at 7:00am to 3:00pm, Resident #4 had been cursing a lot. -There was no documentation Resident #4's primary Care Provider (PCP) was notified of increased inappropriate behaviors in the progress notes. Review of Resident #4's examination or contact by physician's notes revealed: -On 12/16/25, there was documentation for a PCP visit with no changes in medications. -On 03/09/26, there was documentation Resident	D 273		

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D 273	Continued From page 28 #4 was at the clinic for an FL2 form and tuberculosis test. The PCP spoke with the Administrator at the facility, and the guardian would call (no information who she would call). -There were no other physician encounter notes or physician notes available for review, including notification or responses to inappropriate behaviors. Interview with a MA supervisor on 07/30/26 at 3:10pm revealed: -She would report changes in behavior to the oncoming shift. -Resident #4 did not have mental health provider; her PCP managed her mental health medications. -She was aware of no policy or procedure for reporting behavior changes except documenting the behaviors in the resident's spiral bound progress notes book. -She had contacted Resident #4's PCP regarding the resident's increased cursing and crying. Interview with the Administrator on 07/30/26 at 4:00pm revealed: -The MA supervisor documented residents' notes in the wire bound care binder established for each resident. -The MA supervisor should document calls to the PCP or any other provider in the residents' progress notes. -Resident #4 does not curse her when she is staffing, which she did routinely in the evenings due to staff turnover and low census. -Normally staff would inform her of inappropriate behaviors by residents. -There was no documentation Resident #4's PCP had been notified for increased behaviors of cursing or crying.	D 273		

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D 273	Continued From page 29 Attempted telephone interviews with Resident #4's PCP on 07/29/26 at 1:40pm and on 07/30/26 at 11:45am were unsuccessful.	D 273		
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: Based on observations, interviews and record reviews, the facility failed to ensure medications were administered as ordered for 1 of 4 sampled residents (#3) with an order for a medication used to prevent wheezing, chest tightness, and coughing. The findings are: Review of Resident #3's current FL2 dated 07/07/22 revealed diagnoses included hyperlipidemia and right shoulder pain. Review of Resident #3's physician appointment after visit summary (AVS) medication lists dated 06/08/26 revealed there was an order for fluticasone (a medication used to prevent wheezing, chest tightness, and coughing) nasal spray, inhale 2 sprays, in each nostril, two times daily as needed.	D 358		

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D 358	Continued From page 30 Review of Resident #3's May 2026 medication administration record (MAR) revealed there was no entry or documentation for fluticasone nasal spray, inhale 2 sprays, in each nostril, two times daily as needed. Review of Resident #3's June 2026 MAR revealed there was no entry or documentation for fluticasone nasal spray, inhale 2 sprays, in each nostril, two times daily as needed. Review of Resident #3's July 2026 MAR from 07/01/26 to 07/29/26 revealed there was no entry or documentation for fluticasone nasal spray, inhale 2 sprays, in each nostril, two times daily as needed. Observation of Resident #3's medications on hand on 07/29/26 at 2:13pm revealed there was no fluticasone nasal spray for Resident #3 available for administration. Telephone interview with the facility's contracted pharmacy on 07/30/26 at 11:45am revealed: -A staff member from the facility brings Resident #3's medication list into the pharmacy so the medications can be filled. -There was an order on file for Resident #3 for fluticasone nasal spray, inhale 2 sprays, in each nostril, two times daily as needed. -Resident #3's fluticasone nasal spray was last filled in September 2025. -Resident #3's fluticasone was never picked up from the pharmacy. -He was not sure why Resident #2's fluticasone was never picked up from the pharmacy. -If Resident #3 did not have fluticasone available for administration, he was at risk for wheezing, chest tightness, and coughing.	D 358		

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D 358	Continued From page 31 Interview with the Supervisor on 07/30/26 at 11:40am revealed: -She was a medication aide (MA) and administered medications to Resident #3. -She was not aware of Resident #3's fluticasone nasal spray order. -If the medication was not listed on the MAR, she did not administer it. -The Administrator was in charge of Resident #3's chart review. -Resident #3 had not complained of wheezing, chest tightness, and coughing. Interview with the Administrator on 07/30/26 at 3:36pm revealed: -She was aware of Resident #3's fluticasone nasal spray order. -She was in charge of Resident #3's chart review. -During chart reviews, she compared medication list to that months' MARs. -Medication lists were not always accurate due to Resident #3 having multiple providers, so it was difficult to know exactly what the resident was supposed to be taking. -She was not sure how she missed Resident #3's fluticasone nasal spray order. -She expected prescribed medications to be available and administered per physicians orders. Attempted telephone interview with Resident #3's primary care provider (PCP) on 07/30/26 at 11:28am unsuccessful.	D 358		