STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 and a COVID-19 focused Infection Control survey with an onsite visit on 06/25/20 and a desk review survey on 06/23/20 to 07/16/20 and a telphone exit on 07/16/20.	{D 000}	Response to the cited deficiencies do not constitute an admission or agreement by the facility of the truth of the facts alleged or conclusions set forth in the Statement of Deficiencies or Corrective Action Report; the Plan of Correction is prepared solely as a matter of compliance with State law.	8-15-2020
{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: TYPE A1 VIOLATION Based on interviews and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents (#2 and #6) where Resident #6 who was known to wander, eloped without staffs' knowledge for a period of 1 to 4 hours, was found near woods after being seen in the road by a concerned citizen and required emergency room (ER) evaluation; and Resident #2 who had a history of right sided weakness and falls, experienced 15 falls between 02/08/20 and 07/14/20, sustained a head injury and laceration and required ER evaluation on 4 occasions. The findings are: 1. Review of the facility's Missing Resident Policy revealed: -A resident will be considered missing when he/she is not in the facility and we cannot determine his/her whereabouts; and in addition, there is reason to be concerned for the resident's	{D 270}	It is the policy of Eagles Point to provide personal care to residents according to the resident's care plans and attend to any other personal care needs, resident may be unable to attend to themselves. **A1 Personal Care and Supervision 0901-B** *Elopement Protocol* The Executive Director (ED) and Licensed Health Profession Support (LHPS) facility provided training on the need for increased supervision during the egress locks being compromised during the enunciation of the fire alarm. The training included the need to supervise each exit door to ensure the resident are maintained in a safe environment. Specifically, on July 3, and	8-15-2020

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Maria Pellah — TITLE: Ifor/ED — (X6) DATE: 8-13-2020

* The Plan of Correction was reviewed and accepted with Addendum on 8/28/20. Please refer to addendum on pages 6, 34, 36, 58, 81, 86, 88, and 117 of this Statement of Deficiencies.
Wendy Williams 8/28/20

RECEIVED
AUG 13 2020
ADULT CARE LICENSURE SECTION
RALEIGH

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 1 safety. -If the facility discovers a resident is missing the facility would notify the supervisor and all other staff immediately and perform a search of the building and the immediate areas outside the building. -If the resident was not found the facility would immediately notify local law enforcement, 911, North Carolina Project Lifesaver, the residents responsible party, the Department of Social Services and management who was on call. -Staff would initiate a Level II search including a thorough search of the building, grounds, outside structures, dumpster's, storage buildings and vehicles. -Staff will assure that required agencies are notified and an accident/incident report is sent to the Department of Social Services within 48 hours. -The Department of Social Services would to be called immediately in the event of a missing resident. Review of the facility's Identification and Supervision of Confused/Wandering Resident Policy revealed: -The facility would identify residents who walk or wheel around unrestricted and were a threat to leave the facility unattended due to their confusion. -The facility would check door alarms regularly to assure they were working properly. -The facility would notify staff when alarms failed and request to assure extra precautions for residents at risk of wandering. -The facility would repair/reactivate the alarm system as soon as practicable. -The facility would check the operations of the door lock security system, the window systems and gate systems to assure proper working order	{D 270}	8th the Executive Director completed training to all staff on increased observation of residents anytime an alarms system is compromised. (i.e. Fire watch protocol as it relates to the egress locks.) Continued training on July 17, and 21st the LHPS continued training to all staff on increased observation of residents anytime an alarms system is compromised. (i.e. Fire watch protocol as it relates to the egress locks.) The facility ensured the screamer alarms and egress locks are in working condition on July 3, 2020 by the Executive Director. The screamer alarms alert the staff if the mad locks are being manually disengaged. Resident noted to be exhibiting exit seeking behavior will be placed on increased supervision to include 15-30-minute checks. The level of supervision will be determined by observations by personal care aides (PCA), Medication Technicians (Med Techs), Memory Care	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 2 each Monday and Friday. Review of a Fire Watch Instructions Handout provided by the fire department to the night shift medication aide (MA) on 07/03/20 revealed: -Fire Watch Duties directed the facility to assign staff to conduct periodic patrols of all parts of the facility that are affected by the fire alarm failure. This could include attics, crawl spaces, storage rooms, resident rooms, employee break rooms and concealed areas. -The persons performing the fire watch are not permitted to perform any other duties. -The night shift MA and night shift personal care aide (PCA) completed fire watch patrols every 30 minutes beginning at 3:30am and ending at 9:30am on 07/03/20. -The Fire Watch Log area patrolled listed "whole building" by the night shift MA and night shift PCA. Review of Resident #6's current FL-2 dated 09/11/19 revealed: -Diagnoses included dementia, bipolar disorder and schizophrenia. -The resident was constantly disoriented. -The resident was ambulatory. Review of Resident #6's current Assessment and Care Plan dated 08/11/19 revealed: -The resident was always disoriented. -The resident had significant memory loss and must be directed. Telephone interview with a former PCA on 07/16/20 at 10:56am revealed: -She worked on the secured unit with Resident #6 until May 2020. -Resident #6 walked constantly with his head down	{D 270}	Manager (MCM)/Resident Care Coordinator (RCC). This information will be reported to the ED to management team to ensure proper follow up and supervision and notification of the primary care provider. The facility staff were reeducated by the LHPS nurse on 7/17-21/2020 on ensuring facility waking round are completed at the end of each shift. The education for the walking rounds, observation of elopement behavior and disengaged maglocks/screamers will be ongoing during orientation to the facility for new hires. During the weekly at-risk meeting and stand-up/stand down meeting the residents that have been identified with increased elopement behaviors will be reviewed and if warranted further inventions added to their plan of care. Weekly the ED or designee will audit the egress locks and screamer boxes to ensure they remain in proper working order.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 3 -Resident #6 would go up to the exit door and push the door; if the door did not open, he would turn around and keep walking. Review of a Call Detail Report obtained from local law enforcement revealed: -The 911 call center received a call from a concerned citizen at 7:18am on 07/03/20. -The caller reported there was an elderly male wandering and that he appeared lost and confused. -Resident #6 was found at a road near the facility by kitchen staff. -The reported location of the elderly man was 0.4 miles from the facility. Review of an electronic Incident and Accident Event Report for Resident #6 on 07/03/20 at 10:17am revealed: -The day shift MA documented that Resident #6 wandered off from the facility between 6:00am-7:10am on 07/03/20 and was picked up by kitchen staff. -The resident was transported to the local hospital on 07/03/20 at 10:10am. -The day shift MA notified the Administrator, Department of Social Services (DSS) and the primary care provider (PCP) at 10:20am on 07/03/20. -The report was completed by the day shift MA on 07/03/20 with the event time as 10:17am. -The report was closed by the Assistant Director of Operations (ADO) on 07/08/20 at 11:08am. Review of Resident #6's electronic progress note by a day shift PCA on 07/03/20 at 3:39pm revealed: -Resident #6 walked out of the facility between 4:30am and 7:30am. -He was found down the road walking into the	{D 270}	*Fall Prevention* All staff were reeducated on 7/17-21/202 and included in orientation for new hires on fall prevention to included the assessment of resident that are at a fall risk, by completing fall risk evaluating to include medication management on all in house residents. All residents in house were reassessed on fall prevention by the MCM and Assistant ED on 7/22/2020 and care plans updated as appropriate. On 7/22/2020 the area physical therapist completed reeducation on fall prevention, interventions, and appropriate responses to falls. The MCM/RCC were in serviced in the requirement to complete the falls assessment and on admission, after each fall and quarterly by the PT and ED on 7/22/2020.	2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 4 woods when the cook from the kitchen saw him. -The kitchen staff transported the resident back to the facility at 7:35am. -Staff performed a full body assessment. -Resident #6 was transported to the local hospital at 11:04am. Review of Resident #6's electronic progress note by the day shift MA dated 07/03/2020 at 4:12pm revealed: -Resident #6 was discovered missing at 7:00am. -He was observed down the road and a kitchen staff picked him up from the side of the road. -He was wandering in the woods and on the road. -A full body assessment was performed, and the resident was then sent to the local hospital for further evaluation. Confidential telephone interview with a staff revealed: -She arrived for her day shift at 6:40am on 07/03/20 and noticed lights were blinking from the fire alarm going off prior to her arrival. -Once the fire alarm was stopped by the fire department the lights continued to blink throughout the building. -The doors at the main entrance to the facility and locked unit were not secured and there were no staff present at the doors. -When she arrived at the secured unit for her shift a night shift PCA told her that the alarms had been going off since 2:00am. -There were 21 residents on the secured unit. When she arrived at the secured unit one PCA was attempting to monitor 5 exit doors on the locked unit; 3 of the 5 doors exited to the outside. -When kitchen staff arrived for their morning shift, they assisted her in watching the 3 exit doors on the secured unit and monitoring residents. -The fire alarm system went off approximately 1-2	{D 270}	Any resident that has an unsteady gait or has fallen within the past 90 days will be evaluated by physical therapy by August 31, 2020. The care plan will be updated to include the therapy recommendations. Any identified residents that are at risk for falls will be placed on increased supervision based on individual assessed need, and subject to change based upon their functional status and documented on the resident's plan of care. During the weekly at-risk meeting and stand-up/stand down meeting the residents that have been identified with increased elopement behaviors and fall risk behaviors will be reviewed and if warranted further inventions added to their plan of care. Weekly the ED or designee will audit the egress locks and screamer boxes to ensure they remain in proper working order. Also, weekly the ED or designee will review the residents that have increased fall risk and falls to ensure the at risk meeting members the PT has evaluated the residents and increased interventions have been included on the care plan.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 5 times a week. -She had never received training on staff responsibilities and protocols when the fire alarm went off. -She reported a resident head count of 20 to the medication aide (MA). -She continued a resident head count and realized that Resident #6 was missing. -She informed the morning shift MA on the secured unit that Resident #6 was not in the facility. -Resident #6 walked constantly and always looked at the ground while walking. -Resident #6 did not pay attention to where he was going and was not responsive to verbal cues. -She did not think Resident #6 knew where he was and once he left the facility and did not know how to get back. Telephone interview with the local County Emergency Services on 07/16/20 at 1:04pm revealed the fire alarm was activated at the facility on 07/03/20 at 1:53am and 2:49am. Telephone interview with a concerned citizen on 07/15/20 at 2:35pm revealed: -She observed an elderly man walking in the middle of the road on 07/03/20 at approximately 7:45am. -The elderly man was walking down the middle of the road in an area that had a speed limit of 35-45 miles/hour. -She knew the facility was close to where she observed an elderly male wandering. -She called the facility first at approximately 7:45am to report the description of the elderly male because she was concerned he was a resident at the facility. -When she provided a description of Resident #6 to a female staff member at the facility.	{D 270}	The Divisional Director of Clinical Services-Registered Nurse or the Divisional Vice President of Operations will provide management oversight bi-weekly for two months then no less than monthly thereafter to ensure the employment and fall protocol are in place and being implemented to prevent elopements decreased falls. 8-15-2020 D270 Addendum per telephone with Ms. Darla Bellah on 8/28/20. If egress locks are compromised, staff will be stationed at each exit door. The facility will assure there will be enough staff to be stationed at each exit door if the egress locks are compromised. Fire watch protocol for egress locks includes resident head counts that will be documented. Any interventions for supervision for residents with elopement behaviors or increased fall risk and falls will be documented on the resident's plan of care and implemented. ADO will monitor at least twice weekly to assure ED is completing weekly standup/ stand down meetings and tasks. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 6 -She was concerned that the female staff that she spoke with did not seem concerned that the elderly male could have been one of their residents. -She contacted local law enforcement because she was afraid he would get hit by a vehicle. -She contacted local law enforcement on 07/03/20 via telephone at approximately 7:50am. Telephone interview with a kitchen staff on 07/09/20 at 11:17am revealed: -When she entered the facility for her morning shift on 07/03/20 she saw the fire alarm lights blinking. -She observed one MA and one PCA on the Assisted Living (AL) unit. -She observed one PCA on the secured unit. -She did not observe any other staff at exit doors on the locked unit or at the front entrance of the facility. -At 7:20am on 07/03/20, the first shift PCA from the AL unit came into the kitchen and informed her that the facility received a call from a concerned citizen between 7:10am and 7:15am asking if the facility was missing a resident. -She went to the front lobby and a man was standing in the front lobby and reported that a gentleman appeared to be lost and wandering in and out of the woods near his home. -She knew the location the man described to her and she left the facility in her vehicle to attempt to find Resident #6. -She observed Resident #6 walking out of the woods from behind homes 0.4 miles away from the facility. -She assisted Resident #6 to her vehicle and returned him to the facility. -His trousers were wet from the hem to the calf. Confidential telephone interview with a staff	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 7 revealed: -Resident #6 was brought back to the facility by kitchen staff between 7:45am-8:00am. -When he was found, he was still walking and had water at the bottom of his trousers. -She and the day shift MA for the locked unit completed a check of Resident #6's full body. -Resident #6 was taken to the hospital for further evaluation at 11:04am on 07/03/20. -She did not know why Resident #6 was not transported to the local hospital earlier. -Once Resident #6 returned to the facility from the emergency room, he was placed on a 14-day quarantine; she was not instructed to increase supervision for Resident #6. Telephone interview with the day shift MA for the secured unit on 07/08/20 at 2:55pm revealed: -He was the day shift MA that documented an electronic progress note on 07/03/20 at 10:17am. -On 07/03/20 he arrived for his 7:00am shift and noticed the fire lights were still blinking. -Resident #6 had never tried to get out of the facility before the morning of 07/03/20. -He did not receive an update from the night shift MA that was on duty prior to his arrival. -He did not receive an update from the night shift MA on the fire alarms or that the fire department had placed the facility on a fire watch. -The night shift staff did not report that Resident #6 had eloped. -A day shift PCA informed him that Resident #6 was not in his room or in the locked unit at 7:10am. -He did not know how long Resident #6 had been gone. -He called the Administrator to inform her that Resident #6 was not in the facility. -The day shift MA on the AL side informed him that the facility had received a call from a female	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 8 stating that she saw a man wandering in the road and was concerned he lived at their facility. -A kitchen staff found Resident #6 and brought him back to the facility. -He called the Administrator at 7:15am to inform her that Resident #6 had been located and would be returned to the facility by kitchen staff. -Resident #6 was returned to the facility between 7:40am-7:45am. -Resident #6 could not have found his way back to the facility on his own due to his dementia. -He completed a body assessment of Resident #6. -Resident #6 was not placed on 15-30-minute checks. -Resident #6 was unable to leave his room until his 14-day quarantine was complete after he returned from the hospital. -He had to provide Resident #6 with reminders to stay in his room. -The PCAs on his shift were supposed to do a walk-through of the unit with the PCA from the previous shift to obtain an update on each resident. -The PCAs on his shift were supposed to ensure that all residents were accounted for and that they did not have any unmet needs. -This was not done the morning of 07/03/20. -Residents with a diagnosis of dementia had to be watched closely because they were "constantly" forgetful of where they were and why they were in the facility. Telephone interview with a second day shift MA from the AL Unit on 07/08/20 at 4:14pm revealed: -When she arrived for her shift the fire alarm lights were flashing. -She informed the 2 PCAs on her unit that they each had to monitor an exit door since the door locks were not working.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 9 -She observed 2 PCAs from the 7:00pm-7:00am shift sitting in the break room on the AL unit. -She obtained an update from the night shift MA that worked from 7:00pm-7:00am. -The night shift MA reported to her that all residents in the building were accounted for and present. -A day shift PCA assigned to the AL unit informed her that she received a telephone call from someone reporting that there was a man wandering outside that could have been one of the facility's residents. -She notified the Administrator of the call and began to do another head count of residents. -She informed the MA on the secured unit of the telephone call to the Administrator. -She assisted the day shift PCA on the secured unit complete an additional head count of residents on the locked unit and discovered that Resident #6 was not in the facility. -The kitchen staff went to pick up Resident #6 and brought him back to the facility. -She did not think that Resident #6 could have found his way back to the facility due to his diagnosis of dementia. -She went to check on Resident #6 upon his return so she could notify the Administrator of his condition. -The Administrator arrived at the facility on 07/03/20 at 9:30am. -The emergency flashing lights did not stop until 10:00am. -The fire alarms went off frequently in the facility. -When a fire alarm went off staff were expected to complete 15-30-minute checks to ensure residents were in their rooms and safe. -The Fire Department left a Fire Prevention Log for facility staff to complete every 30 minutes. -Staff were expected to walk through the facility to ensure all residents were present and safe.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 10 Telephone interview with the Adult Home Specialist (AHS) on 07/09/20 at 4:22pm revealed: - She was assigned to monitor the facility. -The Department of Social Services (DSS) was appointed legal guardianship of Resident #6 on 05/21/2020. -She had a voicemail from the day shift MA that worked on the secured unit on 07/03/20 at 3:54pm. -The voicmail recording revealed that they day shift MA left her a message explaining that Resident #6 was out of the facility from 4:30am-7:30am on 07/03/20. -The voicemail recording revealed that Resident #6 was wandering in and out of the woods and that he was sent to the Emergency Department (ED)to be sure he did not have any injuries. -The AHS expected the facility staff to notify the DSS on call social worker for that morning instead of just leaving a voice message. -The AHS voicemail message had a number for any emergency calls to page the social worker on call. -Facility staff failed to page the on call social worker on 07/03/20. A second telephone interview with the day shift MA from the secured unit on 07/14/20 at 6:03pm revealed: -He left a voicemail for Resident #6's PCP on 07/03/20 at 10:20am. -He left a voicemail for the AHS on 07/03/20 at 10:20am and was not aware at that time that he needed to speak with the social worker on call. -When he arrived at the facility for his shift on 07/03/20 there was not any staff standing at the exit doors on the secured unit. -His recorded message on the AHS voicemail which stated Resident #6 had been out of the	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 11 facility from "approximately 4:30am-7:30am" on 07/03/20 was incorrect and not accurate. Review of Resident #6's hospital ED discharge instructions dated 07/03/20 for revealed: -Resident #6 was assessed at 12:45pm. -EMS reported the facility staff were concerned about redness to Resident #6's left hand and an open skin wound on his left forearm. -Resident #6 had healing wounds on his left forearm and soft tissue edema to the left hand. -The ED discharge diagnosis for Resident #6 was an abrasion of upper left extremity. Telephone interview with a night shift PCA on 07/14/20 at 1:26pm revealed: -She worked the night shift from 7:00pm-7:00am on 07/03/20. -A night shift PCA that was assigned to work the AL unit on 07/03/20 left his shift at 11:00pm and did not return. -She was not assigned to the secured unit and did not see Resident #6. -The fire alarms sounded in the facility at 12:00am, 1:30am and 2:00am. -The fire department (FD) responded to the facility two times; the second time the FD could not turn the fire alarm off. -The facility had to wait for their security representative to arrive in order to turn off the hallway blinking lights. -She attempted to reach the Administrator by telephone and was unsuccessful. -She then called the Assistant Executive Director/Business Office Manager (AED/BOM) to report the problems with the fire alarm. Telephone interview with a second night shift PCA who worked the secured unit on 07/14/20 at 2:32pm revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 12 -She worked from 7:00pm-7:00am on 07/03/20 on the secured unit. -The first fire alarm sounded between 12:00am and 1:00am on 07/03/20. -The second fire alarm sounded at 3:00am on 07/03/20. -All exit doors remain unlocked when the fire alarm goes off; the exit doors remained unlocked after the second alarm through the end of her shift. -Staff were expected to stand at each door in the secured unit to ensure no residents attempted to leave the building to ensure their safety. -There was not enough staff on the locked unit to monitor all doors during her shift on 07/03/20. -She monitored the double doors and one exit door on 07/03/20 from 3am to 7am. -There was one additional night shift PCA that worked on the secure unit with her on 07/03/20 from 7:00pm-7:00am. -She did not see Resident #6 the night of 07/02/20 into 07/03/20. Review of Resident #6's point of care entry dated 07/03/20 revealed: -Resident #6 received personal care from the night shift PCA at 4:56am on 07/03/20. -Resident #6 was dressed in his clothing, socks and shoes from the night shift PCA at 4:56am on 07/03/20. Telephone interview with a third night shift PCA who worked the AL side on 07/16/20 at 12:20pm revealed: -She had never been trained on a fire drill or a fire watch at the facility. -She was not aware of what she needed to do to protect the residents of the facility until the Fire Department instructed her on 07/03/2020. -She was instructed by the Fire Department to	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 13 complete the Fire Watch Form every 30 minutes, she was expected to walk through the facility every 30 minutes to ensure all residents were safe and she did not smell smoke anywhere in the facility. -She documented a walk through of the facility every 30 minutes beginning at 3:30am. -The Fire Department explained that they needed one PCA to complete the Fire Watch Log until their security company was able to repair the alarms and blinking lights. -She was only able to locate one-night shift PCA working the locked unit. -She located a second night shift PCA that was working the locked unit in an empty room, and later located the same PCA in the restroom. -She was present when the night shift MA attempted to contact the Administrator by phone on 07/03/2020 at 4:00am and was unsuccessful. -She was present when the night shift MA contacted the Assistant Executive Director/Business Office Manager (ADO/BOM) on 07/03/2020 at 4:00am to provide her with an update of the Fire Watch and unsecured doors. Telephone interview with Resident #6's PCP on 07/09/20 at 12:30pm revealed: -She was not notified of Resident #6's elopement from the facility until 07/06/2020. -The facility did not notify her on 07/03/20 that Residetn #6 had eloped. -She was notified by the Area Director of Operations (ADO) that Resident #6 had eloped. -She expected to be notified immediately when a resident eloped. -She had concerns that it was very hot on the morning of 07/03/20 and that facility staff were unaware he was missing with extremely high temperatures outside. -According to weather.com the high temperature	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 14 forecasted for 07/03/20 was 93 degrees. -Resident #6 was put at a high risk of being injured or dying due to a recess pond in front of the facility. -Resident #6 was at a high risk of being injured or dying if he had been hit by a motor vehicle. Telephone interview with the Administrator on 07/08/20 at 6:01pm revealed: -The nightshift MA notified the Area Director of Operations (ADO) that the fire alarm was activated at 3:30am on 07/03/20. -She was notified in a group text message from the ADO at 4:00am on 07/03/20 that the facility was on Fire Watch. -She was directed by the ADO to contact the security company to notify them that a fire alarm in a room was giving a false signal. -The Fire Department placed the facility on a Fire Watch because the fire alarms went off "a couple of times." -She instructed staff to complete a census of the building, ensure all residents were accounted for and to ensure there was a staff member at each door because the doors were not secure. -She was notified at 7:10am on 07/03/20 by the daytime MA working on the AL side of the facility that Resident #6 was not in the building. -She was notified at 7:35am on 07/03/20 by the daytime MA working the AL side that an employee had left to pick up the resident. -It was reported to her by staff that prior to shift change at 7:00am there were 2 overnight PCAs sitting in the break room. -She was concerned that staff were not monitoring the doors at the facility. -She did not know if the facility had notified law enforcement that Resident #6 was missing. -It was her understanding that the day shift MA for the secure unit and the ADO had contacted	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 15 Resident #6's PCP on 07/03/20. -The day shift MA was responsible for contacting Resident #6's PCP. -She was not aware of "all the exit seeking behaviors" by residents on the locked unit until 07/03/20. -She was on her way to the facility at 7:35am when she was notified by staff that a kitchen staff had picked up Resident #6 and returned him to the facility. -The nightshift MA was responsible for the entire facility. -There were 4 PCAs and 1 MA working the night shift on 07/03/20. -The ADO had explained to her that there was enough night staff covering the facility. -She expected staff to monitor the facility and make rounds every 30 minutes during a fire watch. -Staff documented every 30 minutes on the Fire Watch Log. -She expected staff to remain at every exit door in the facility during a fire alarm or fire watch. -She expected to be notified immediately when the fire alarms sounded and when the facility was under a Fire Watch. Telephone interview with Area Director of Operations (ADO) on 07/08/20 at 5:50pm revealed: -When the fire alarms were activated in the facility, she expected staff to be present at all doors in the facility. -When the facility was under a Fire Watch, she expected staff to be present at all doors in the facility. -The facility protocol and standard operating procedures required that a staff member was expected to monitor every exit door in the facility until the facility was secure and all doors secured.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 16 -During a Fire Watch a staff member was expected to monitor the facility every 30 minutes and check throughout the facility for any smoke. -She knew there were more exit doors than the number of staff on duty to monitor for more than 4 hours; management should have volunteered to come in and help the staff. She did not know why that was not done. Attempted interview on 07/16/20 at 10:34am with the PCA assigned to Resident #6 for the night shift on 07/03/20 was unsuccessful. Attempted interview on 07/14/20 at 2:30pm with the night shift MA for 07/03/20 was unsuccessful. 2. Review of Resident #2's current FL-2 dated 06/16/20 revealed: -Diagnoses included bilateral pneumonia and dementia. -There was no documentation of ambulatory status. -Resident #2 was disoriented constantly. Review of Resident #2's Care Plan dated 09/11/19 revealed: -Resident #2 needed a walker as an assistive device. -Resident #2's memory was forgetful and needed reminders. Review of incident and accidents reports and progress notes, revealed there were 15 falls from 02/08/20 to 07/14/20. Review of the facility's Accident/Falls/Emergency and Fire Safety Policy revealed: -Residents were to be assessed after a fall. -If the Resident was injured, the Resident was not to be moved.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 17 -The staff were to determine if the Resident was breathing, conscious and checked for pulse. -The staff were administered CPR if necessary and were to have checked for a DNR. -The staff were to have administered first aid if necessary. -The staff were to call for emergency assistance if needed. -The staff were to complete an incident and accident report. -The staff were to contact the PCP and family of the Resident. Review of Resident #2 Licensed Health Professional Support (LHPS) dated 06/10/20 revealed: -Resident #2 required an assistive device for ambulation. -Resident #2 was to use a walker. Review of Resident #2's accident/incident report dated 02/08/20 revealed: -Resident #2 fell in the hallway. -Resident #2 was not injured from the fall. Review of Resident #2's hospital discharge summary on 02/08/20 revealed: -Resident #2 was seen for difficulty walking. -In-home therapy was recommended to strengthen lower extremity to maintain long-term ambulatory status. Review of Resident #2's an accident/incident report dated 03/21/20 at 2:35pm revealed: -Resident slipped and fell in the dining room. -Resident #2 was unable to walk and was weak. -Resident #2 was alert and oriented. -A fall prevention program was put into place to check vital signs every shift for three days, monitor for bruising, change in mental status and	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 18 injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. -First aid was not administered. Review of Resident #2's electronic progress note dated 03/21/20 at 3:53pm revealed: -Resident #2 "went down the hall without walker, urinated in hallway and slipped on urine." -Resident #2 was using his walker. -Resident #2 did not hit his head. -The medication aide(MA) took vital signs. -Resident #2 did not complain of pain. -There was no documentation of implementation of any fall prevention measures or increased supervision. Review of Resident #2's accident/incident report dated 05/19/20 at 10:36am revealed: -Resident #2 was found lying on the dining room floor. -There were no visible injuries. -Resident #2 was helped up off of the floor and walked away using his walker. -A fall prevention program was put into place to check vital signs every shift for three days, monitor for bruising, change in mental status and injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. -First aid was not administered. Review of Resident #2's accident/incident report dated 05/30/20 at 7:10pm revealed: -Resident #2 was found on the hallway floor. -Resident #2 had a laceration injury on his eyebrow/head that was bleeding and was sent to the hospital. -First aid was administered to the wound. -There was no documentation of implementation	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 19 of any fall prevention measures or increased supervision. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's hospital discharge summary on 05/30/20 revealed: -Resident #2 was diagnosed with a fall and head injury. -The CT scan had no significant findings. -The wound over Resident #2's left eyebrow was cleaned and monitored for infection. -Recommendations were provided for fall precaution. Review of Resident #2's electronic progress note dated 05/30/20 at 7:29pm for Resident #2 revealed: -Resident #2 was found by a personal care aide (PCA) on the floor in the hallway bleeding from his head and sent to the emergency room. -The PCA notified the MA of Resident #2 falling. Review of a primary care provider (PCP) visit note dated 06/03/20 revealed: -Resident #2 was seen for follow up due to a fall, had residual right sided weakness from a previous cerebral vascular accident and needed assistance with transfers and ambulation. -Resident #2 ambulated with a walker and had an unsteady gait. -Under the plan section there was documentation for fall precautions, increased supervision and physical and occupational therapies. Telephone interview with a MA on 07/15/20 at 5:13pm revealed: -Resident #2 fell on 05/30/20 because he was walking down the hall without his walker. -Resident #2 went to emergency department (ED)	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 20 and returned after the end of her shift. -She could not remember if Resident #2 was placed on 30-minute checks after returning from the ED. -Resident #2's falls started in April or May 2020 and were due to the resident refusing to use his walker. -She had tried putting tennis balls on the walker because it made a "screeching" noise, but that did not help Resident #2 to use the walker. -She provided Resident #2 with a wheelchair because the resident would not just sit in his room; Resident #2 would push the wheelchair and sometimes sit in it. -Resident #2 had a limp and used the handrails or the wall when walking. -There was a third PCA working on the locked unit specifically for Resident #2. -She could not remember when the third PCA worked or for how long. Review of Resident #2's accident/incident report dated 06/06/20 at 10:46am revealed: -Resident #2 was found on the floor in his suitemate's room by a housekeeper without injury. -There was documentation the fall prevention program was initiated. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's electronic progress note dated 06/06/20 at 10:41am revealed: -Resident #2 was found on the floor in his suitemate's room without injury. -There was no documentation of implementation of any fall prevention measures or increased supervision. Review of Resident #2's accident/incident report	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 21 dated 06/08/20 at 3:38pm revealed: -There was documentation Resident #2 was found on the floor "yesterday (06/07/20)" on the floor in the hallway in front of another resident's room. -There was documentation the incident occurred on 06/07/20 at 3:00pm. -There was documentation the fall prevention program was initiated. -There was no documentation of monitoring and/or safety checks. Review of Resident #2's accident/incident report dated 06/13/20 at 2:30pm revealed: -Resident #2 was found on the floor in his room. -Resident #2 was sent to the emergency room and admitted to the hospital for pneumonia. -Resident #2 vital signs were checked. -First aid was not administered. -There was documentation the fall prevention program was initiated which included checking vital signs every shift for three days. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's electronic progress note dated 06/13/20 at 3:03pm revealed: Resident #2 was found on his bedroom floor and sent to the emergency room. -The MA took Resident #2's vital signs. Review of hospital discharge instructions dated 06/13/20 through 06/16/20 for Resident #2 revealed Resident #2 was treated for a fall and pneumonia. Review of Resident #2's electronic progress notes on 06/19/20 at 3:45pm revealed: -Resident #2 was found lying on the floor. -A body assessment was completed and there	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 22 were no bruises or skin tear. -The MA documented Resident #2 was "fine" and was seated on his bed. Review of Resident #2's accident/incident report dated 06/20/20 at 10:47am revealed: -Resident #2 was found lying on the floor in his room without injury. -There was documentation the fall prevention program was initiated which included checking vital signs every shift for three days. -There was documentation to monitor the resident's status for 72 hours for bruising, change in mental status/condition, pain or injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's accident/incident report dated 06/25/20 at 3:36pm revealed: -Resident #2 was found on the floor in another resident's room. -There were no injuries. -First aid was not administered. -A fall prevention program was put into place to check vital signs every shift, monitor for change in mental status and injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's electronic progress note dated 06/25/20 at 3:46pm revealed: -Resident #2 was found on the floor sitting beside another resident's bed without injury. -There was no documentation of implementation of any fall prevention measures or increased supervision. Telephone interview with a PCA on 07/15/20 at 4:19pm revealed:	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 23 -She was doing rounds on 06/25/20 and found Resident #2 sitting on the floor and the resident's roommate had the resident by the arm. -It looked as if Resident #2's roommate was trying to help him up. -All residents were checked every 2 hours; she and the PCA she worked with liked to check residents "periodically", meaning every 30 minutes to 1 hour. Telephone interview with a MA on 07/14/20 at 5:51pm revealed: -He had found Resident #2 sitting on the floor by another resident's bed on 06/25/20. -MA stated it "appeared" another resident had pulled Resident #2 off of the other bed. -Resident #2 informed the MA that he was not injured. -He did not interview Resident #2 or the suitemate about why Resident had been sitting on the floor. -He checked Resident #2 vital signs. Review of Resident #2's accident/incident report dated 07/01/20 at 8:48pm revealed: -Resident #2 was found on the lounge floor near the courtyard. -Resident #2 did not exhibit any pain. -First aid was not administered. -A fall prevention program was put into place to check vital signs every shift, monitor for change in mental status and injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's progress notes dated 07/01/20 at 9:08pm revealed: -Resident #2 was found lying on the lounge floor. -Resident #2 stated he was not hurt or injured. -A skin assessment was completed on Resident	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 24 #2. -There were not any bruises or bumps found. -Resident #2 did not want to go to the hospital. -Resident #2's Primary Care Physician was contacted. Telephone interview with a MA on 07/15/20 at 5:13pm revealed: -She assisted Resident #2 with getting up after he fell on 07/01/20. -Resident #2 had refused to wear his shoes and had "grip" socks on that were "quite turned around." -She knew Resident #2 had refused to wear his shoes because the PCA yelled out while dressing the resident, "[name of Resident #2] doesn't want to wear his shoes today." -Resident #2 was challenging because staff could settle him into his room, go and check other residents and come back to find Resident #2 in the hall holding onto the handrail and refusing to go back in his room. -The Memory Care Coordinator (MCC) and Administrator knew about Resident #2 being a challenge because they had seen the resident do the same thing. -She was instructed by the MCC to watch Resident #2 which was hard to do with just her and 2 PCAs. Review of Resident #2's electronic progress notes dated 07/04/20 at 7:50am revealed: -Resident #2 was found on the floor in his room. -There were no injuries. -Resident #2's PCP was contacted. -Resident #2 was taken to the hospital. Review of Resident #2's accident/incident report dated 07/04/20 at 3:55pm revealed: -Resident #2 was found on the floor without injury	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 25 in room #226 which had been vacant at 3:45pm. -Resident #2 did not exhibit any pain. -First aid was not administered. -There was documentation the fall prevention program was initiated which included checking vital signs every shift for three days. -There was documentation to monitor the resident's status for 72 hours for bruising, change in mental status/condition, pain or injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's hospital discharge summary dated 07/10/20 revealed: -The reason for the visit was due to leg pain. -Resident #2 was diagnosed with pain in soft tissues of limb. -The x-rays were negative for fracture or dislocation. Review of Resident #2's accident/incident report dated 07/14/20 at 2:39am revealed: -Resident #2 was found lying on his back on the floor in his room without injury. -Resident #2 was sent to the emergency room. -There was documentation the fall prevention program was initiated which included checking vital signs every shift for three days. -There was documentation to monitor the resident's status for 72 hours for bruising, change in mental status/condition, pain or injuries related to the fall. -There was no documentation of the frequency of monitoring and/or safety checks. Review of Resident #2's hospital discharge summary dated 07/14/20 revealed, Resident #2 was treated for a fall.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 26 Telephone interview with MA on 07/14/20 at 5:51pm revealed: -Resident #2 had last fallen on 07/14/20. -Resident #2 had a fall prevention into place to check vital signs, skin tear and mental status. -Resident #2 had 30-minute to a one-hour check for falls. -The falls checks had not been documented. Review of Resident #2's accident/incident report dated 07/14/20 at 6:54am revealed: -Resident #2 fell in his room around 2:39am. -Resident #2 did not exhibit any pain. -First aid was not administered. Review of hospital discharge summary on 07/14/20 revealed: -Resident #2 was diagnosed with a fall. -CAT scan and C-spine testing showed chronic changes and no acute pathology. Review of Resident #2's physical therapy notes dated 06/29/20, 07/08/20, 07/09/20, 07/13/20 and 07/14/20 revealed, It was difficult for Resident #2 to follow verbal/tactile cues and the resident exhibited resistance by squeezing the caregiver's hands and grabbing items. Telephone interview with the Physical Therapist (PT) on 07/16/02 at 1:03pm revealed: -Resident #2 started physical therapy on 06/29/20. -Resident #2 required mobile assistance. -Resident #2 was not safe due to falls. -Resident #2 would follow a physical therapy command based upon his mood. -Resident #2 had difficulty following physical therapy commands. -The PT recommended a bed alarm for Resident #2.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 27 -The PT did know if the bed alarm had been installed. Telephone interview with the PCP on 07/16/20 at 11:51am revealed: -The PCP saw Resident #2 was on 06/22/20. -The PCP was aware of Resident #2's fall history. -She recommended that a fall prevention plan be put into place with at least thirty-minute checks a few weeks prior to the 06/22/20 visit. -There was not enough staff on the memory care unit to provide 1:1 assistance for Resident #2. -The PCP was not aware of Resident #2's footwear being an issue with his mobility. Telephone interview with a personal care aide (PCA) on 06/23/20 at 4:01pm revealed: -Resident #2 needed increased supervision because he needed a walker to ambulate but would get up on his own without the walker and fall. -The PCAs would check on Resident #2 "periodically" and constantly when staff went back and forth on the halls. -All residents were checked every 2 hours. -The MA let the PCAs know if there were residents on every 30-minute checks; Resident #2 was not on every 30-minute checks on 06/23/20. Telephone interview with a second PCA on 07/13/20 at 3:30pm revealed: -Resident #2 was not steady when he walked because of his bedroom shoes. -Resident #2 walked more stabled when he wore his sneakers. Telephone interview with a third PCA on 07/13/20 at 3:35pm revealed, she had worked with Resident #2 "a handful of times" and saw that the	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 28 resident was unsteady walking due to his shoes; the resident walked better in sneakers. Telephone interview with a forth PCA on 07/14/20 at 1:23pm revealed: -She had witnessed Resident #2 sitting on the floor. -She informed the MA of Resident #2 being on the floor. -Resident #2's balance is off when he walks and getting out of bed. -Resident #2 wears his bedroom shoes which caused him to lose his balance. -Resident #2 used his walker more than his wheelchair. Telephone interview with a fifth PCA on 07/14/20 at 2:33pm revealed: -Resident #2 had a history of falls. -She last witnessed Resident #2 fall about two months ago. -Resident #2 was encouraged to use his walker. -She completed two-hour checks on the residents. Confidential telephone interview with a staff revealed: -There was usually one MA and two PCAs on the locked unit. -PCAs would sit in the front common area or hide somewhere on their phones instead of helping with resident care. -There were some residents that would sit in common area up front, so staff were supposed to monitor that area. -It was hard to monitor all the halls on the locked unit because the back hall could not be seen from the front. -The MAs did not assist with resident care because they said it was the PCAs job.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 29 -There were not enough PCAs to keep an eye on the residents in the locked unit that needed more frequent checks because of wandering, behaviors and falls. Telephone interview with the MCC 06/23/20 at 1:58pm revealed: -Resident #2 was on increased supervision for falls and having returned from the hospital. -Residents on increased supervision were residents that had been placed on 72-hour monitoring. -She did not know when Resident 2 had been placed on increased supervision. -The staff initiated 72-hour monitoring by completing an accident/incident report following a fall. -When a resident was placed on 72-hour monitoring meant the MAs checked vital signs every shift and both the MAs and PCA checked the residents for bruises and mental status changes. -All residents were routinely checked every 2 hours; Resident #2 did not have time intervals for increased supervision such as every 30 minutes or every hour. -Staff checked Resident #2 every 2 hours and "kept an eye on him because of his falls." -Resident #2 did not have a bed/chair alarm. -She did not know if the bed alarmed had been ordered. -She and the Administrator decided when to place a resident on every 30-minute checks. -Residents placed on every 30-minute checks were communicated to staff in the morning stand up meeting. -She also entered an order into the computer system for the MAs to document that every 30-minute checks were completed for their shift.	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 30 Telephone interview with the MCC on 07/16/20 at 1:44am revealed: -The MCC wrote the order for approval for physical therapy. -She did not know when physical therapy was started for Resident #2. -She constantly "redirected" Resident #2 when he walked. -There was a fall prevention put into place for Resident #2. -The fall prevention consisted of checking vitals and documented how Resident #2 was doing. -Resident #2 had not received thirty minute or one hour checks due to limited staffing. -The MA was responsible for making sure the safety checks were completed. Telephone interview with the Administrator on 07/14/20 at 3:06am revealed: -Resident #2 fell often and went out to the hospital often, sometimes more than once in one day. -The Administrator had noticed Resident #2 had difficulty walking without his walker. -Resident #2 needed encouragement to use his walker to prevent falls because he did not like to use the walker and had a lot of falls. -Resident #2 was placed on a thirty-minute fall check on the week of 07/05/20 but was limited due to staffing. -Resident #2 was number one on her list for falls management because of her concern for his falls. -She had contacted the regional clinical person last week for approval to place Resident #2 on every 30-minute checks due to the high number of falls. -She was told every 30-minute checks had to be limited to a certain time frame to assure staff compliance. -She was given approval for every 30-minute	{D 270}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 270}	Continued From page 31 checks, but she was waiting for the PCP to sign the new care plan before the checks were implemented. -She had told the ADO and BOM/AED about the plan to place Resident #2 on every 30-minute checks, but she had not instructed the staff on every 30-minute checks. Telephone interview with the Area Director of Operation on 07/16/20 at 2:30pm revealed: -The ADO was not familiar with Resident #2's fall history. -A fall prevention plan was to be put into place for Resident #2 eight weeks ago. The facility failed to provide supervision for 2 of 7 sampled residents (#2, #6) who had been identified by staff as a constantly disoriented and confused. The facility's failure to supervise two residents resulted in Resident #6 being missing from the facility without staff knowledge for 1 to 4 hours, being found near a wooded area after being seen in the road and requiring emergency room evaluation and Resident #2 experiencing 15 falls, 4 visits to the emergency department and a head injury with a laceration. The facility's failure resulted in physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/20 with an addendum on 07/16/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020.	{D 270}		
{D 273}	10A NCAC 13F .0902(b) Health Care	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 32 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: TYPE A2 VIOLATION Based on observations via video conference, interviews, and record reviews, the facility failed to assure notification of the primary care provider for 4 of 6 residents (#1, #2, #3, #6) sampled related to a leg wound that became infected and required an oral antibiotic and wound care by home health (#3); a resident who developed three wounds on the right upper thigh requiring wound care by home health (#2); a resident with severe irritation of his genitals and severe itching all over his body (#6); and failure to obtain physical therapy for a resident with a referral for deconditioning (#1). The findings are: 1. Review of Resident #3's current FL-2 dated 03/30/20 revealed: -Diagnoses included polyneuropathy, fracture of lower end of right humerus, emphysema, essential hypertension, hyperlipidemia, hypothyroidism, general muscle weakness, and difficulty walking. -The resident was documented as semi-ambulatory and continent of bowel and bladder. -The resident's skin was documented as normal. Review of Resident #3's Resident Register revealed: -The resident was admitted to the facility on	{D 273}	**A2 Healthcare 0902-B** The corrective action for the resident #3 and #2 was to complete a head to skin assessment by the medication aide and reviewed by the MCM. The skin assessment indicated no further skin issues. The correction for resident #6 and #2 was to notify the primary care provider and a skin scraping was performed to rule out scabies. The scrapings were negative. The Emilite creamed was ordered by the PCP and administered. 8-5-2020 For resident #1 the PCP provided an order for PT to evaluate and treat as indicated on 8/12/2020. On 7/17-21/2020 the LHPS nurse reeducated the medication aids on proper primary care provider notification and documentation of the changes. This consisted of the following: • Diet order changes and decreased meal intake • Weight monitoring • Deconditioning	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 33 03/31/20. -The resident required assistance with bathing, dressing, nail care, skin care, and hair/grooming. -The resident used a walker and wheel chair. -The resident's memory was adequate. Review of Resident #3's assessment and care plan dated 04/13/20 revealed: -The resident required limited assistance with toileting, ambulation, dressing, grooming, and transferring. -The resident required extensive assistance with bathing. -The resident had daily incontinence of bowel and bladder. -The resident had limited strength in upper extremities and bilateral general weakness. -The resident was oriented but forgetful and needed reminders. Review of Resident #3's progress notes dated 06/02/20 at 11:03pm revealed: -The resident was putting on lotion on her left leg when she made a skin tear on the left leg. -There was no further documentation of what caused the skin tear. -A bandage was applied to it. -There was no documentation the resident's primary care provider (PCP) was notified. Review of Resident #3's body evaluation and observation forms revealed: -On 06/03/20 at 8:30pm: the resident had her left lower leg wrapped from an injury and said she could not take a shower until it was covered. -On 06/06/20 at 8:30pm, 06/11/20 at 8:00pm, 06/20/20 at 9:30pm, and 06/25/20 at 7:00pm: no new marks were noted and the wound on her leg was not documented.	{D 273}	• Fall Risk • Medication refusal or changes • Skin Integrity • Elopement behaviors • And any other variance to resident specific behavior that could indicate an underlying medical convers. condition. per Dana Bella on 8/26/20. WWilliams 8/26/20 On 7/17-21/2020 the medication aides were reeducation on current standing or prescribed order that are not therapeutic or have reach their level of treatment. The orders will be reviewed with the PCP for changes or adaptations to the orders for continued therapeutic treatment. All care staff were reeducation on 7/17-21/2020 by the LHPS nurse on appropriate procedure for completing the body evaluations forms which included the t=following: PCA completes the form 3 times per week and PRN, Med Aide/SIC on shift to sign eval after review, if skin issue noted PCP with be notified; Completed body eval forms will be placed in the ED box for final review and follow up if warranted.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 34 Review of Resident #3's standing house orders dated 04/07/20 revealed: -There was an order for minor skin tears or abrasions. -The instructions were to clean area with normal saline; apply Neosporin or equivalent; cover with band-aid or gauze and tape; and change as needed until healed. (Neosporin is an antibiotic ointment used to treat skin infections.) Review of Resident #3's June 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for a standing order for skin tear to apply Neosporin and dry gauze daily and as needed until healed; "if not healed after 7 days notify physician. Chart daily, was bandage changed and dressing applied? Yes or No". -The standing order for Neosporin was initialed from 06/03/20 - 06/09/20 during the 7:00am to 3:00pm shift except it was documented as resident refused on 06/05/20. -There was no further documentation of the standing order for Neosporin after 06/09/20 and no documentation the skin tear healed or the physician was contacted. Review of Resident #3's physician's orders dated 06/18/20 revealed: -There was an order for Keflex 250mg 1 capsule twice a day for 7 days. (Keflex is an antibiotic used to treat infections.) -There was an order for home health nursing referral for wound care. Review of Resident #3's June 2020 e-MAR revealed Resident #3 was administered 14 doses of Keflex 500mg twice a day for 7 days from 06/03/20 - 06/10/20 as ordered.	{D 273}	The MCM/RCC will review the completed physician orders to ensure they are followed upon and implemented. The management team to review the progress notes to identify any areas of needed follow-up. Transportation staff were reeducation on importance of documenting any appointments cancelled/rescheduled by the primary care provider office in residents progress notes as well as notify MCC/RCC to ensure proper follow up. Reeducate RDD/MCC on importance of daily follow up of activities from the previous day to include resident progress notes, vital signs and MD notification needed. During the weekly at-risk meeting and stand-up/stand down meeting the residents that have been identified with MD notifications, weekly skin assessments, and changes in resident symptoms. Weekly the ED or designee will audit the progress notes, 24 hours reports and skin assessments for further recommendations and follow up as indicated.	20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 35 Telephone interview with the Memory Care Coordinator (MCC) on 07/16/20 at 1:43pm revealed: -She was not notified of Resident #3's skin tear on 06/02/20 when staff noted it in the progress notes. -She was not reviewing progress notes at that point because the Resident Care Coordinator (RCC) had quit and she was the only clinical staff so she did not have time to review the progress notes. -She looked at the wound (could not recall what date) and the wound was a little red but she did not notice any drainage or swelling. -She contacted the resident's PCP who ordered an antibiotic for the wound on 06/18/20. -The medication aides (MAs) and personal care aides (PCAs) were supposed to report everything to her but no one had reported the wound to her. Telephone interview with a MA on 07/15/20 at 6:06pm revealed: -She saw the resident's leg wound on 06/03/20 or 06/04/20 and it looked like someone "took a chunk out of her skin". -The wound was deep and the size of a "nickel". -The wound was red, swollen, and had a little white drainage. -She told the licensed health professional support (LHPS) nurse about the wound when she saw it and she thought the LHPS nurse wrapped it. -The MAs started administration of a standing order for triple antibiotic ointment for Resident #3's leg wound. -The standing order did not help and the wound got infected and the resident had to take an antibiotic. -She did not recall if anything was done for the resident's wound once they completed the standing order on 06/09/20 until her PCP was	{D 273}	D273 Addendum per telephone with Ms. Darla Bellah on 8/28/20. The RCC, MCM, and ED are auditing at least 5 resident records per week to assure compliance with health care. The RCC, MCM, and Transportation staff are responsible for scheduling + making appointments. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 36	{D 273}		

notified and ordered the antibiotic on 06/18/20.
-The wound was getting better now because a home health nurse had been coming to dress it.

Telephone interview with the facility's contracted LHPS nurse on 07/16/20 at 11:32am revealed:
-One of the MAs reported Resident #3's leg wound to her (could not recall date).
-She looked at the wound right after she was informed and it looked like a tiny skin tear at that time.
-The MCC told her they had a standing order for an antibiotic ointment for skin tears they could use.
-She thought the facility was following the protocol for the standing order.
-About 2 weeks later (could not recall date), a PCA asked her to look at the resident's leg wound.
-It looked red around the wound and she told the MA and the MCC to notify the provider.
-She was not notified of any concerns about the resident's leg wound until the PCA asked her to look at the wound.

Telephone interview with Resident #3's PCP on 07/08/20 at 10:35am revealed:
-The first time she was notified of a wound on Resident #3's left leg was on 06/18/20.
-The wound was infected so she ordered an antibiotic on 06/18/20 and home health nursing for wound care.
-She was not aware the resident had the wound since 06/02/20 or that staff had implemented a standing order for Neosporin since the wound began as a skin tear.
-She would have expected to be notified when the skin tear did not heal after implementing the standing order.
-She saw the resident during another tele-visit on

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 37 06/22/20 and the wound was looking better after 4 days of taking the antibiotic. Review of Resident #3's home health skilled nursing visit note dated 06/25/20 revealed: -The resident was seen on 06/25/20 for a referral for wound care to left ankle wound. -The wound was edematous (swollen) with erythema (redness) and had a small amount of serosanguinous (thin, watery and pink in color) drainage. -The wound was cleaned and dressed. -The resident reported she was taking antibiotics and the wound looked better but it was still not healing. Review of Resident #3's home health skilled nursing visit notes revealed: -The resident's left leg wound was cleaned and dressed by a home health nurse on 06/29/20, 07/02/20, and 07/06/20. -On 07/06/20, the would bed was noted to be pink and yellow with a small amount of serosanguinous drainage and no odor. Observation and interview via video conference with Resident #3 on 07/14/20 at 1:35pm revealed: -When she first got the skin tear on her leg, the MAs put an ointment on it but they did not do anything else because they wanted to wait for a nurse to treat it. -The wound on her leg "got a little red around it" and she had to take an antibiotic. -Eventually a nurse treated it but she could not recall when. -The wound "looks a lot better". Telephone interview with Resident #3's family member on 07/09/20 at 9:50am revealed: -He was aware the resident had a wound on her	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 38 leg. -He did not know if there was a delay in the facility obtaining wound care for the resident's leg wound. -The resident had expressed concerns to him about the leg wound for about a week (could not recall the date). -The leg wound got infected and the resident received an antibiotic and a nurse was now coming in the facility to dress the wound. Telephone interview with the Administrator on 07/14/20 at 3:05pm revealed: -She was told about Resident #3's leg wound "a month ago". -She saw the resident's leg wound but she could not recall when she saw it and she did not remember how it looked. -The MCC or MAs were responsible for notifying the PCP of any wounds or concerns about a resident's condition and it should be documented in the progress notes. -To her knowledge, Resident #3's PCP was not notified of the resident's leg wound until 06/18/20 when it was infected and an antibiotic was ordered. Telephone interview with the Area Director of Operations (ADO) on 07/16/20 at 2:33pm revealed: -The PCAs should notify the MAs, MCC, or RCC of any wounds on residents. -She could not find any documentation that Resident #3's PCP was notified of her leg wound prior to 06/18/20, when the resident's wound was infected and required an antibiotic and wound care by home health. 2. Review of Resident #2's current FL-2 dated 06/16/20 revealed, diagnoses included bilateral	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 39 pneumonia and dementia. Review of Resident #2's Care Plan dated 09/11/19 revealed, there were no documentation for any wound care for Resident #2. a. Review of Resident #2 physician's order dated 01/08/20 revealed: -The rash had improved. -Resident #2 had a dermatology appointment. -There was not a date noted for the dermatology appointment. Review of an appointment notice from a dermatology office dated on 01/17/20 revealed, Resident #2 had a dermatology appointment scheduled on 04/27/20 at 10:10am. Review of the Resident #2's Body Evaluation and Observation forms on 04/16/20 revealed: -Resident #2 had continued to scratch "intensely". -He had scratched the large sore on his upper right thigh. -There was a sore on Resident #2's upper left thigh. Review of the Resident #2's Body Evaluation and Observation forms on 04/21/20 revealed: -Resident #2 did not have any new marks on the upper right and upper left thigh area. -A skin ointment was applied to the dry skin. Review of the Resident #2's Body Evaluation and Observation forms on 05/05/20 revealed: -Resident #2 did not have any new marks on upper right thigh area. -Resident had "picked open white meat" on right upper thigh. -Resident reported the upper right thigh had continued to itch.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 40 Review of the Resident #2's Body Evaluation and Observation forms on 05/17/20 revealed: -Resident #2 did not have any new marks on the upper right thigh area. -There were old scars identified. Review of the Resident #2's Body Evaluation and Observation forms on 06/06/20 revealed: -Resident #2 did not have any new marks on upper right thigh area. -Resident was still picking at the "old sore". Review of the Resident #2's Body Evaluation and Observation forms on 06/09/20 revealed Resident #2 did not have any new marks on upper right area. Review of the Resident #2's Body Evaluation and Observation forms on 06/23/20 revealed Resident #2 did not have any new marks on upper right thigh area. Review of Licensed Health Professional Support (LHPS) evaluations dated 04/15/20 and 06/10/20 for Resident #2 revealed, there was no documentation of issues with the resident including itching, scratching and wounds. Telephone interview with the LHPS Nurse on 07/16/20 at 11:31am revealed: -She worked at the facility 16 hours per week but was out of work from February through April 2020. -No one had reported any concerns related rashes, itching, scratching or wounds for Resident #2. Review of a home health nurse (HHN) visit note dated 06/29/20 for Resident #2 revealed:	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 41 -The HHN found Resident #2 with no dressings in place to the right upper thigh. -The HHN cleaned and dressed the wounds with a transparent occlusive dressing to deter the resident from picking at the wound and removing the dressing. Review of an HHN visit note dated 07/02/20 for Resident #2 revealed: -The HHN found Resident #2 with no dressings in place to right upper thigh. -The HHN cleaned and dressed the wounds with a transparent occlusive dressing to deter the resident from picking at the wound and removing the dressing. Review of an HHN visit note dated 07/06/20 for Resident #2 revealed: -The HHN found Resident #2 with no dressings in place to the right upper thigh. -The HHN cleaned and dressed the wounds with a transparent occlusive dressing. Telephone interview with the HHN on 07/16/20 at 1:03pm revealed: -Twice weekly wound care was initiated on 06/29/20 for Resident #2 for 3 wounds on his outer right thigh. -When she first saw Resident #2's wounds on his upper right thigh, the outer edges of the wounds were starting to heal and only the center of the wounds was red and open. -She found Resident #2 with no dressing in place to all three wounds, except for one visit. -On one visit there was a dressing on one of three of Resident #2's wounds. -She had asked staff to call her if the dressings came off; she was at the facility at least 3 times a week and could have replaced the dressing. -Resident #2's wounds without a dressing was a	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 42 risk for infection and a risk for the wounds not to heal. -There was no dressing present on the wounds at the 06/29/20 home health visit. -She noticed the wounds had been picked. -Resident #2 had two wounds on his upper right thigh and one wound on the outside of this upper left thigh. -The home health care nurse changed the wound dressings twice weekly. -Some of Resident #2's wounds had healed. -PCP stated the wound was at risk for infection and properly healing due to improper care. b. Review of Resident #2's progress notes dated 03/29/20 at 6:32am for Resident #2 revealed: -Resident #2 "opened up" wounds on his right upper thigh; the "higher" wound was getting larger. -Resident #2 picked at the scab so that "a deep layer of white meat was showing." -Resident #2 stated, "Don't nobody care if the [expletive] leg comes off." -The staff notified the Supervisor of the findings. -There was no documentation Resident #2's primary care provider (PCP) was contacted. Review of Resident #2's progress notes dated 04/07/20 revealed: -Resident #2 was found picking the wound at his right upper thigh; the resident picked at the wound "so bad" his hands, incontinence brief and sheets were bloody. -The staff notified the supervisor of the findings. -There was no documentation Resident #2's PCP was contacted. Review of Resident #2's progress notes dated 04/17/20 at 6:36am revealed: -A personal care aide (PCA) had observed	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 43 Resident #2 "digging his sores" and his hands were bloody. -Resident #2 reported the wound "He itched so bad that his skin was on fire." -There was no documentation Resident #2's PCP was contacted. Review of Resident #2's progress notes dated 06/16/20 at 6:10pm revealed, Resident #2 returned from the hospital at 4:15pm. Review of Resident #2's progress notes dated 06/16/20 at 6:10pm for revealed the resident returned from the hospital with dressings on two wounds on his right hip. Review of Resident #2's progress notes dated 06/17/20 at 12:07pm revealed: -The memory care coordinator (MCC) had spoken with the PCP about the two wounds on Resident #2's upper right thigh. -The PCP had ordered home health care for wound care for Resident #2. -The MCC had contacted the home health care agency. Review of Resident #2's progress notes dated 06/25/20 at 3:46pm revealed: -A nurse had observed Resident #2 for wound care for upper right thigh. -The wound was treated with silver dressing and nonstick foam adhesive. Review of a PCP physician's order for Resident #2 dated 06/17/20 revealed: -There was a note to the PCP documenting Resident #2 had returned from the hospital with two open sores on his right thigh. -The note requested an order for home health nursing care.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 44 -There was an order for home health nursing care for wound care by the PCP. Telephone interview with Resident #2's PCP on 07/16/20 at 11:57am revealed: -Concerns for itching, scratching and sores had been brought to her attention prior to 06/17/20 for Resident #2. -A delay in reporting open wounds was concerning for the wound progressing to more than superficial scratch and for the development of an infection. Review of Resident #2's hospital discharge summary dated 06/13/20 through 06/16/20 for Resident #2 revealed, emergency room notes dated 06/13/20 documented Resident #2 having old appearing abrasions to his right lateral thigh. Review of Resident #2's PCP visit note dated 06/22/20 for Resident #2 revealed, Resident #2 was seen for right leg wounds which were healing. Telephone interview with PCP on 07/09/20 at 11:53am revealed: -The Resident #2 was last seen on 06/22/20. -She was not aware if the dermatology appointment was scheduled and attended. -The upper right thigh and upper left thigh wounds was at risk for infection and properly healing due to improper care. -Resident #2's right upper thigh wound looked more like a pressure wound. -Resident #2 should had continued using the skin cream. Telephone interview with a third PCA on 07/14/20 at 1:23pm revealed: -She had noticed Resident #2 scratching his	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 45 upper right thigh often. -The PCA informed the MA of Resident #2 scratching after noticing Resident #2 was his thigh. -The MA would apply cream and a gauze to the wound on Resident #2's upper right tight. Telephone interview with a medication aide (MA) on 07/14/20 at 5:51pm revealed: -The MA was familiar with Resident's #2 scratching often. -The MA was not familiar with any dermatology appointment for Resident #2. -He had applied cream to the irritated area on Resident #2's upper right thigh on 03/29/20 and 04/04/20. -The MCC scheduled all residents' appointments. Telephone interview with the MCC on 07/16/20 at 1:44pm revealed: -Resident #2 had two wounds on the upper right thigh when he returned from the hospital on 06/16/20. -Resident #2 did not have any wounds prior to the hospital stay. -Resident #2 was taken to the dermatologist on the incorrect date for the dermatology appointment in February 2020. -She did not know about the April 27th dermatology appointment. -She did not know if the dermatology appointment had been rescheduled. -She was the person responsible for scheduling all Residents' appointments. Telephone interview with the Administrator on 07/14/20 at 3:06pm revealed, she was not familiar with Resident #2's skin issues. Telephone interview with Area Director of	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 46 Operation (ADO) on 07/16/20 at 2:30pm revealed: -Resident #2 had gone to the dermatologist on the wrong day in February 2020. -Resident #2 had a dermatology appointment in April 2020 but the office was closed. -The April 2020 dermatology appointment was not rescheduled. -The MCC was responsible for making medical appointments. -She was not familiar with Resident #2's wound care. -She knew the home health nurse (HHN) came in weekly and had cleaned and dressed Resident #2's wounds. 3. Review of Resident #6's current FL-2 dated 09/11/19 revealed: -Diagnoses included dementia, bipolar disorder and schizophrenia. -The resident was constantly disoriented. -The resident was ambulatory. Review of Resident #6's current Assessment and Care Plan dated 08/11/19 revealed: -The resident was always disoriented. -The resident had significant memory loss and must be directed. -The resident was ambulatory. Review of an electronic progress note by a personal care aide (PCA) for Resident #6 on 04/07/20 at 6:00am revealed: -Resident #6 was restless most of the night, he was up on 4 different occasions and had removed his clothes. -He was itching "horribly" and stayed in the TV room from 2:00am-6:15am due to his inability to sleep. -The PCA notified the medication aide (MA) and	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 47 the MA stated there was nothing he could have as needed for his itching. -There was no documentation that Resident #6's PCP had been notified of his itching. Review of an electronic progress note by a PCA for Resident #6 on 04/17/20 at 6:41am revealed: -Resident #6 undressed himself 9 times, he had extreme redness over his whole body and between his toes. -The PCA continued to redress him and put him back to bed. -There was no documentation that Resident #6's PCP had been notified of his itching. Review of an electronic Incident and Accident Event Report for Resident #6 dated 05/02/20 revealed: -A PCA documented on 05/02/20 at 10:00am that Resident #6 had a severe redness around the tip of his genitals. -On 05/06/20 at 9:19am the MCC documented the report as invalidated due to incorrect data. -Resident #6's PCP was not notified of the severe redness. -There was no documentation explaining what the incorrect data was on the report that the MCC invalidated. Review of an electronic progress note by a PCA for Resident #6 dated 05/27/20 at 6:16am revealed that he had an open sore on his left foot and was out of bed on and off during the night. Telephone interview with a former PCA on 07/15/20 at 6:20pm revealed: -She had seen scabies before and saw a similar rash on a few of residents including Resident #6 in April 2020. -She reported the concern to the MCC, the	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 48 Business Office Manager (BOM)/Assistant Executive Director (AED) and the Administrator but nothing was done. -Resident #6's rash and itching were so bad; the resident would remove his clothes and scratch all over every night. -She reported Resident #6's rash, itching and scratching to the MA every night she worked. -She told the MCC, BOM/AED and Administrator about cleaning Resident #6's room, linens and clothing. -She was told she did not know what she was talking about and could not diagnose scabies. Telephone interview with a PCA on 06/24/2020 at 4:25pm revealed: -She had observed red bumps on Resident #6, he itched frequently, and she applied cream to his skin. -She had observed scabs on Resident #2, and he picked at his skin often. Telephone interview with a MA on 07/06/20 at 3:58pm revealed: -Resident #6 was being treated for a rash with permethrin applied once per week and left on for 8 hours. (Permethrin is used to treat scabies.) -The cream was ordered for every Wednesday and Resident #6 had received two applications. Telephone interview with the MCC on 07/06/20 at 1:42pm revealed: -Resident #6 had a rash with red bumps on his chest and arms that he scratched "a lot". -The resident's PCP prescribed a cream and the rash cleared up. Review of a PCP visit note dated 05/07/20 for Resident #6 revealed: -He had several red sores on his abdomen that	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 49 look like bug bites. -She prescribed permethrin cream for his sores. Review of a PCP visit note dated 06/23/20 for Resident #6 revealed: -He was seen for a rash and itching. -He had a red rash all over his body. -Educational materials were provided for care instructions of his rash. Telephone interview with Resident #6's PCP on 07/09/20 at 11:55am revealed: -She suspected scabies as the cause of Resident #6's rash and itching. -She prescribed permethrin cream for Resident #6 and the rash improved indicating the cause was likely scabies. -She instructed staff on precautions and cleaning requirements at the time she ordered the permethrin. Telephone interview with the MCC on 07/16/20 at 1:44pm revealed: -She knew Resident #6 was treated with permethrin cream which was used to treat scabies. -She was not told specifically Resident #6 was being treated for scabies, so she did not implement procedures related to caring for a resident with scabies. -When a resident had scabies, she was responsible for informing the Administrator who would contact the corporate clinical staff to find out what needed to be done. Telephone interview with the Administrator on 07/14/20 at 3:06pm revealed: -There were no cases of scabies at the facility since she was hired on 05/04/20. -She had not been notified of any residents that	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 50 had scabies at the facility. -She did remember a former PCA telling her about a concern of scabies in the facility but "she was not a doctor." -If staff suspected a resident had scabies, she would expect them to notify the residents PCP and document in the resident's record. Based on interviews and record reviews, Resident #6 was not interviewable. 4. Review of Resident #1's current FL-2 dated 05/19/20 revealed -Diagnosis included hemorrhoids, edema, hypocalcemia and thrombocythemia. -She was semi-ambulatory and used a wheelchair. Review of Resident #1's Resident Register dated 09/14/16 revealed Resident #1 required assistance getting out of her wheelchair and she required assistance with bathing, toileting, dressing and ambulation. Review of Resident #1's Care Plan dated 11/15/19 revealed she had a limited range of motion and limited strength in her upper extremities and she ambulated with the assistance of a walker and wheelchair. Review of Licensed Health Professional Support (LHPS) Quarterly Review dated 05/13/20 revealed: -Staff assisted her with transfers when needed. -She used a walker for short distances and her wheelchair for longer distances. -Staff assisted her with her walker and wheelchair as needed. Review of outpatient report from provider on	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 51 01/21/20 revealed: -Resident #1 had a diagnosis of primary osteoarthritis of her right hip, end-stage osteoarthritis and endometrial cancer. -She received an x-ray guided therapeutic right hip injection for pain management. Review of Resident #1's home health progress note on 03/09/20 revealed she complained of discomfort in her right shoulder and would like to begin physical therapy. Review of Resident #1's home health recertification electronic progress note dated 06/22/20 revealed: -Resident #1 was having trouble putting on her socks and shoes and requiring more assistance from the Assisted Living (AL) staff. -She continued to require assistance from the AL staff for safe mobility, personal care and safety awareness. -She was able to walk only with the supervision or assistance of another person. -The home health nurse provided an update to the Memory Care Coordinator (MCC) that Resident #1 would benefit from physical therapy. -The MCC informed the home health nurse that the facility was not permitting therapy into the facility at this time due to COVID-19, that once restrictions were lifted, she would be able to obtain an order for a therapy evaluation for increased strengthening. Video conference call with Resident #1 on 07/10/20 at 3:51pm revealed: -She had a decrease in her overall strength, and she wanted to receive physical therapy to increase her independence and mobility. -She used her walker more in the past but due to her decline in strength she had been using her	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 52 wheelchair more often. -She denied any recent falls. Telephone interview with Resident #1's responsible party on 07/10/20 at 4:00pm revealed: -She was concerned about Resident #1's decrease in mobility and strength. -She believed Resident #1 would benefit from physical therapy. Telephone interview with the Administrator on 07/14/20 at 3:21pm revealed: - The facility continued to allow physical therapy services for residents because physical therapy services were considered vital services for the residents. -She was not aware that Resident #1 had not received a physical therapy referral due to COVID-19. -Physical therapy services were being provided in the facility on her first day of employment with the facility on 05/04/20. -The MCC would have been responsible for contacting Resident #1's PCP to request an order for a physical therapy evaluation. -A referral for physical therapy services should have been made by the MCC or the medication aide (MA) to Resident #1's PCP. Telephone interview with the MCC on 06/23/20 at 2:20pm revealed: -When she was informed of an unmet need a resident had, she and/or MA would assess the resident. -The MCC or the MA were responsible for making the appropriate referral to the resident's PCP. -She did not know why Resident #1's PCP had not been contacted about a referral for a physical therapy evaluation.	{D 273}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 53 Telephone interview with Resident #1's home health nurse on 07/15/20 at 12:18pm revealed: -Resident #1 needed physical therapy due to chronic hip issues and general deconditioning. -She would also benefit from occupational therapy to increase her independence with her personal care needs. The facility failed to notify Resident #1's PCP of a leg wound from 06/02/20 until 06/18/20 resulting in the wound becoming infected and requiring an oral antibiotic and wound care by home health skilled nursing; failed to notify Resident #2's PCP of intense scratching which caused the development of three wounds on a resident's right upper thigh requiring wound care by home health skilled nursing; failed to notify Resident #6's PCP of severe irritation of his genitals and severe itching all over his body; and failed to obtain physical therapy for Resident #1 with a referral due to deconditioning and weakness. The facility's failure placed the residents at substantial risk of serious physical harm or neglect and constitutes a Type A2 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/20 for this violation. CORRECTION DATE FOR THE TYPE A2 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020.	{D 273}		
{D 338}	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21,	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 54 Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local Health Department (LHD) were implemented and maintained when caring for 77 residents during the global Coronavirus (COVID-19) pandemic as related to the testing of staff and residents immediately following a direct care staff testing positive for COVID-19; screening of staff and visitors for symptoms of COVID-19; and safety precautions to reduce the risk of transmission and infestation of scabies including the availability and use of personal protective equipment (PPE) by staff and environmental cleanliness. The findings are: 1. Review of the CDC guidelines for the prevention and spread of the Coronavirus disease in long term care facilities revealed: -Personnel should always wear a face mask while in the facility. -All essential visitors should be screened for the presence of fever and symptoms of the virus when entering the building. -All personnel should practice social distancing (remain at least six feet apart) when in common areas. -Implement social distancing among residents. Review of the resident roster dated 06/23/20	{D 338}	**D 338 10 A NCAC 13F .0909 Resident Rights** On July 17-21, 2020, the LHPS nurse completed an Infection Control Inservice related to COVID-19, bed bugs and scabies. On July 7, 2020, the LHPS nurse completed an in-service on COVID-19 screening and the requirements of COVID-19 quarantine. As a matter of record the residents that were identified during the survey to have had scabies have been seen by the PCP and scabies was not the diagnosis and confirmed by the laboratory. On August 11, 2020 residents and employees were tested for COVID-19 and results are pending. Any positive test results will ne forwarded to the local health depart as required by the state law. Any outside positive result that is not the property of the facility continue to be the responsibility of the testing site to report their results to the local health department.	9-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 55 revealed there were 77 residents on the roster with 56 residents residing on the assisted living (AL) and 21 residents residing in the secured unit of the facility. Review of the facility's Infection Control 21 Coronavirus (COVID-19) policy with a review date of 03/09/20 revealed: -The most important sources of Coronavirus virus are the infected persons. The incubation period, or time between exposure to Coronavirus and appearance of the first symptoms is 1-14 days. -Residents and/or Community staff with Coronavirus-like illness, especially if there is a cluster (two or more cases of Coronavirus-like illness within 72 hours) should be tested for Coronavirus. Contact the local health department (LHD) for appropriate diagnostic laboratory test recommendations. -Health Department personnel can provide information about Coronavirus activity in the area and about diagnostic specimen collection and coordination. -During an outbreak, once a single laboratory confirmed case of Coronavirus has been identified, it is likely thare are other cases among exposed persons. Observation during the facility tour on 06/24/20 beginning at 11:44am revealed: -No sign for COVID-19 precautions was observed at the outside entrance. -The facility had a separate designated changing area in the front of the facility for staff use in changing from street clothes to required facility clothes and donning personal protection equipment (PPE) consisting of facial masks, gloves, and foot coverings. Review of the facility's "COVID-19 Screening	{D 338}	The facility staff were reeducated on the location of the personal protective equipment on July 7, 2020 by the ED. They were further educated on donning and dolphin the required PPE and ensuring they had the necessary supplies. On June 15, 2020, the facility was provided a tablet for the completion of an electronic format COVID-19 screening tool. This tool has parameters that will alert the management and not allow for information to be entered that are outside of normal parameters (i.e. a false thermal temperature of 61 F.) The screening tool has been updated to include all necessary question from the CDC guidance on screening evaluations.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 56 Checklist for All Visitors and Staff " revealed: -There was a physical questionaire and an electronic copy to be completed. -All individuals (staff, other health care workers, family, visitors, vendors) entering the building must complete this screening checklist. -There were spaces for date, community name, name of associate/visitor and name of screener. The following questions were listed on the screening checklist with a space to check yes or no: -Question #1-have you washed your hands or used alcohol-based hand sanitizer for at least 20 seconds. -Question #2-Do you have any of the following symptoms with the following symptoms listed: fever [temperature of 99.6 degrees Fahrenheit (F) or higher]; sore throat; cough; new shortness of breath; pink eye; recent loss of taste or smell; or diarrhea. (If Yes to any, restrict them from entering the building, If No to all, proceed to question #3 for staff and question #4 for all others.) -Question #3. For Staff & Health Care Providers (e.g. health care workers, such as home health, hospice, physical therapy): 3a. Check temperature and document results: Fever present? yes or no (If Yes, restrict from entering the building. If NO, proceed to step 3b. 3b. Ask if they have worked in facilities or locations with recognized COVID-19 cases, yes or no. (If Yes, ask if they worked with any person(s) with confirmed COVID-19). If Yes (to worked in facilities or locations with recognized COVID-19 cases) require them to wear PPE including mask, gloves, gown before any contact with residents & proceed to step 4. (If No, proceed to step 4.) -Question #4. Allow entry to building and remind	{D 338}	The facility staff will be screened by the receptionist during the day shift hours and after hours by the supervisor in charge (SIC). The receptionist and SIC will utilize the electronic screening tool and any abnormalities will be alerts to the management staff and immediate actions taken to quarantine or further actions as the symptom warrant. The MCM/RCC will make walking round to ensure the infection processes are in place daily. The infection control observation from the waling round will be reviewed with the management team, in the weekly standards of care, stand up stand down meeting for further recommendation or systemic changes to occur for the prevention of any further infection issues. The MCM/RCC will place resident or staff on the necessary IC procedure to include quarantine upon immediate identification and notify the PCP for the protection of all other resident and staff.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 57 the individual to: Wash their hands or use hand sanitizer throughout their time in the building. Do not shake hands with, touch or hug individuals during their visit. Review of a resident's electronic progress notes revealed documentation dated 06/18/20 "PCP [primary care provider] notified of a positive COVID [test] of an Employee. Temps [temperatures] to be taken twice daily. PCP will be notified of elevated temps." Review of the resident's June 2020 electronic medication administration record (eMAR) revealed: -There was an entry for "COVID-19 Precaution" with times of temperature check and monitoring scheduled for 7:00am to 3:00pm and 3:00pm to 11:00pm daily, with a start date of 06/17/20 and end date of 06/30/20. -Special instructions read: If a resident begins to display symptoms/fever greater than 99.6 degres F or difficulty breathing, the community should do the following: complete the COVID-19 form in Matrix, add all vital signs for every shift, add O2 sat (oxygen saturation level). -There were entries for temperatures documented 2 times daily with a start date of 06/18/20 and end date of 06/30/20. The range was from 95.1 degrees F to 98.7 degrees F. Review of the facility's training on the general topic of COVID-19 precautions, including handwashing techniques review, along with signatures of the attendees were provided. Telephone interview with the Memory Care Coordinator (MCC) on 06/30/20 at 9:00am revealed: -There were no confirmed COVID-19 cases in the	{D 338} D338	Addendum per telephone with Ms. Darla Bellah on 8/28/20. Inservices noted were completed for all staff. If any communicable disease is suspected, facility protocol for infection control will be followed. If any staff report they have tested positive for COVID-19 via an independent entity, the ED will immediately contact the local Health Department to confirm result and staff will be on leave until results are confirmed. COVID-19 screening is the responsibility of the receptionist during the day and the supervisor on duty during evenings, nights and when receptionist is not on duty. ED will monitor daily to assure screenings are done as required. RCC / MCM audit PPE supply at least weekly on Thursdays and turn in list to ED, who will order any needed supplies. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 58 facility. -The Licensed Health Professional Support (LHPS) Nurse conducted an in-service at the facility for COVID-19 training on handwashing, using PPE, monitoring temperature changes in staff and residents when COVID-19 first started. -The MCC was responsible for scheduling staff, including MAs, and managing residents' health care related issues. -One medication aide (MA) had notified the facility by text message on 06/16/20 (after having worked the evening shift) that she had tested positive for COVID-19 at a second job. -The MA and 2 personal care aides (PCAs) were currently unable to work due to suspected COVID-19 exposure. -The staff had been requested to provide the facility with negative COVID-19 test results before being allowed to return to work. -She did not think the staff had provided results for a COVID-19 test. -The facility had not tested any staff or residents for COVID-19 as far as she knew. Telephone interview with the Administrator on 07/02/20 at 1:41pm revealed: -She was informed on 06/16/20 by the Area Director of Operations (ADO) that a MA had texted the ADO regarding positive COVID-19 test results at a second job on 06/16/20. -The Administrator had not notified the local Health Department (LHD) because she did not have confirmation of a positive COVID-19 test from the MA's second employer. -The MA had not worked since 06/16/20 and had not provided confirmation of COVID-19 test results as requested. Telephone interview with the ADO on 07/02/20 at 1:52pm revealed:	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 59 -She became aware via a text message on 06/16/20 from a night shift medication aide/Supervisor, MA/S, she had been tested for COVID-19 at a second work place. -The ADO requested that the MA/S send a copy of the test results to her when received. -On 06/18/20, the ADO received a text message from the MA/S stating the test result was positive for COVID-19. -The ADO requested a copy of the MA/S's COVID-19 test results. -The night shift MA/S was responsible to administer medications as needed to residents of the facility including the secured unit and assisted living unit. -The MA/S was responsible to assist PCAs with any resident care as needed including assisting with transfers and incontinence care. -She learned from facility staff that 2 PCAs were socially interacting with the MA/S, who had tested positive for COVID-19, just prior to 06/16/20. -The 2 PCAs were removed from the schedule and asked to obtain negative COVID-19 test results prior to returning to work. (The staff had not provided negative COVID-19 test as of 07/02/20). -The ADO contacted the facility's PCP's Physician's Assistants (PAs) to inform the PA a staff member was reported to have a potitive COVID-19 test result and request any instruction regarding monitoring residents. -The ADO had not contacted the LHD regarding a staff testing positive for COVID-19 because the MA/S did not provide a copy of the COVID-19 test results to verify she had tested positive. -The MA/S was removed from the schedule starting 06/18/20 until two negative tests for COVID-19 were provided by the staff. -A representative from the LHD had been routinely contacting the facility to check on the	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 60 availability of PPE and to offer to be used as a resource if needed. -As far as she knew, nobody from the LHD had contacted the facility recently to request information about COVID-19 status for residents or staff. -The LHPS Nurse had conducted COVID-19 training for handwashing and use of PPE (verified with sign-in sheets) dated 06/18/20 and 06/19/20. Review of the facility's Rotation A Schedule for 06/03/20 to 06/17/20 and Rotation A Schedule for 06/18/20 to 07/02/20 revealed: -The MA/S who tested positive for COVID-19 worked 7:00pm to 7:00am on 06/05/20, 06/06/20, 06/07/20, 06/10/20, 06/11/20, 06/12/20, 06/15/20 and 06/16/20. -The MA/S was the only MA scheduled on the nights she worked. -The MA/S was not on the schedule to work from 06/18/20 to 07/02/20. Telephone interview with an infection control Nurse at the LHD at 3:40pm revealed: -The LHD had not called the facility requesting status on COVID-19 for staff or residents. -The Nurse monitored the COVID-19 reporting website for results of COVID-19 testing in facilities or individuals. -The facility was responsible to contact the HD to report cases of COVID-19 and receive information and direction for monitoring and controlling COVID-19. -The LHD would review the latest COVID-19 recommendations for staff or resident quarantine from the CDC. Telephone interview with the facility's Regional Vice President/Infection Control Nurse (RVP/ICN) on 07/02/20 at 4:35pm revealed:	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 61 -The COVID-19 protocol was implemented at the beginning of April 2020 and all CDC guidelines were implemented with each update on COVID-19 management. -The corporate office notified facilities of updates via email and phone conferences and it was up to facility leadership team (Administrator and MCM) and LHPS Nurse to train the staff on updates. -There should have been documentation of trainings and in-services done by the facility's leadership team and LHPS Nurse. -The corporate office monitored the CDC and DHHS for COVID-19 guidelines and updates at a minimum of weekly but often 2 to 3 times each week and emailed the facility leadership team on updates. -The RVP/ICN was aware a staff had been identified with COVID-19 but no official test results had been presented by the staff to verify a positive test result. -Without a confirmed positive test result for COVID-19 for the staff member or more than one positive confirmed COVID-19 for staff and/or resident, the facility did not have to report a positive COVID-19 test to the LHD. -The RVP/ICN monitored all the regional facilities closely for staff and/or residents showing signs of COVID-19 symptoms during routine monitoring. -No additional staff and no resident had displayed signs or symptoms of COVID-19 during routine monitoring as of 07/02/20. -Corporate management was arranging for all residents and staff at the facilities to be routinely tested to get a baseline COVID-19 status for the company. -The facility was monitoring all residents for COVID-19 symptoms which included daily temperature checks and observations for signs of respiratory symptoms (like cough). -The ADO and MCC contacted the PCP's PA and	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 62 Nurse Practitioner (NP) to obtain orders for increased screening for COVID-19 symptoms as a reaction to the MA/S informing the ADO by text of a positive COVID test at a second place of employement without receiving verification of test results. -The facility had not had routine testing for COVID-19 done but it should be on the schedule for testing soon. Telephone interview with the MA/S on 07/09/20 at 9:29am revealed: -She worked as a MA from 7:00pm to 7:00am and was responsible for administering 8:00pm medications to all the residents in the facility and supervising the PCAs on her shift. -She had been out of work since 06/17/20 when she tested positive for COVID-19 through her other employer that tested employees by nasal swabs every week. -She was called by her other employer on 06/16/20 or 06/17/20 and informed of her COVID-19 positive test result done that 06/15/20. -She contacted the ADO at the facility and told the ADO of her positive COVID-19 test result. -The ADO told her she could not return to work at the facility until after a COVID-19 negative test result. -The ADO told her to bring the paperwork when she had a negative test result and for when she was positive. -Her other employer told her they would provide the paperwork when she tested negative for COVID-19. -She did not have any symptoms of COVID-19 and had not had any prior positive test results. -The LHD had called her sometime between 06/29/20-07/02/20 but did not ask her if she was employed anywhere else. -The facility allowed employees to check their	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 63 own temperatures and and document the reading on staff and visitor log. -The facility was not using the electronic tablet to document screening questions and staff temperatures on her last day of work on 06/16/20. Telephone interview with the MCC on 07/06/20 at 1:42pm revealed: -She found out on 06/17/20 the MA/S had tested positive for COVID-19 from a mutual acquaintance who worked with the MA/S at her other job. -She contacted the MA/S on 06/18/20. -The MA/S reported her other employer informed her of the positive test result on 06/17/20. -The ADO spoke with the MA/S on 06/18/20 and requested written proof of the positive test result. -The MA/S last worked MA for the night shift on 06/16/20. -The MA/S was not symptomatic while at work at the facility but had a fever while working at her other job. -The staff was tested at a state-operated facility and sent home. -She did not contact the LHD; she did not know who was responsible for contacting the LHD. - "The only thing we (the MCC and ADO) did was contact the clinical director" who advised increased temperature checks for residents to twice daily; it was the ADO who spoke with RVP/ICN. -There were no residents with symptoms of COVID-19; the MAs checked residents for symptoms daily and documented on the electronic medication record (eMAR). -The ADO instructed her to contact the residents' PCPs about residents' possible exposure to COVID-19. -On 06/18/20, she sent a text message to two of the three PCPs that a staff who had been on duty	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 64 for 12 hours on 06/16/20 into 06/17/20, tested positive for COVID-19; the ADO contacted the third PCP. -She was instructed by the ADO to have "(all staff) continue doing what (all staff) had been doing" which was wearing medical face masks "all the way up" and only test for COVID-19 if symptomatic. -The LHPS Nurse did a training for staff on 06/19/20. -The training included hand washing, glove use, symptoms, asymptomatic COVID-19 positive status, how to wear a mask and putting on PPE. Telephone interview with the LHPS Nurse on 07/16/20 at 11:31am revealed: -She worked at the facility 16 hours per week but was not in the facility from February through April 2020. -There was a computer training for all staff the third week of April on COVID-19 infection prevention. -She conducted an in-person training with staff on infection control and COVID-19 on 06/18/20 and 06/19/20. -The training covered how to wash your hands, donning/doffing PPE, COVID-19 symptoms, changing clothing and review of general infection control. Telephone interview with the Administrator on 07/08/20 at 5:20pm revealed: -She spoke with the LHD on 07/06/20 informing them of the staff who reported testing positive for COVID-19. -She was told by the LHD in order for the COVID-19 positive test result to be reportable, there had to be documentation of the result. -The LHD instructed her to call back when she had documentation a staff tested positive for	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 65 COVID-19. -The LHD did not ask her for the name of the staff who reported testing positive for COVID-19. -She did not tell the LHD the details of the staff's other employer; she told the LHD the staff worked at "another community". Telephone interview with the ADO on 07/08/20 at 5:20pm revealed the staff reported her 1st COVID-19 test was positive, and she was awaiting the results of the 2nd test. Telephone interview with Infection Control Nurse at the LHD on 07/09/20 at 10:39am revealed: -The Administrator told her the facility had a "potentially positive" staff, so she was unable to give any guidance to the Administrator. -If the Administrator had provided the name of the staff and the name of the other employer it would have made a difference in the recommendations to the Administrator. -She would have advised the Administrator to start testing of all the staff and residents. Telephone interview with the LHD's Director of Nursing on 07/09/20 at 10:39am revealed: -If the LHD had been made aware of the staff's name and other employer, she would have assured the staff was quarantined, contact tracing would have been done and the staff's contacts would have been quarantined. -The facility should have tested all staff and residents for COVID-19 upon notification of a staff testing positive for COVID-19. -The facility was responsible for negotiating testing of staff and residents through a laboratory vendor. -The facility should have taken the staff at her word related to testing positive for COVID-19, and not required the staff to break quarantine to	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 66 provide paperwork of the test result. Telephone interview with a PCP on 07/09/20 at 11:55am revealed: -She was contacted by the ADO and told a staff tested positive for COVID-19 but the staff did not have any direct contact with residents. -She recommended testing for all staff and all residents in response to the staff testing positive for COVID-19 because of concern for the spread of the virus to residents and staff. -A large number of individuals had tested positive for COVID-19 and were asymptomatic therefore unknowingly spreading the virus. -She had informed the ADO that she was able to provide mass testing of all staff and residents, but the ADO declined. -She had encouraged the facility test residents and staff because the facility was located in a county that had already been identified as a "hot spot" for COVID-19. -She offered the facility mass testing of all staff and residents the end of April 2020. Telephone interview with the ADO on 07/09/20 at 2:07pm revealed: -The LHD had not been in contact with her or the Administrator since 07/06/20. -She was aware of CDC and NC DHHS guidelines related to COVID-19. -She would contact the LHD to clarify the name and other employer of the staff that tested positive. 2. Review of the facility's "COVID-19 Screening Checklist for All Visitors and Staff " revealed: -There was a physical questionnaire and an electronic copy to be completed. -All individuals (staff, other health care workers, family, visitors, vendors) entering the building	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 67 must complete this screening checklist. -There were spaces for date, community name, name of associate/visitor and name of screener. The following questions were listed on the screening checklist with a space to check yes or no: -Question #1-have you washed your hands or used alcohol-based hand sanitizer for at least 20 seconds. -Question #2-Do you have any of the following symptoms with the following symptoms listed: fever [temperature of 99.6 degrees Fahrenheit (F) or higher]; sore throat; cough; new shortness of breath; pink eye; recent loss of taste or smell; or diarrhea. (If Yes to any, restrict them from entering the building, If No to all, proceed to question #3 for staff and question #4 for all others.) -Question #3. For Staff & Health Care Providers (e.g. health care workers, such as home health, hospice, physical therapy): 3a. Check temperature and document results: Fever present? yes or no (If Yes, restrict from entering the building. If NO, proceed to step 3b. 3b. Ask if they have worked in facilities or locations with recognized COVID-19 cases, yes or no. (If Yes, ask if they worked with any person(s) with confirmed COVID-19). If Yes (to worked in facilities or locations with recognized COVID-19 cases) require them to wear PPE (personal protective equipment) including mask, gloves, gown before any contact with residents & proceed to step 4. (If No, proceed to step 4.) -Question #4. Allow entry to building and remind the individual to: Wash their hands or use hand sanitizer throughout their time in the building. Do not shake hands with, touch or hug individuals during their visit.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 68 Review of the facility's Employee/Visitor Screening Log dated 05/15/20 through 06/26/20 revealed: -The headings at the top of each page included: date, time, Supervisor/screener name and signature, employee/visitor name and signature, Yes or No Questions 1 through 5 and if yes, next steps. -Staff and visitor temperatures were documented in the last column (if yes, next steps). -There were numerous staff and visitor entries with no Supervisor/screener name or signature documented. -For example, 16 entries from 05/17/20 at 6:50 (am/pm not specified) through 05/18/20 at 7:00 (am/pm not specified), 48 entries from 05/29/20 at 3:15 (am/pm not specified) through 06/01/20 at 6:10 (am/pm not specified) and 44 entries from 06/19/20 at 6:40 (am/pm not specified) through 06/22/20 at 7:30 (am/pm not specified). -There were 46 entries with no Yes or No documented for Questions 1 through 5. -There were 12 entries with no documentation of the staff's/visitor's temperature. -There were 22 temperatures documented between 61.0 and 93.5 (Celsius or Fahrenheit not specified). Confidential telephone interview with a staff revealed: -The thermometers at the facility had not been working; the staff was not sure exactly how long. -The thermometers would give the same exact reading on different staff and/or residents repeatedly. -The staff did not report the issue with the thermometers to management because "everyone knew," everyone coming into the building used the same thermometers. -She never received a demonstration from the	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 69 facility on the proper way to put on and take off PPE. -She observed staff continuously wearing the same pair of gloves. Second confidential telephone interview with a staff revealed: -There was never a designated staff at the front desk to check staff temperatures prior to the start of their shift. -Staff checked their own temperatures and entered their information on the electronic tablet at the front desk. Telephone interview with a medication aide (MA) on 07/09/20 at 9:29am revealed: -Staff were responsible for checking their own temperature, completing the log at the front desk and changing their clothes into clothing worn at work only before clocking in. -She did not know if anyone was responsible for checking the log and monitoring staff. Observation of the screening process on 06/25/20 at 11:30am revealed: -There was an electronic tablet at the front desk used to enter answers for a COVID-19 symptom and exposure questionnaire. -The front desk receptionist used an infrared thermometer to check visitors' temperatures. -There was a visitor and staff log at the front desk for staff and visitors to record screening information. Interview with the Administrator on 06/25/20 at 11:40am revealed: -Staff were screened by a designated staff using the electronic tablet and infrared thermometer upon entrance to the facility. -Staff then entered the changing room to change	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 70 their clothing and footwear before clocking in for work. -The changing room was divided into a dirty side to remove clothing and clean side to dress in new clothing. Telephone interview with the Memory Care Coordinator (MCC) on 07/06/20 at 1:42pm revealed: -Staff temperatures were checked prior to the start of their shift. -If staff had an elevated temperature, they were sent for COVID-19 testing and then home for quarantine. Telephone interview with the Area Director of Operations (ADO) on 07/09/20 at 2:07pm revealed: -The front desk receptionist, Supervisor or Business Office Manager (BOM)/Assistant Executive Director (AED) screened staff and visitors for COVID-19 symptoms and exposure. -The Supervisor knew to come to the front desk at the change of shift to screen staff coming to work. -The electronic tablet was put in place on 06/25/20; prior to that all screening information was completed on paper. -Staff should not be completing their own screening for COVID-19 symptoms and exposure. -Staff and visitors were monitored for temperatures greater than 99.6 degrees Fahrenheit (F). -She was not able to specify who monitored documented entries on the staff and visitor screening log. -She had not paid attention to the abnormally low temperatures documented on the screening log. -She would have to review the actual	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 71 questionnaire staff and visitors completed to see if screening questions had been completed. Upon request on 07/09/20, staff and visitor questionnaires were not provided for review. 3. According to the Centers for Disease Control (CDC): Until successfully treated, patients with crusted scabies should be isolated from other patients who do not have crusted scabies. Direct skin-to-skin contact between a patient with crusted scabies and his/her caretakers and visitors should be eliminated by following strict contact precautions, including the use of protective garments such as gowns, gloves, and shoe covers. The patient's room should be cleaned thoroughly. Bedding and clothing used by a person with scabies should be machine-laundered using the hot water and hot dryer cycles. Review of the facility's Infection Control Policy dated 02/27/20 revealed: -Failure to positively identify scrapings does not necessarily exclude the diagnosis (of scabies). -Affected residents should remain on contact precautions until 24 hours after the last treatment. -There was documentation of steps including following primary care provider orders, initiating contact precautions, laundering the resident's clothing and cleaning the immediate environment as well as common areas. Confidential telephone interview with a staff revealed: -Since May 2020, Resident #6 had rashes and was constantly digging at his skin. -Resident #6's rash looked pink/red and was scaly. -The facility was frequently out of supplies; the	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 72 facility ran out of gloves daily. -Staff were normally walking up and down the hall with the same gloves on, used the same gloves to change both residents in a suite then carried the dirty incontinence brief to the trash room before removing the gloves. -Staff used small size vinyl cafeteria gloves often, which were difficulty to properly put on for bigger hand sizes. -There were medical gloves (large size only) available for staff on 06/25/20, the first day in two months. Review of an electronic progress note by a personal care aide (PCA) for Resident #6 dated 04/07/20 at 6:00am revealed: -Resident #6 was restless most of the night, he was up on 4 different occasions and had removed his clothes. -He was itching "horribly" and stayed in the TV room from 2:00am-6:15am due to his inability to sleep. -The PCA notified the medication aide (MA) and the MA stated there was nothing he could have as needed for his itching. Review of an electronic progress note by a PCA for Resident #6 dated 04/17/20 at 6:41am revealed: -Resident #6 undressed himself 9 times; he had extreme redness over his whole body and between his toes. -The PCA continued to redress him and put him back to bed. Review of an electronic progress note by a PCA for Resident #6 dated 05/27/20 at 6:16am revealed that he had an open sore on his left foot and was out of bed on and off during the night.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 73 Telephone interview with a former PCA on 07/15/20 at 6:20pm revealed: -She had seen scabies before and saw a similar rash on a few of residents including Resident #6 in April 2020. -She reported the concern to the Memory Care Coordinator (MCC), the Business Office Manager (BOM)/Assistant Executive Director (AED) and the Administrator but nothing was done. -Resident #6's rash and itching were so bad; the resident would remove his clothes and scratch all over every night. -She reported Resident #6's rash, itching and scratching to the MA every night she worked. -She told the MCC, BOM/AED and Administrator that staff needed gowns and gloves for scabies; staff were never provided with gowns and the facility ran out of gloves for one week near the end of March 2020 to the beginning of April 2020. -She told the MCC, BOM/AED and Administrator about cleaning Resident #6's room, linens and clothing. -She was told she did not know what she was talking about and could not diagnose scabies. Telephone interview with a PCA on 06/24/2020 at 4:25pm revealed: -She had observed red bumps on Resident #6, he itched frequently, and she applied cream to his skin. -She had observed scabs on Resident #2, and he picked at his skin often. Telephone interview with a MA on 07/06/20 at 3:58pm revealed: -Resident #6 was being treated for a rash with permethrin applied once per week and left on for 8 hours. (Permethrin is used to treat scabies.) -The cream was ordered for every Wednesday and Resident #6 had received two applications.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 74 -There were a few other residents with similar rashes. Telephone interview with the MCC on 07/06/20 at 1:42pm revealed: -Resident #6 had a rash with red bumps on his chest and arms that he scratched "a lot". -The resident's primary care provider (PCP) prescribed a cream and the rash cleared up. -The facility had two gowns available in the medication room in case a resident came back positive for COVID-19. -If a resident tested positive, she or the Administrator would contact the regional person to get more gowns. Review of a PCP visit note dated 05/07/20 for Resident #6 revealed: -He had several red sores on his abdomen that look like bug bites. -She prescribed permethrin cream for his sores. Review of a PCP visit note dated 06/23/20 for Resident #6 revealed: -He was seen for a rash and itching. -He had a red rash all over his body. -Educational materials were provided for care instructions of his rash. Telephone interview with Resident #6's PCP on 07/09/20 at 11:55am revealed: -She suspected scabies as the cause of Resident #6's rash and itching. -She prescribed permethrin cream for Resident #6 and the rash improved indicating the cause was likely scabies. -Several other residents had been treated for scabies also. -Staff should have initiated contact precautions using a gown and gloves for contact with the	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 75 resident. -Resident #6's clothing and linens should have been laundered and his room cleaned when he received the treatment to prevent reinfection and spread of scabies. -She instructed staff on precautions and cleaning requirements at the time she ordered the permethrin. Observation of storage room on the locked unit on 06/25/20 at 12:47pm revealed: -There were no gowns. -There 5 individual boxes of medical face masks and 1 box containing 24 boxes of 50 face masks. -There were 6 boxes containing 10 boxes of 100 small, medium, large and extra-large sized food service gloves. -There were 3 individual boxes of 100 small size medical gloves. -There were 6 large boxes labeled "face shields". Interview with the Administrator on 06/25/20 at 12:44pm revealed: -There were a few gowns kept in the front office and on medication carts if needed. -Staff did not have to use gowns because they changed their clothing upon arrival to work. -Staff wore masks and performed hand hygiene frequently throughout their shift. Interview with the Area Director of Operations (ADO) on 06/25/20 at 12:53pm revealed: -The facility did not have a supply of gowns. -The supply the facility had was exhausted by home health nurses at the onset of state emergency orders (03/13/20). -If there was a need for gowns for infection control issues such as scabies, she would contact the corporate office. -The corporate office would arrange for delivery	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 76 of gowns "within a day or two". Telephone interview with a PCA on 07/14/20 at 1:20pm revealed she worked on both the assisted living unit and the secured unit and had never worn a gown to provide care for any resident at the facility. Telephone interview with a second PCA on 07/14/20 at 2:33pm revealed she worked on the secured unit and had never worn a gown to provide care for any of the residents. Telephone interview with the MCC on 07/16/20 at 1:44pm revealed: -She knew Resident #6 was treated with permethrin cream which was used to treat scabies. -She was not told specifically Resident #6 was being treated for scabies so she did not implement procedures related to caring for a resident with scabies. -When a resident had scabies she was responsible for informing the Administrator who would contact the corporate clinical staff to find out what needed to be done. Telephone interview with the Licensed Health Professional Support (LHPS) Nurse on 07/16/20 at 11:31am revealed: -She worked at the facility 16 hours per week with the exception of February through April 2020. -Scabies was not a topic that was discussed at new hire orientation or annual infection control trainings. -No one had reported any residents having scabies or being treated for scabies. -No one had reported any concerns related rashes, itching, scratching or wounds for Resident #6.	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 77 Telephone interview with the Administrator on 07/14/20 at 3:06pm revealed: -The facility had not used gowns since her hire date of 05/04/20. -The Area Director of Operations (ADO) was initially responsible for ordering supplies. -There were no cases of scabies at the facility since she was hired on 05/04/20. -She had not been notified of any residents that had scabies at the facility. -She did remember a former PCA telling her about a concern of scabies in the facility but "she was not a doctor." -If staff suspected a resident had scabies, she would expect them to notify the residents PCP and document in the resident's record. Based on interviews and record reviews, Resident #6 was not interviewable. The facility failed to adhere to CDC and NC DHHS guidelines for COVID-19 to include recommendations for immediate testing of staff and residents for COVID-19 following notification a direct care staff tested positive for COVID-19; screening of staff and visitors for symptoms of COVID-19; and safety precautions to reduce the risk of transmission and infestation of scabies including the availability and use of personal protective equipment (PPE) by staff and environmental cleanliness. The facility's failure to adhere to CDC guidelines and their established protocol for COVID-19 resulted in a significant risk of exposure and transmission of COVID-19 for all residents; and the failure to implement the use of PPE and environmental cleaning placed residents on the secure unit at risk for transmission of scabies. The facility's failure placed residents at serious risk of physical harm	{D 338}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 338}	Continued From page 78 and death which constitutes a Type A2 violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/02/20 with an addendum on 07/09/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020.	{D 338}	**10 A NCAC 13F .1002 (a) Medication Orders** The updated FL2 was received and clarified with the PCP on July 7, 2020 during the survey for resident #2. The Med Aids were re educated on ensuring the FL2, discharge summaries or ancillary services orders (psychiatric, podiatry, rehabilitation, dental) are received for new and re admission and sent to the PCP for clarification of order and to ensure these are received in a timely manner for quality of care by the LHPS nurse on August 15, 2020. The ED, MCM and RCC will implement chart audits to review and ensure the orders have been received for ancillary,	8-15-2020
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to clarify medication orders for 1 of 5 residents sampled (#2) who received multiple medications that were not included on an FL-2 from a hospital stay or did not match previous orders. The findings are: Review of Resident #2's FL-2 dated 08/21/19	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 79 revealed: -Diagnoses included atherosclerosis coronary artery bypass, congestive heart failure, cerebrovascular disease, cognitive impairment, and generalized muscle weakness. -There was an order for Zoloft 150mg 1 tablet daily. (Zoloft is an antidepressant.) -There was an order for Trazodone 25mg 1 tablet at bedtime. (Trazadone is an antidepressant also used to treat insomnia.) -There was an order for Fish Oil 500mg 2 capsules once daily. (Fish Oil is used to lower cholesterol.) -There was an order for Vitamin D3 50,000 units once a month. (Vitamin D3 is used to treat Vitamin D deficiency.) Review of Resident #2's physician's orders dated 03/04/20 revealed: -There was an order for Vitamin D3 50,000 units 1 capsule once a month. -There was an order for Latanoprost 0.005% instill 1 drop in both eyes at bedtime. (Latanoprost is used to treat glaucoma.) -There was an order for Minerin Cream, apply topically to skin once a day. (Minerin Cream is a moisturizer used to treat dry, rough, scaly, itchy skin.) -There was an order for Trazadone 50mg take ½ tablet (25mg) at bedtime. -There was an order for Fish Oil 340/1000mg take 1 capsule once a day. -There was an order for Zoloft 100mg take 1 and ½ tablets (150mg) once a day. -There was an order for Ferrous Sulfate 325mg 1 tablet once a day. (Ferrous Sulfate is an iron supplement used to treat anemia.) Review of Resident #2's physician's orders revealed:	D 344	new and readmissions. These audits will be reviewed in the daily stand up and stand down meetings to ensure the orders are processed and clarified daily so no delay in treatment or medication administration will occur. Any discrepancies will be reviewed monthly with the PCP by the ED to ensure the medication and quality of care and services are maintained. Any recommendation from the PCP will be implemented to ensure residents are receiving their necessary care and services.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 80 -There was an order dated 06/03/20 to decrease Zoloft to 50mg once a day. -There was a second order dated 06/11/20 for Zoloft 50mg 1 tablet once a day. Review of Resident #2's current FL-2 dated 06/16/20 revealed: -Diagnoses included bilateral pneumonia and dementia. -There was an order for Zoloft 100mg 1 tablet daily. -There was an order for Trazodone 50mg 1 tablet nightly. -There was an order for Omega 3 Fatty Acid 300/1000mg take 2 grams daily. (Omega 3 is Fish Oil used to lower cholesterol.) -There was no order for Vitamin D3, Ferrous Sulfate, Latanoprost eye drops, or Minerin Cream. Review of Resident #2's After Visit Summary from a hospital visit from 06/13/20 - 06/16/20 revealed: -The resident was admitted to the hospital on 06/13/20 with diagnoses of fall and aspiration pneumonia. -The form included a medication list but it was not signed by a prescribing practitioner. -The medication list included Fish Oil Omega 3 Fatty Acids 300/1000mg take 2 grams daily; Zoloft 100mg daily, and Trazodone 50mg nightly. -The medication list did not include any entries for Vitamin D3, Ferrous Sulfate, Latanoprost eye drops, or Minerin Cream. Review of Resident #2's clarification of orders form dated 06/17/20 revealed: -The resident returned from a hospital visit from 06/13/20 - 06/16/20. -Handwritten medications on the form included Omega 3 Fatty Acid, Zoloft 100mg, and	D 344	D344 Addendum per telephone with Ms. Darla Bellah on 8/28/20. The RCC, MCM, and ED are auditing at least 5 resident records per week to assure compliance with medication orders. The RCC, MCM, and medication aides are responsible for clarifying medication orders. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 81 Trazadone 50mg. -The dosage and instructions for these 3 medications were not included on the form. -The column to continue medications was marked for Omega 3 Fatty Acid, Zoloft, and Trazodone but the orders were incomplete. -There were no entries on the form to clarify Vitamin D3 50,000 units, Latanoprost 0.005% eye drops, Ferrous Sulfate, or Minerin Cream. Review of Resident #2's physician's orders and progress notes revealed no documentation the primary care provider (PCP) had been contacted to clarify the incomplete and unclear medication orders. Review of Resident #2's June 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Vitamin D3 50,000 units take 1 capsule every month and it was documented as administered on 06/29/20 at 8:00am. -There was an entry for Ferrous Sulfate 325mg 1 tablet every day and it was documented as administered at 8:00am from 06/01/20 - 06/30/20, except 06/14/20 - 06/16/20 when the resident was hospitalized. -There was an entry for Fish Oil 340/1000mg 1 capsule every day at it was documented as administered at 8:00am from 06/01/20 - 06/13/20. -There was a second entry for Omega 3 Fish Oil 300/1000mg take 1 capsule every day and it was documented as administered at 8:00am on 06/17/20. -There was a third entry for Omega 3 Fish Oil 300/1000mg take 2 capsules (2 grams) every day and it was documented as administered at 8:00am from 06/18/20 - 06/30/20. -There was an entry for Latanoprost 0.005% eye	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 82 drops, instill 1 drop in both eyes at bedtime and it was documented as administered at 9:00pm daily from 06/01/20 - 06/30/20, except 06/14/20 - 06/15/20 when the resident was hospitalized. -There as an entry for Minerin Cream apply topically to skin every day and it was documented as administered on the 7:00am - 3:00pm shift daily from 06/01/20 - 06/30/20, except 06/14/20 - 06/16/20 when the resident was hospitalized. -There was an entry for Zoloft 100mg take 1 and ½ tablets (150mg) every day and it was documented as administered at 8:00am from 06/01/20 - 06/05/20. -There was a second entry for Zoloft 50mg take 1 tablet every day and it was documented as administered at 8:00am from 06/06/20 - 06/13/20 and not administered when hospitalized on 06/14/20 - 06/16/20. -There was a third entry for Zoloft 100mg take 1 tablet every day and it was documented as administered at 8:00am from 06/17/20 - 06/30/20. -There was an entry for Trazodone 50mg take ½ tablet (25mg) at bedtime and it was documented as administered at 9:00pm from 06/01/20 - 06/13/20 and not administered when hospitalized on 06/14/20 - 06/15/20. -There was a second entry for Trazodone 50mg 1 tablet at bedtime and it was documented as administered at 9:00pm from 06/17/20 - 06/30/20. Review of Resident #2's July 2020 e-MAR dated 07/01/20 - 07/14/20 revealed: -There was an entry for Ferrous Sulfate 325mg 1 tablet every day and it was documented as administered at 8:00am from 07/01/20 - 07/14/20. -There was an entry for Omega 3 Fish Oil 300/1000mg 1 capsule every day at it was documented as administered at 8:00am from 07/01/20 - 07/14/20. -There was an entry for Latanoprost 0.005% eye	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 83 drops, instill 1 drop in both eyes at bedtime and it was documented as administered at 9:00pm daily from 07/01/20 - 07/13/20. -There as an entry for Minerin Cream apply topically to skin every day and it was documented as administered on the 7:00am - 3:00pm shift daily from 07/01/20 - 07/14/20. -There was an entry for Zoloft 100mg take 1 tablet every day and it was documented as administered at 8:00am from 07/01/20 - 07/14/20. -There was an entry for Trazodone 50mg 1 tablet at bedtime and it was documented as administered at 9:00pm from 07/01/20 - 07/13/20. Telephone interview with a medication aide (MA) on 06/23/20 at 3:09pm revealed: -When a resident returned from the hospital with discharge paperwork, the Memory Care Coordinator (MCC) reviewed the orders. -The MAs did not go through any of the orders, that was the responsibility of the MCC. -She was not aware of any issue with Resident #2's medications. Telephone interview with the MCC on 06/23/20 at 1:57pm revealed: -When a resident returned from the hospital, the resident had to have a new FL-2. -The MCC compared orders on the new FL-2 to the resident's orders prior to the hospitalization and the MCC would fill out a medication order clarification form. -The PCP would sign off on the medication clarification form and she would fax the form to the pharmacy. -She made sure all of the medications were current and available at the facility. A second telephone interview with the MCC on 07/16/20 at 1:43pm revealed:	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 84 -She was responsible for clarifying medication orders and she used a form to clarify orders. -She usually compared the new FL-2 with the medication orders prior to a hospitalization and clarified anything that was different. -She could not explain why she did not clarify all of the medication orders when Resident #2 returned from the hospital on 06/16/20. -She was very busy during that time with 3 admissions at one time and she must have overlooked it. Telephone interview with the Administrator on 07/14/20 at 3:05pm revealed: -The MCC was responsible for medications, including clarification of medication orders. -There was no system to monitor the MCC to assure medication responsibilities were being completed. -She was not aware of any issues with Resident #2's medications. Telephone interview with Resident #2's PCP on 07/16/20 at 11:57am revealed: -If a medication that Resident #2 was previously taking before his hospitalization was different or omitted from the FL-2 or the clarification form, the facility should have contacted her for further clarification. -Resident #2's Latanoprost eye drops would have been originally prescribed by an eye doctor. -Resident #2 should be receiving Latanoprost eye drops daily since the drops were for glaucoma. -Unless the hospital checked an iron level and the discharge paperwork had a discontinue order, the resident would still need to take the Ferrous Sulfate. -She decreased the Zoloft and Trazodone prior to the resident's hospitalization in June 2020 because the resident had been falling and those	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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 344	Continued From page 85 two medications could cause drowsiness and contribute to falls. -The resident should be taking Zoloft 50mg daily and Trazodone 25mg at bedtime because he could have increased falls at the higher doses. Based on interviews and record reviews, Resident #2 was not interviewable.	D 344		
{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: TYPE A1 VIOLATION Based on observations via video conference, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents sampled (#2, #3) including errors related to medications for pain, neuropathy, anxiety, low potassium levels, swelling / congestive heart failure, and constipation including missing multiple doses of these medications (#3); and for errors with eye drops used to treat glaucoma (#2). The findings are:	{D 358}	**Medication Administration .1004** On 7/10/20 100% cart audit completed to establish baseline of medications needed in the facility. This was reviewed by MCC/ED for follow up of medication orders to pharmacy. 8-15-2020 On 7/11/20 Schedule for cart audits reestablished for med techs to follow to ensure medications are on hand for all residents. RCC/MCC to monitor for completion and ensure medications are in-house. 8-15-2020 7/17/20-7/21/20 Med techs were reeducated by LHPS nurse that controlled substances require a new actual prescription each month. Prescriptions are to be requested and medications are to be reordered when no less than 7 doses/day supply is left in the resident's supply. per Darla Bellah in 8/28/20. 8-15-2020 William 8/28/20 7/17/20-7/21/20 LHPS nurse to rein-service medication staff on appropriate management of medication orders. 8-15-	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 86 1. Review of Resident #3's current FL-2 dated 03/30/20 revealed diagnoses included polyneuropathy, fracture of lower end of right humerus, emphysema, essential hypertension, hyperlipidemia, hypothyroidism, general muscle weakness, and difficulty walking. a. Review of Resident #3's current FL-2 dated 03/30/20 revealed an order for Oxycodone 5mg 1 tablet every 6 hours as needed (prn) for pain. (Oxycodone is a narcotic pain reliever used to treat moderate to severe pain.) Review of Resident #3's physician's orders dated 04/10/20 revealed: -There was a prescription dated 04/10/20 for 120 tablets of Oxycodone 5mg take 1 tablet 4 times a day. -The prescription was electronically signed on 04/10/20 at 6:11pm. Review of Resident #3's physician's orders dated 05/12/20 revealed: -There was a prescription dated 05/12/20 for 120 tablets of Oxycodone 5mg take 1 tablet 4 times a day. -The prescription was electronically signed on 05/12/20 at 3:54pm. Review of Resident #3's April 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Oxycodone 5mg 1 tablet every 6 hours as needed for pain. -Oxycodone was documented as administered on a prn basis on 84 occasions from 04/01/20 - 04/30/20. -There was no entry for a scheduled dose of Oxycodone on the e-MAR.	{D 358}	7/17/20-7/21/20 LHPS reeducated med techs on the order processing system to ensure healthcare referral and follow up. Once medication has been reordered by med tech, order will be placed on the 24-hr communication log for follow up by the medication techs until received. If there is a delay on the arrival of the medication, RCC/MCC/ED will be notified within 24 hours for follow up of medication. Providers will be notified by RCC/MCC/ED of any medication dose not given due to unavailable medication.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 87 Review of Resident #3's May 2020 e-MAR revealed: -There was an entry for Oxycodone 5mg 1 tablet every 6 hours as needed for pain. -Oxycodone was documented as administered on a prn basis on 84 occasions from 05/01/20 - 05/31/20. -There was no entry for a scheduled dose of Oxycodone on the e-MAR. Review of Resident #3's June 2020 e-MAR revealed: -There was an entry for Oxycodone 5mg 1 tablet every 6 hours as needed for pain. -Oxycodone was documented as administered on a prn basis on 74 occasions from 06/01/20 - 06/30/20. -There was no entry for a scheduled dose of Oxycodone on the e-MAR. Review of Resident #3's July 2020 e-MAR dated 07/01/20 - 07/12/20 revealed: -There was an entry for Oxycodone 5mg 1 tablet every 6 hours as needed for pain. -Oxycodone was documented as administered on a prn basis on 23 occasions from 07/01/20 - 07/12/20. -There was no Oxycodone documented as administered after 11:38am on 07/04/20 until 07/06/20 at 9:04am. -There was no entry for a scheduled dose of Oxycodone on the e-MAR. Telephone interview with a personal care aide (PCA) on 07/13/20 at 3:35pm revealed: -Resident #3 would complain of pain in her hands and legs and the pain in her hands would affect the strength in her hands and cause weakness. -She would let the medication aide (MA) on duty know when the resident reported pain.	{D 358}	D358 Addendum per telephone with Ms. Darla Bellah on 8/28/20. The medication aides complete weekly medication cart audits to assure medications are available and not expired. Medications are to be reordered when no less than a 7-day supply is left in the resident's supply. The DDCS completes random med pass observations bi-weekly. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 88 -When the resident requested pain medication, she seemed anxious and would rub her hands and said things like she was "ready to die because hurting so bad". Telephone interview with a MA on 07/13/20 at 4:28pm revealed: -Resident #3's Oxycodone was unavailable for a "few days about 2 weeks ago". -The resident usually had to request the Oxycodone because it was prn. -The resident usually complained of cramping and pain in her hands. Telephone interview with a second MA on 07/14/20 at 6:27pm revealed: -Around the weekend of 07/04/20, Resident #3 ran out of Oxycodone for 2 to 3 days. -The facility's procedure was to give at least give a 7-day notice to the primary care provider (PCP) when a new prescription was needed and do not wait until the resident ran out of the medication. -She felt like the issue with Resident #3's Oxycodone being unavailable was "passed along and not taken care of". -She thought the MAs were responsible for making sure medications were on hand and if they had difficulties, they should report it to the Memory Care Coordinator (MCC) or Resident Care Coordinator (RCC). -Resident #3 usually requested the Oxycodone at least 2 times during her shift and the resident complained a lot about pain in her bones and fingers. -She thought the resident was out of the Oxycodone when she last worked on 07/05/20. -The resident complained of pain and rubbed her hands, the same as usual that day. -She thought she requested a new prescription from the PCP on 07/03/20 but she was not sure	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 89 because everything was closed for the holiday. -She was not aware there was an on-call number that would go directly to the PCP's phone. -Resident #3's Oxycodone had always been listed on the e-MAR as prn medication. -She was not aware of Oxycodone ever being scheduled on a routine basis on the e-MARs. Telephone interview with the RCC on 07/15/20 at 7:55am revealed: -During the weekend of 07/04/20, the daytime MAs tried to get in touch with the PCP because an order for Resident #3's Oxycodone was faxed but they needed a hard script. -He thought complications were caused by the pharmacy being closed and the PCP being on vacation. -He was not aware there was an on-call phone number for the PCP at the time. -The resident usually asked for the Oxycodone at 10:00pm on the evenings he worked. -He thought the resident ran out of Oxycodone on 07/05/20. -The resident had requested the Oxycodone but he had to tell the resident that she did not have any available for administration. -The resident said she was "in real bad pain", because her hands were hurting. -The resident was rubbing her hands. -The resident's family member called and was upset so he explained to the family member they needed a hard script. -The resident's family member took 4 Oxycodone 5mg tablets to the facility in a bottle that was not labeled sometime after 11:00pm that night. -He and the resident's family member "googled" the 4 tablets' description and imprint code to make sure they were the same medication that was ordered for the resident. -The pills were Oxycodone 5mg tablets, so he	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 90 documented it and the family member signed the paper. -He also made a handwritten controlled substance sheet and a handwritten MAR for the 4 Oxycodone tablets to be administered. -He administered one tablet to the resident after the family member brought them to the facility. Review of Resident #3's handwritten medication count sheet for Oxycodone 5mg dated 07/06/20 revealed: -The quantity documented on the sheet was 4 tablets of Oxycodone 5mg. -The first dose documented as administered on the form was 1 tablet on 07/06/20 at 12:45am, leaving a balance of 3 tablets. -The second dose was documented as administered on 07/06/20 at 9:04am, leaving a balance of 2 tablets. -A third dose was documented as administered on 07/06/20 at 5:02pm, leaving a balance of 1 tablet. -The last tablet was not documented as administered on the form. Review of Resident #3's handwritten MAR for Oxycodone for July 2020 revealed: -There was a handwritten entry for Oxycodone 5mg 1 tablet every 6 hours as needed for pain. -Oxycodone was documented as administered on 3 occasions on 07/06/20, with the initials of the MAs corresponding with the names of the MAs documented as administering the 3 doses on the handwritten medication count sheet dated 07/06/20. Telephone interview with a pharmacist and a pharmacy technician at the facility's contracted pharmacy on 07/10/20 at 1:47pm revealed: -The pharmacy dispensed 120 Oxycodone 5mg	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 91 tablets on 04/10/20, 05/12/20, and 07/06/20 with instructions to take 1 tablet 4 times a day. -She could not determine if the facility reached out to them prior to 07/06/20 regarding the Oxycodone. -The pharmacy also dispensed 60 Oxycodone 5mg tablets on 07/08/20 based on an electronic order they received with instructions for 1 tablet every 6 hours as needed for pain. -The pharmacy staff entered the orders into the e-MAR system but someone at the facility had to approve the orders before they went live in the e-MAR system. Observation and interview via video conference with Resident #3 on 07/14/20 at 1:35pm revealed: -Two weeks ago or less, the facility ran out of her Oxycodone and that was not the first time they had run out of it. -She had told the MAs they should order when the supply was getting low and not wait until after she ran out. -She had neuropathy "real bad" from when she had stage 4 colon cancer and took chemotherapy, so she needed the Oxycodone for pain. -They were out of the Oxycodone about 1 and ½ days but "it seemed like forever". -She had pain in her hands, arms, shoulder and feet. -It started with tingling, bad pain, and burning sensations. -When she was out of the Oxycodone, her pain level was between a 9 and 10 (pain scale with 0 = no pain and 10 = worst possible pain) and she had tears rolling down her face. -When she took Oxycodone her pain level generally came down to a 2 level. -She asked the MA why she was not getting her pain medication and the MA told her they were	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 92 out of it. -She had some Oxycodone left over when she had been in rehabilitation for a broken shoulder prior to being admitted to the facility. -Her family member had to bring 4 Oxycodone tablets to the facility until the facility could get some in. Telephone interview with Resident #3's family member on 07/09/20 at 9:50am revealed: -The resident called the family member on Sunday night (07/05/20) around 10:30pm and she was in a "bad fix". -The resident told the family member she had not received any pain medication in about 2 and ½ days. -The resident had colon cancer in 2006 and had chemotherapy which caused significant neuropathy with a lot of pain in her extremities. -The resident's neuropathy had been getting worse in the last two months. -The resident usually took Oxycodone up to every 6 hours for the pain. -The resident was told she did not receive Oxycodone because the pharmacy did not deliver it. -He spoke with the MA on the telephone that night and was told by the MA they had to have a written prescription to get the medication. -The MA said he would call the pharmacy but the MA called back about 10 minutes later and said there was no prescription so the pharmacy would not send it. -He had some Oxycodone at home left over from the resident's stay at a rehabilitation facility prior to being admitted to the facility. -He left his home at 11:00pm on Sunday night, 07/05/20, and took 4 Oxycodone 5mg tablets to the facility. -He thought Oxycodone tablets were finally	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 93 delivered to the facility from the pharmacy sometime late Monday night, 07/06/20. -This was the second time the facility had run out of the resident's Oxycodone. -She usually took a minimum of 3 Oxycodone tablets per day but she could take up to 4 tablets per day. Telephone interview with Resident #3's PCP on 07/08/20 at 10:35am revealed: -The facility called her on 07/06/20 about needing a prescription for the resident's pain medication. -She had written a prescription on 04/10/20 and on 05/12/20 for Oxycodone 5mg 4 times a day and each prescription was for 120 tablets each time. -She was not aware Resident #3 had not been receiving the Oxycodone on a scheduled basis 4 times a day. -Resident #3 had bad arthritis, polyneuropathy, and a recently fractured right shoulder that caused the resident's pain and was the reasons she needed the Oxycodone. -She was not aware the resident had missed doses of Oxycodone and she was concerned missing the Oxycodone could cause withdrawal symptoms and breakthrough pain. -The resident had a history of stage 4 colon cancer and the chemotherapy had caused the resident to suffer from polyneuropathy, so the Oxycodone was used chronically to help with the pain caused by the neuropathy. -She changed the order and wrote a prescription for Oxycodone 5mg every 6 hours as needed for pain on 07/08/20 for 60 tablets. A second telephone interview with Resident #3's PCP on 07/14/20 at 10:12am revealed: -If the facility sent a fax to her office on the weekend, she would not receive that fax until she	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 94 returned to work on Mondays. -The facility staff were supposed to use the on-call number for her office on the weekends because the call would go directly to her phone and she would answer it. -She needed the facility to give her a 48 to 72 hour notice for refills but she tried to do the refills as soon as possible once a request was received. -If the facility had a one week supply of medication remaining, they should go ahead and let her know they needed a new prescription. Telephone interview with the MCC on 06/30/20 at 8:44am revealed: -Sometimes residents' medications were unavailable to administer because the medications were not reordered in time. -The MAs were supposed to reorder medications when there was a 7-day supply left but the MAs were not following the process. -She had re-educated the MAs on the ordering process to make sure medications were being ordered timely. -The MAs were supposed to do medication cart audits daily during each shift. -She was supposed to do medication cart audits every week to check behind the MAs but she had not done weekly cart audits because she did not have time with all of her other duties. Telephone interview with the Administrator on 07/14/20 at 3:05pm revealed: -She did not know Resident #3's Oxycodone was unavailable until last week. -She found out Resident #3's family member had to bring some Oxycodone to the facility because there was none available for administration. -The MAs should have reported Oxycodone was unavailable to her or the Assistant Executive Director / Business Office Manager (AED/BOM)	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 95 since the MCC position was vacant last week. -The MAs were supposed to get a new prescription at least one week before the resident ran out of medication but that was not done. Telephone interview with the Area Director of Operations (ADO) on 07/16/20 at 2:33pm revealed: -The MAs were responsible for getting refills or new medication orders when there was a 7-day supply on hand. -The MCC and RCC were responsible for following up to make sure this was done by the MAs. Review of Resident #3's physician's orders dated 07/06/20 revealed: -There was a prescription written on 07/06/20 for 120 tablets of Oxycodone 5mg take 1 tablet 4 times a day. -The prescription was electronically signed on 07/06/20 at 11:52am. Review of Resident #3's physician's orders dated 07/08/20 revealed: -There was a prescription written on 07/08/20 for 60 tablets of Oxycodone 5mg. -The instructions were to take 1 tablet every 6 hours as needed for pain. -The prescription was electronically signed on 07/08/20 at 2:03pm. -There was a note on the prescription to discontinue the scheduled dose. b. Review of Resident #3's current FL-2 dated 03/30/20 revealed: -There was an order for Potassium Chloride ER 20mEq 1 tablet in the morning. (Potassium Chloride is for low potassium levels.) -There was an order for Furosemide 20mg 1	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 96 tablet once a day. (Furosemide is used to treat swelling and congestive heart failure.) -There was an order for Prednisone 5mg 1 tablet once a day. (Prednisone may be used to treat pain cause by inflammation.) -There was an order for Colace 100mg 1 tablet once a day. (Colace is stool softener.) -There was an order for Senna 8.6mg 1 tablet once a day. (Senna is a laxative.) Review of Resident #3's progress notes dated 06/23/20 at 12:14pm revealed a medication aide (MA) faxed updated physician orders to the pharmacy for the resident (no medication names were specified). Review of Resident #3's June 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Colace 100mg 1 tablet once daily with a scheduled administration time of 8:00am. -Colace was documented as administered on 06/01/20 - 06/10/20, 06/13/20, 06/14/20, 06/17/20, and 06/24/20. -Colace was not documented as administered on 16 days due to the medication being unavailable including 06/11/20, 06/12/20, 06/15/20, 06/16/20, 06/18/20 - 06/23/20, and 06/25/20 - 06/30/20. -There was an entry for Furosemide 20mg 1 tablet every morning with a scheduled administration time of 8:00am. -Furosemide was documented as administered on 06/01/20 - 06/10/20, 06/13/20, 06/14/20, 06/17/20, 06/18/20, 06/23/20, and 06/26/20 - 06/28/20. -Furosemide was not documented as administered on 12 days due to the medication being unavailable including 06/11/20, 06/12/20, 06/15/20, 06/16/20, 06/19/20 - 06/22/20,	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 97 06/24/20, 06/25/20, 06/29/20, and 06/30/20. -There was an entry for Potassium Chloride ER 20mEq 1 tablet in the morning with a scheduled administration time of 8:00am. -Potassium Chloride was documented as administered on 06/01/20 - 06/10/20, 06/13/20, 06/14/20, 06/17/20, 06/18/20, 06/22/20, 06/23/20, and 06/26/20 - 06/28/20. -Potassium Chloride was not documented as administered on 11 days due to the medication being unavailable including 06/11/20, 06/12/20, 06/15/20, 06/16/20, 06/19/20 - 06/21/20, 06/24/20, 06/25/20, 06/29/20, and 06/30/20. -There was an entry for Prednisone 5mg 1 tablet once daily with a scheduled administration time of 8:00am. -Prednisone was documented as administered on 06/01/20 - 06/10/20, 06/13/20, 06/14/20, 06/17/20, 06/18/20, 06/22/20, 06/23/20, 06/26/20 and 06/28/20. -Prednisone was not documented as administered on 12 days due to the medication being unavailable including 06/11/20, 06/12/20, 06/15/20, 06/16/20, 06/19/20 - 06/21/20, 06/24/20, 06/25/20, 06/27/20, 06/29/20, and 06/30/20. -There was an entry for Senna 8.6mg 1 tablet once daily with a scheduled administration time of 8:00am. -Senna was documented as administered on 06/01/20 - 06/10/20, 06/13/20, 06/14/20, 06/17/20, 06/18/20, 06/22/20, 06/23/20, 06/26/20 - 06/28/20. -Senna was not documented as administered on 11 days due to the medication being unavailable including 06/11/20, 06/12/20, 06/15/20, 06/16/20, 06/19/20 - 06/21/20, 06/24/20, 06/25/20, 06/29/20, and 06/30/20. Review of Resident #3's July 2020 e-MAR dated	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 98 07/01/20 - 07/12/20 revealed: -There was an entry for Colace 100mg 1 tablet once daily with a scheduled administration time of 8:00am. -Colace was not documented as administered on 8 days from 07/01/20 - 07/08/20 due to the medication being unavailable. -Colace was documented as administered from 07/09/20 - 07/12/20. -There was an entry for Furosemide 20mg 1 tablet every morning with a scheduled administration time of 8:00am. -Furosemide was documented as administered on 07/01/20, 07/02/20, and 07/09/20 - 07/12/20. -Furosemide was not documented as administered on 6 days from 07/03/20 - 07/08/20 due to the medication being unavailable. -There was an entry for Potassium Chloride ER 20mEq 1 tablet in the morning with a scheduled administration time of 8:00am. -Potassium Chloride was documented as administered on 07/01/20 - 07/03/20, and 07/09/20 - 07/12/20. -Potassium Chloride was not documented as administered on 5 days from 07/04/20 - 07/08/20 due to the medication being unavailable. -There was an entry for Prednisone 5mg 1 tablet once daily with a scheduled administration time of 8:00am. -Prednisone was documented as administered on 07/01/20, 07/03/20, and 07/09/20 - 07/12/20. -Prednisone was not documented as administered on 6 days due to the medication being unavailable including 07/02/20 and 07/04/20 - 07/08/20. -There was an entry for Senna 8.6mg 1 tablet once daily with a scheduled administration time of 8:00am. -Senna was documented as administered on 07/01/20, 07/02/20, and 07/09/20 - 07/12/20.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 99 -Senna was not documented as administered on 6 days from 07/03/20 - 07/08/20 due to the medication being unavailable. Telephone interview with a pharmacist and a pharmacy technician at the facility's contracted pharmacy on 07/10/20 at 1:47pm revealed: -The pharmacy usually sent automatic weekly multi-dose packages of the residents' medications to the facility as long as they had refills or current orders. -They received Resident #3's FL-2 dated 03/30/20 when the resident was admitted to the facility at the end of March 2020. -The pharmacy needed new orders for refills for the resident's medications. -The pharmacy received orders for some of the resident's medications on 04/02/20 but not the Furosemide, Potassium Chloride, Colace, Senna, or Prednisone. -The pharmacy faxed the facility each week if medications needed refills or new orders. -The pharmacy sent refill requests for Resident #3's medications to the facility on 06/10/20, 06/17/20, and 07/01/20. -The refill request sheets were emailed to the Administrator, Memory Care Coordinator (MCC), and Resident Care Coordinator (RCC). -The facility contacted the pharmacy on 06/18/20 and reported some medications, including Furosemide, Potassium Chloride, Prednisone, Senna, and Colace, were missing from the multi-dose packs for Resident #3. -The facility was told they needed refills or new orders for those medications. -The facility faxed new physician's orders for Resident #3 on 07/08/20 which included those 5 medications. -The pharmacy dispensed 28 Furosemide 20mg tablets on 04/09/20 and 05/07/20; and 14 tablets	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 100 on 07/08/20. -The pharmacy dispensed 8 Colace 100mg tablets on 03/31/20; 28 tablets on 04/09/20 and 05/07/20; and 14 tablets on 07/08/20. -The pharmacy dispensed 28 Potassium Chloride ER 20mEq tablets on 04/09/20 and 05/07/20; and 14 tablets on 07/08/20. -The pharmacy dispensed 28 Prednisone 5mg tablets on 04/09/20 and 05/07/20; and 14 tablets on 07/08/20. -The pharmacy dispensed 8 Senna 8.6mg tablets on 03/31/20; 28 tablets on 04/09/20 and 05/07/20; and 14 tablets on 07/08/20. Observation and interview via video conference with Resident #3 on 07/14/20 at 1:35pm revealed: -She had been without some of her scheduled medications but she did not know which ones or if the facility had them in stock again. -She did not know if she was having symptoms from not receiving the unavailable medications. -She had problems in the past with constipation but none recently. -She had a lot of swelling in both feet and legs and "they stay that way". Telephone interviews with a MA on 06/23/20 at 3:09pm and 07/10/20 at 3:30pm revealed: -Resident #3 recently had problems with her medications being unavailable. -The resident had been out of at least 5 of her medications and missed doses for the last 2 weeks. -Those 5 medications were not in the resident's weekly multi-dose packs. -The resident was out of Colace, Prednisone, Furosemide, Potassium Chloride, and one other medication (could not recall the name of it). -The pharmacy needed updated orders but the issue had not been resolved yet and the resident	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 101 was still out of those medications. -She did not know why the issue had not been resolved or why the medications were still unavailable. -She faxed a request last week (on 07/02/20) to Resident #3's primary care provider (PCP) for updated orders. -Last week was the first time she had requested orders from the PCP and she did know if anyone had contacted the PCP prior to that. -The MAs were supposed to contact the PCP for orders 7 days before a resident ran out of medications. -She had also contacted the pharmacy twice to reorder the medications, but she could not recall when and the pharmacy did not tell her anything when she reordered the medications. Another telephone interview with the same MA on 07/15/20 at 6:06pm revealed: -She faxed Resident #3's PCP about the 5 unavailable medications on 07/02/20 and she texted her on 07/07/20. -The PCP said she had emailed orders to the MCC but the MCC was no longer working at the facility at that time and no one could get into the computer to check her emails to get the orders. -She did not know if anyone contacted the PCP in June 2020 when the medications first ran out. -MAs should document medications were unavailable on the eMAR since they ran out in June 2020 until they were received in July 2020. -The medications were not available until received on 07/08/20. Telephone interview with a second MA on 07/08/20 at 4:14pm revealed: -The pharmacy usually sent multi-dose packs automatically each week. -The pharmacy had only been sending 2 or 3 pills	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 102 in Resident #3's multi-dose packs and she had missed some medications for at least the last week or two. -The MA on duty was responsible for calling the pharmacy if medications were not received. -She had not worked on the medication cart with Resident #3's medications in about a month so she was not sure why the resident's medications had been unavailable. -She thought all of Resident #3's medications were at the facility now. Telephone interview with a third MA on 07/14/20 at 6:27pm revealed: -When she first started working, Resident #3 was out of some medications (could not recall which medications) and she relayed it to the MA who trained her and the MCC, who informed her the resident needed new prescriptions. -She thought those medications were received from the pharmacy around 07/08/20. -The facility's procedure was to at least give a 7-day notice to the PCP when a new prescription was needed and do not wait until the resident ran out of the medication. -She thought the MAs were responsible for making sure medications were on hand and if they had difficulties, they should report it to the MCC or RCC. Telephone interview with Resident #3's PCP on 07/08/20 at 10:35am revealed: -She was first contacted by the facility on Monday, 07/06/20, to sign a six-month physician's order sheet for Resident #3's medications. -She was not aware the resident had not been receiving Prednisone, Furosemide, Potassium Chloride, Senna, and Colace. -She expected the facility to let her know if a resident missed more than 3 doses of a	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 103 medication. -She had seen the resident during tele-visits on 06/18/20 and 06/22/20 for a wound but no staff at the facility mentioned during the visits that the resident was out of any medications or that they needed her to sign any medication orders. -She had significant concerns about the resident missing dosages of all those medications. -The resident was taking Prednisone for the polyneuropathy and missing the medication could cause the neuropathy to get worse and cause more pain. -Missing doses of the Senna and Colace could cause constipation. -Missing doses of Furosemide and Potassium Chloride could lead to fluid overload in congestive heart failure, which could further complicate symptoms and lead to death. Telephone interview with the MCC on 06/30/20 at 8:44am revealed: -Sometimes residents' medications were unavailable to administer because the medications were not reordered in time. -The MAs were supposed to reorder medications when there was a 7-day supply left. -The pharmacy sometimes sent a paper to the facility indicating they were out of refills, a new prescription was needed, or if there was an issue with a resident's insurance. -They usually got those papers back from the pharmacy within an hour of sending a fax request for refills if there was a problem with getting the refills. -If she saw one of the faxed forms from the pharmacy, she would follow up on it because the MAs were not following the process. -She had re-educated the MAs on the ordering process to make sure medications were being ordered timely.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 104 -The MAs were supposed to do medication cart audits daily during each shift. -She was supposed to do medication cart audits every week to check behind the MAs but she had not done weekly cart audits because she did not have time with all of her other duties. -The MAs were supposed to notify the PCP of any missed doses of medications on a physician form and it should be filed in the resident's record. A second telephone interview with the MCC on 07/16/20 at 1:43pm revealed: -She was not notified of Resident #3's medications being unavailable. -She saw a fax from the pharmacy (did not recall date) indicating they needed signed physician's orders for the medications. -She told the MA to get physician's orders for the medications and fax to the pharmacy and the medications were supposed to be sent after that. -She did not know why there was a delay in sending the medications after that. Telephone interview with the Assistant Executive Director / Business Office Manager (AED/BOM) on 07/10/20 at 3:30pm revealed: -The Administrator received a paper from the pharmacy at the end of June 2020 that Resident #3 needed new orders for the 5 medications. -The Administrator was new and did not know what it meant so the AED/BOM explained to the Administrator what needed to be done. -She did not reach out to the PCP because she assumed the Administrator would take care of it, but she did not. Telephone interview with the Administrator on 07/14/20 at 3:05pm revealed: -The MCC was responsible for medications,	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 105 including medication orders. -There was no system to monitor the MCC to assure medication responsibilities were being completed. -She did not know Resident #3's medications were unavailable until last week. -She found out Resident #3 was out of medication during a stand-up meeting on Monday, 07/06/20. -The MAs had not reported any issues with medications being unavailable. -The MAs should have reported it to her or the AED/BOM since the MCC position was vacant last week. -The MAs were responsible for getting a new prescription at least one week before the resident ran out of medication but that was not done. Telephone interview with the Area Director of Operations (ADO) on 07/16/20 at 2:33pm revealed: -The MAs were responsible for getting refills or new medication orders when there was a 7-day supply on hand. -The MCC and RCC were responsible for following up to make sure this was done by the MAs. Review of Resident #3's updated physician's orders dated 07/08/20 revealed: -There was an order for Colace 100mg 1 tablet once daily. -There was an order for Furosemide 20mg 1 tablet every morning. -There was an order for Potassium Chloride ER 20mEq 1 tablet in the morning. -There was an order for Prednisone 5mg 1 tablet once daily. -There was an order for Senna 8.6mg 1 tablet once daily.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 106 2. Review of Resident #2's current FL-2 dated 06/16/20 revealed diagnoses included bilateral pneumonia and dementia. Review of Resident #2's physician's orders dated 03/04/20 revealed there was an order for Latanoprost 0.005% instill 1 drop in both eyes at bedtime. (Latanoprost is used to treat glaucoma and expires 6 weeks after the bottle is opened.) Review of Resident #2's April 2020 electronic medication administration record (e-MAR) revealed: -There was an entry for Latanoprost 0.005% eye drops, instill 1 drop in both eyes at bedtime -Latanoprost was documented as administered at 9:00pm daily from 04/01/20 - 04/30/20. -There was no documentation of any missed doses or refusals. Review of Resident #2's May 2020 e-MAR revealed: -There was an entry for Latanoprost 0.005% eye drops, instill 1 drop in both eyes at bedtime. -Latanoprost was documented as administered at 9:00pm daily from 05/01/20 - 05/31/20. -There was no documentation of any missed doses or refusals. Review of Resident #2's June 2020 e-MAR revealed: -There was an entry for Latanoprost 0.005% eye drops, instill 1 drop in both eyes at bedtime. -Latanoprost was documented as administered at 9:00pm daily from 06/01/20 - 06/30/20, except 06/14/20 - 06/15/20 when the resident was hospitalized. Review of Resident #2's July 2020 e-MAR dated	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 107 07/01/20 - 07/14/20 revealed: -There was an entry for Latanoprost 0.005% eye drops, instill 1 drop in both eyes at bedtime. -Latanoprost was documented as administered at 9:00pm daily from 07/01/20 - 07/13/20. Review of pharmacy dispensing records for Resident #2 from January 2020 - July 2020 revealed: -There was one 2.5ml bottle of Latanoprost 0.005% eye drops dispensed on 03/26/20. (A 2.5ml bottle contains approximately a 25-day supply if administered 1 drop in each eye at bedtime as ordered.) -There were no other bottles of Latanoprost 0.005% eye drops dispensed during this time period. Video conference and interview with a medication aide (MA) and the Assistant Executive Director/Business Office Manager on 07/15/20 at 9:50am revealed: -There was one 2.5ml bottle of Latanoprost 0.005% on hand for Resident #2 that was dispensed on 03/26/20. -The bottle was over half full of medication. -There was a handwritten notation on a label that the bottle was opened on 03/29/20, indicating the medication would have been expired 6 weeks from that date, (on 05/10/20). -There were no other bottles of Latanoprost 0.005% on hand for Resident #2. Telephone interviews with the MA on 07/15/20 at 10:09am and 5:13pm revealed: -The Latanoprost bottle dispensed on 03/26/20 was the only bottle on hand and it was the current supply being used. -She had not noticed the Latanoprost eye drops were expired.	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 108 -She did not recall seeing another bottle of eye drops for the resident. Telephone interviews with the MCC on 06/30/20 at 8:44am and 07/16/20 at 1:43pm revealed: -The MAs were supposed to do medication cart audits daily during each shift. -She was supposed to do medication cart audits every week to check behind the MAs but she had not done weekly cart audits because she did not have time with all of her other duties. -She did not know why Resident #2's Latanoprost eye drops had not been administered as ordered or why the bottle being used was expired. Telephone interview with Resident #2's PCP on 07/16/20 at 11:57am revealed: -Resident #2's Latanoprost eye drops would have been originally prescribed by an eye doctor. -Resident #2 should be receiving Latanoprost eye drops daily since the drops are for glaucoma, which is a chronic condition. Based on interviews and record reviews, Resident #2 was not interviewable. The facility failed to administer medications as ordered for Resident #3 who missed doses of 5 scheduled medications from 06/11/20 - 07/07/20, including medications for neuropathy, congestive heart failure / swelling, low potassium levels, and constipation due to the medications being unavailable in the facility. Resident #3, who had a history of stage 4 colon cancer, polyneuropathy caused by chemotherapy, and a recent right shoulder fracture ran out of Oxycodone on a holiday weekend resulting in the resident having pain so severe, it caused tears to run down her face and a family member had to bring Oxycodone to the facility for the resident to help	{D 358}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 358}	Continued From page 109 relieve her pain. Resident #2's eye drops for glaucoma were not administered as ordered as evidenced by a 25-day supply of eye drops opened on 03/29/20 still being over half full on 07/15/20, and the bottle had expired. The failure of the facility to administer medications as ordered resulted in serious neglect and serious physical harm and constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/09/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020.	{D 358}		
D914	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, interviews and record reviews, the facility failed to ensure residents were free of neglect as related to personal care and supervision, health care, medication administration, residents' rights related to COVID-19 prevention, and implementation for the total operation and management of the facility. The findings are: 1. Based on interviews and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents (#2 and #6) where Resident	D914	**G.S. 131D-21(4) Declaration of Resident Rights** Paragraph 1, 2 and 4: The corrective action for the residents that were identified in the sample (#1, #2, #3, #4 and #6) are addressed in the specific cited deficiencies. Paragraph 3: The corrective action for COVID19 Infection control is addressed in the previous cited deficiency. Paragraph 5: The corrective action for the administration of the facility is addressed in D980 G.S. 131D-25 Implementation.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D914	Continued From page 110 #6 who was known to wander, eloped without staffs' knowledge for a period of 1 to 4 hours, was found near woods after being seen in the road by a concerned citizen and required emergency room (ER) evaluation; and Resident #2 who had a history of right sided weakness and falls, experienced 15 falls between 02/08/20 and 07/14/20, sustained a head injury and laceration and required ER evaluation on 4 occasions. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations via video conference, interviews, and record reviews, the facility failed to assure notification of the primary care provider for 4 of 6 residents (#1, #2, #3, #6) sampled related to a leg wound that became infected and required an oral antibiotic and wound care by home health (#3); a resident who developed three wounds on the right upper thigh requiring wound care by home health (#2); a resident with severe irritation of his genitals and severe itching all over his body (#6); and failure to obtain physical therapy for a resident with a referral for deconditioning (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local Health Department (LHD) were implemented and maintained when caring for 77 residents during the global Coronavirus (COVID-19) pandemic as related to the testing of staff and residents immediately following a direct care staff testing	D914		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D914	Continued From page 111 positive for COVID-19; screening of staff and visitors for symptoms of COVID-19; and safety precautions to reduce the risk of transmission and infestation of scabies including the availability and use of personal protective equipment (PPE) by staff and environmental cleanliness. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation).] 4. Based on observations via video conference, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents sampled (#2, #3) including errors related to medications for pain, neuropathy, anxiety, low potassium levels, swelling / congestive heart failure, and constipation including missing multiple doses of these medications (#3); and for errors with eye drops used to treat glaucoma (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] 5. Based on observations via video conference, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, residents' rights, and medication administration. [Refer to Tag D980, G.S. 131D-25 Implementation (Type A1 Violation).]	D914		
D980	G.S. § 131D-25 Implementation G.S. 131D-25 Implementation Responsibility for implementing the provisions of this Article shall rest with the administrator of the facility. Each facility shall provide appropriate	D980		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 112 training to staff to implement the declaration of residents' rights included in G.S. 131D-21. This Rule is not met as evidenced by: TYPE A1 VIOLATION Based on observations via video conference, interviews, and record reviews, the Administrator failed to assure the total operation of the facility to meet and maintain rules related to personal care and supervision, health care, residents' rights, and medication administration. The findings are: Confidential telephone interview with a staff revealed: -There was no communication between management and staff. -Staff reported resident care concerns to the Memory Care Coordinator (MCC), Business Office Manager (BOM)/Assistant Executive Director (AED) and the Administrator and nothing was done. -Resident care concerns included not having enough staff to supervise residents on the secured unit, not having supplies such as gloves, paper towels, incontinence briefs, towels, wash clothes and sheets, residents having bruises and rashes on their bodies and residents not having incontinence care provided. Telephone interview with the MCC on 06/30/20 at 8:44am revealed: -She was no longer employed with the facility as of 06/29/20. -She had been the only "clinical" staff at the facility who handled orders. -The Administrator walked the floor at the facility "every now and then" but the Administrator was	D980	**G.S. 131D-25 Implementation.** The administrator of record quit without notice on July 14, 2020 during the survey. The administration of the facility was then placed on the Area Director of Operation and who's license was placed over the facility. The management company assumes the stance that the profession integrity of the previous administer had led to the cited deficiencies. The management team assert the following has been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 113 usually shut up in her office with the blinds and door closed. -The Administrator "did not really" interact with the residents or get to know the residents. A second telephone interview with the MCC on 07/06/20 at 1:45pm revealed: -The previous Resident Care Coordinator (RCC) left the facility at the end of May 2020 and the current RCC was hired after that. -The current RCC only trained with the MCC for one day before he was pulled to work as a medication aide (MA) on night shift because they were short staffed. -The current RCC was still working on night shift as a MA and had not started doing RCC duties. -She was the MCC but she covered the secured unit and the assisted living side for carrying out care coordinator duties since the RCC was working as a MA. -She had been the staff responsible for processing orders, contacting providers and vendors, completing FL-2s, quality improvement reports, admissions, and staff scheduling when she was employed by the facility. Telephone interview with the Administrator on 07/14/20 at 3:05pm revealed: -She started working at the facility on 05/04/20 and left employment with the facility that morning on 07/14/20. -She reported being the 7th Administrator at the facility within the last 1 and ½ years. -She reported the Administrator before her was only at the facility for 3 weeks. -The former MCC was responsible for everything clinical, including medication orders, contact with the pharmacies and all providers. -She did not do any monitoring of the former MCC.	D980	implemented to ensure the administration of the facility is within the governing regulations. The management team will ensure adherence to the NC State regulation as well as any established company policies and procedures with oversight of the Area Director of Operations and divisional team. The facility has hired a licensed assisted living administrator who also carries a nursing license and has 20 plus years documented AL experience. The ADO will conduct meetings with the management team to review and discuss expectation of each department head. The ED or designee will make daily facility round an address any concerns with the appropriate department heads at that time to include disciplinary action up to termination.	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 114 -In the absence of the former MCC, staff reported clinical concerns to the Area Director of Operations (ADO) because she was still learning the clinical process such as orders and medications. -The former MCC was responsible for contacting primary care providers (PCPs) with resident concerns and making referrals. -The former MCC had all the PCP and agency contact information which she was still learning. -The former MCC was responsible for all the orders, pharmacy issues and closing out accident reports for all residents. -There was no system to monitor the former MCC to assure medication responsibilities were being completed. -The former RCC left the position a little after she started as the Administrator in May 2020. -A new RCC was hired but he had been filling in as a MA on night shift and not working as the RCC. Telephone interview with the ADO on 07/14/20 at 9:42am revealed she would be serving as the Interim Administrator at the facility starting today, 07/14/20. Noncompliance identified at violation levels included: 1. Based on interviews and record reviews, the facility failed to provide supervision for 2 of 7 sampled residents (#2 and #6) where Resident #6 who was known to wander, eloped without staffs' knowledge for a period of 1 to 4 hours, was found near woods after being seen in the road by a concerned citizen and required emergency room (ER) evaluation; and Resident #2 who had a history of right sided weakness and falls, experienced 15 falls between 02/08/20 and	D980	The ADO will make weekly visits and round for further recommendation as it related to quality of care, infection control processes, COVID 19 screenings, and follow up to the stated plan of correction for this SOD. The MCM/RCC will make walking round to ensure the infection processes, quality of care, and other cited deficient areas are in place daily. These observations will be reviewed with the management team, in the weekly standards of care, stand up stand down meeting for further recommendation or systemic changes to occur for the prevention of any further issues. The ED, MCM and RCC will implement chart audits to review and ensure the	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 115 07/14/20, sustained a head injury and laceration and required ER evaluation on 4 occasions. [Refer to Tag D270, 10A NCAC 13F .0901(b) Personal Care and Supervision (Type A1 Violation).] 2. Based on observations via video conference, interviews, and record reviews, the facility failed to assure notification of the primary care provider for 4 of 6 residents (#1, #2, #3, #6) sampled related to a leg wound that became infected and required an oral antibiotic and wound care by home health (#3); a resident who developed three wounds on the right upper thigh requiring wound care by home health (#2); a resident with severe irritation of his genitals and severe itching all over his body (#6); and failure to obtain physical therapy for a resident with a referral for deconditioning (#1). [Refer to Tag D273, 10A NCAC 13F .0902(b) Health Care (Type A2 Violation).] 3. Based on interviews, observations and record reviews, the facility failed to ensure recommendations and guidance by the Centers for Disease Control (CDC), the North Carolina Department of Health and Human Services (DHHS) and directives from the local Health Department (LHD) were implemented and maintained when caring for 77 residents during the global Coronavirus (COVID-19) pandemic as related to the testing of staff and residents immediately following a direct care staff testing positive for COVID-19; screening of staff and visitors for symptoms of COVID-19; and safety precautions to reduce the risk of transmission and infestation of scabies including the availability and use of personal protective equipment (PPE) by staff and environmental cleanliness. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights	D980	orders have been received for ancillary, new and readmissions. These audits will be reviewed in the daily stand up and stand down meetings to ensure the orders are processed and clarified daily so no delay in treatment or medication administration. Any discrepancies will be reviewed monthly with the PCP by the ED to ensure the medication and quality of care and services are maintained. Any recommendation from the PCP will be implemented to ensure residents are receiving their necessary care and services. The DVPO and DDCS to monitor reports remotely no less that 2 times per week to ensure follow up of incident reports, medication management and any other compliance issues that may require immediate corrective actions. A weekly call to include the DVPO, DDCS, ED, MCM, RCC, ADO, LHPS and SIC will be conducted to follow up on the implementation of the plan of correction for this SOD	8-15-2020

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 116 (Type A2 Violation).] 4. Based on observations via video conference, interviews, and record reviews, the facility failed to administer medications as ordered and in accordance with the facility's policies for 2 of 5 residents sampled (#2, #3) including errors related to medications for pain, neuropathy, anxiety, low potassium levels, swelling / congestive heart failure, and constipation including missing multiple doses of these medications (#3); and for errors with eye drops used to treat glaucoma (#2). [Refer to Tag D358, 10A NCAC 13F .1004(a) Medication Administration (Type A1 Violation).] The Administrator, who was responsible for the overall operations of the facility, failed to assure responsibility for the implementation of rules and regulations governing supervision, health care, medication administration, and residents' rights. The Administrator's failure to assure responsibility resulted in Resident #6 who had a diagnosis of dementia eloping without staff's knowledge and wandering in the road and woods; Resident #2 experiencing 15 falls resulting in serious injury with multiple emergency room visits; Resident #3 having a leg wound that the PCP was not notified about until it was infected and an antibiotic and home health wound care was needed; Resident #2 having intense scratching not reported to the PCP which caused the development of three wounds on the resident's right upper thigh requiring wound care by home health; and Resident #3 missing multiple doses of multiple medications including a narcotic pain reliever resulting in the severe pain related to neuropathy caused by chemotherapy for a past history of stage 4 colon cancer. The Administrator failed to ensure recommendations and guidance by the	D980	Divisional Oversite of the facility will be provided with the DVPO and DDCS remotely and with onsite visits biweekly to ensure compliance with this SOD-plan of correction. Any discrepancies found will result in correction or redevelopment of the stated plan of correction. 9-2020 D980 Addendum per telephone with Ms. Darla Bellah on 8/28/20. The Administrator will work at the facility Mondays through Fridays from 8am - 5pm and other times as needed. The Administrator will be on-call and the Administrator's contact information will be posted and available for staff if needed. The Administrator is responsible for checking behind the RCC and MCM to assure tasks are completed on a daily basis. W. Williams 8/28/20	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL096051	A. BUILDING: _____ B. WING _____	R 07/16/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
EAGLE'S POINTE	901 WEST NEW HOPE ROAD GOLDSBORO, NC 27534

(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
D980	Continued From page 117 CDC, the NC DHHS, and the local Health Department (LHD) were implemented and maintained when caring for 77 residents during the global Coronavirus (COVID-19) pandemic as related to the testing of staff and residents immediately following a direct care staff testing positive for COVID-19. The Administrator's failure to assure responsibility for implementation of rules and regulations governing assisted living facilities resulted in serious physical harm and serious neglect which constitutes a Type A1 Violation. The facility provided a plan of protection in accordance with G.S. 131D-34 on 07/16/20 for this violation. CORRECTION DATE FOR THE TYPE A1 VIOLATION SHALL NOT EXCEED AUGUST 15, 2020.	D980		