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 _____	05/30/2024

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 an annual survey on 05/29/24 to 05/30/24.	D 000		
D 074	10A NCAC 13F .0306(a)(1) Housekeeping And Furnishings 10A NCAC 13F .0306 Housekeeping And Furnishings (a) Adult care homes shall: (1) have walls, ceilings, and floors or floor coverings kept clean and in good repair; This Rule is not met as evidenced by: Based on observations, interviews, and record reviews, the facility failed to ensure the floors were kept clean in residents' rooms and bathrooms and on the Jackson Hall dayroom. The findings are: Review of local county's Department of Environmental Health facility inspection dated 09/13/22 revealed: -The facility score was 97 and the status code was an A. -There was a total of 3 demerits issued. -The facility received 1 demerit for not having clean floors on the Jackson Hall and floors were sticky. -The facility received 1 demerit for the walls and ceiling not being cleaned. -The facility received 1 demerit for the handwashing cleaning station not being properly cleaned and disinfected.	D 074		

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 _____	05/30/2024

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 074	Continued From page 1 Observation of a residents' dayroom on the Jackson Hall 05/29/24 at 9:20am revealed the floor had a clear sticky film on the floor. Observation of room 179 on 05/29/24 at 9:29am revealed: -The room floor had not been swept. -There was clothing placed on the floor and the closet floor. -The bathroom floor had not been swept or mopped. Observation of room 179 on 05/30/24 at 7:42am revealed the bathroom had a strong urine odor. Interview with the resident in room 179 on 05/29/24 at 9:29am revealed: -Staff had not cleaned his room the day prior. -Staff were to come and clean his room on 05/29/24. -Staff had not taken out his trash daily. -He could not remember when housekeeping had last cleaned the bathroom. Interview with a personal care aide (PCA) on 05/30/24 at 9:42am revealed: -She organized and cleaned room 179. -She had not cleaned the room 179 bathroom. Observation of room 186 on 05/29/24 at 9:36am revealed: -The floor under the bed and night had red particles. -The bathroom shower had black particles on the floor. -There were black particles on the bathroom floor. Interview with the resident in room 186 on	D 074		

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 _____	05/30/2024

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 074	Continued From page 2	D 074		

05/29/24 at 9:36am revealed:
-Staff had not cleaned his room or the bathroom in a few days.
-Staff had not taken out his trash.
-He would clean his room sometimes.

Interview with a second PCA on 05/30/24 at 9:42am revealed:
-She had changed the bed linen in room 186 at times.
-The resident who resided in room 186 would not always allow staff to enter his room.

Interview with a second PCA on 05/29/24 at 3:17pm revealed:
-She assisted with residents' laundry.
-She had taken out residents' trash whenever housekeeping was not on duty.
-The PCAs were responsible for changing the residents' bedlinen on their assigned shower days or as needed.
-The housekeeper had not worked on 05/29/24.
-The housekeeping staff were responsible for cleaning the residents' rooms and bathrooms.

Second observation of the residents' dayroom on 05/29/24 at 3:11pm revealed the floor had not been swept and mopped and the floor had a clear sticky substance.

Third observation of the residents' dayroom on 05/30/24 at 7:46am revealed the floor had not been swept and mopped and the floor had a clear sticky substance.

Interview with the housekeeper on 05/30/24 at 9:27am revealed:
-She worked 5 days a week and alternated working on weekends.
-She had not been scheduled off two days in a

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 _____	05/30/2024

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 074	Continued From page 3 row unless it was on a weekend. -She had started cleaning the common areas of the facility first before cleaning the residents' rooms. -She was responsible for sweeping, mopping and dusting the common areas of the facility and the residents' room and their bathrooms. -The PCAs were responsible for changing the residents' bedlinen. -The residents who would often refuse to have their rooms cleaned, were cleaned when they were not in the room. -She had not cleaned the dayroom in a couple days. -She was the only housekeeper on staff and was trying to keep all the residents' rooms clean and had not come in to clean the dayroom. Interview with the Executive Director (ED) on 05/30/24 at 3:15pm revealed: -The facility had one housekeeper on staff. -The facility used a sister facility maintenance staff to assist with maintenance issues only and not housekeeping duties. -She would be hiring a second housekeeper. -The PCAs were responsible for assisting with residents' laundry and changing their bedlinen. -The PCAs were to assist in taking out the residents' trash on the days when the housekeeper was not working.	D 074		
D 255	10A NCAC 13F .0801(c)(1) Resident Assessment 10A NCAC 13F .0801Resident Assessment (c) The facility shall assure an assessment of a resident is completed within 10 days following a significant change in the resident's condition using the assessment instrument required in Paragraph (b) of this Rule. For the purposes of	D 255		

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 _____	05/30/2024

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 255	Continued From page 4 this Subchapter, significant change in the resident's condition is determined as follows: (1) Significant change is one or more of the following: (A) deterioration in two or more activities of daily living; (B) change in ability to walk or transfer; (C) change in the ability to use one's hands to grasp small objects; (D) deterioration in behavior or mood to the point where daily problems arise or relationships have become problematic; (E) no response by the resident to the treatment for an identified problem; (F) initial onset of unplanned weight loss or gain of five percent of body weight within a 30-day period or 10 percent weight loss or gain within a six-month period; (G) threat to life such as stroke, heart condition, or metastatic cancer; (H) emergence of a pressure ulcer at Stage II, which is a superficial ulcer presenting an abrasion, blister or shallow crater, or higher; (I) a new diagnosis of a condition likely to affect the resident's physical, mental, or psychosocial well-being such as initial diagnosis of Alzheimer's disease or diabetes; (J) improved behavior, mood or functional health status to the extent that the established plan of care no longer matches what is needed; (K) new onset of impaired decision-making; (L) continence to incontinence or indwelling catheter; or (M) the resident's condition indicates there may be a need to use a restraint and there is no current restraint order for the resident.	D 255		

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 _____	05/30/2024

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 255	Continued From page 5 This Rule is not met as evidenced by: Based on observations, interviews, and record reviews the facility failed to ensure a significant change assessment and care plan was completed for 1 of 5 residents sampled (#3) related to a stage 3 pressure ulcer on the right buttock. The findings are: Review of Resident #3's current FL2 dated 10/11/23 revealed diagnoses included moderate mental retardation, Cardiovascular Accident with right side hemiparesis, osteoarthritis, osteoporosis, right hand contracture. Review of Resident #3's Resident Register revealed she was admitted to the facility on 03/13/23. Review of Resident #3's assessment and care plan revealed: -The care plan was signed by Resident #3's primary care provider (PCP) on 01/12/24. -Resident #3 required maximum assistance with toileting, ambulation, bathing, dressing, grooming and transferring. -Resident #3 required limited assistance with eating. Review of Resident #3's primary care provider (PCP) notes dated 05/01/24 revealed Resident #3 has a stage 3 pressure ulcer on the right buttock. Review of the facility's contracted home health agency notes dated 05/07/24 revealed Resident #3 was first seen for wound care on 05/07/24.	D 255		

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 _____	05/30/2024

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 255	Continued From page 6 Interview with the Executive Director (ED) on 05/30/24 at 5:58pm revealed: -She was not aware Resident #3's care plan had not been updated to include the stage 3 pressure ulcer to the right buttock. -The Resident Care Coordinator (RCC) was responsible for updating the care plan. -The RCC was out on extended leave. -She became the ED 7 days ago, on 05/22/24, and was not the ED when the significant change occurred and the care plan needed to be updated. -She did not realize the care plan needed to be updated. Interview with the Regional Vice President of Operations on 05/30/24 at 5:58pm revealed: -The RCC was directly responsible for updating the care plan. -The ED was responsible for following up behind the RCC to ensure the care plan was updated. -The RCC worked with the MA and personal care aide (PCA) to identify the needs of the residents and discussed the needs with the PCP when the care plan was submitted to the PCP.	D 255		
D 269	10A NCAC 13F .0901(a) Personal Care and Supervision 10A NCAC 13F .0901 Personal Care and Supervision (a) Adult care home staff shall provide personal care to residents according to the residents' care plans and attend to any other personal care needs residents may be unable to attend to for themselves. This Rule is not met as evidenced by: Based on observations, interviews and record	D 269		

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 _____	05/30/2024

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 269	Continued From page 7	D 269		

reviews, the facility failed to provide personal care assistance for 1 of 5 sampled residents (#1) who required staff assistance with incontinence care.

The findings are:

Review of Resident #1's current FL2 dated 06/07/23 revealed:
-Diagnoses included athscl heart disease of native coronary artery without angina pectoris, unspecified dementia without behavioral disturbance.
-Resident was continent with both bowel and bladder.

Review of Resident #1's Resident Register revealed the resident was admitted to the facility on 02/15/20.

Review of Resident #1's assessment and care plan revealed:
-The care plan was signed by Resident #1's primary care provider (PCP) on 06/21/23.
-Resident #1 required limited assistance with eating, bathing and grooming.
-The was no documentation of Resident #1 needing assistance with toileting.

Review of the Licensed Health Professional Support (LHPS) dated 12/21/23 revealed:
-Resident #1used a wheelchair, an assistive device for ambulation that required physical assistance.
-There was no documentation of Resident #1 need of incontinence care.

Observation of Resident #1 room on 05/29/24 at 9:36am and 3:13pm revealed there was a strong smell of urine in the room.

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 _____	05/30/2024

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 269	Continued From page 8 Interview with Resident #1 on 05/30/24 at 5:39pm revealed: -He had not worn incontinent briefs. -He had not received any incontinence care from the staff. -He could use the bathroom without staff assistance. Interview with a personal care aide (PCA) on 05/30/24 at 9:42am revealed: -She assisted residents with personal care needs to include incontinent care. -She had not completed incontinent care for Resident #1. -Resident #1 refused personal care assistance and did not like staff to be in his room. Interview with a second PCA on 05/30/24 at 9:49am revealed: -She assisted residents with incontinent care. -She did not know if Resident #1 needed assistance with incontinent care but felt he did because she had observed the urine order coming from Resident #1. -Resident #1 had refused personal care with toileting when she offered. Interview with a medication aide (MA) on 05/30/24 at 5:33pm revealed: -She did not know if Resident #1 had an order to wear worn incontinent briefs. -She had observed Resident #1 trying to urinate in the hallway corner because he would sit outside for longs period. -Resident #1 had refused personal care from staff. -The PCAs assisted with residents' personal care needs. Interview with the Primary Care Physician (PCP)	D 269		

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 _____	05/30/2024

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 269	Continued From page 9 on 05/30/24 at 4:43pm revealed: -Resident #1 had bladder incontinence issues for a while and he had worn incontinent briefs. -She could not provide dates of the incontinent diagnosis because she did not have Resident #1's progress notes available to review. Interview with the Executive Director (ED) on 05/30/24 at 5:57pm revealed: -She was trying to learn of the residents clinical and personal care needs since her hire on 05/22/24 and had not become familiar with Resident #1's FL2 and care plan. -Resident #1 had an incontinence episode urinated in the hallway earlier on 05/30/24. -She did not know why Resident #1 had the incontinence episode because he would not provide a reason to staff. -She tried to obtain the PCP's progress notes for Resident #1, but the notes were not accessible. Attempted telephone interview with Resident #1's Guardian on 05/30/24 at 9:15am was unsuccessful.	D 269		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews, and record reviews the facility failed to ensure referral and follow-up to meet the health care needs of 1 of 5 sampled residents (#4) related to failing to ensure the resident was referred to an infectious disease specialist for osteomyelitis (infection in the bone)	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 _____	05/30/2024

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 10	D 273		

of the left foot as ordered by his podiatrist.

The findings are:

Review of Resident #4's current FL-2 dated 04/23/24 revealed:
-Diagnoses included acute kidney injury, abdominal pain, and gastrointestinal bleed.
-The resident was semi-ambulatory.

Review of Resident #4's Resident Register revealed the resident was admitted to the facility on 03/09/23.

Review of Resident #4's left 3rd toe radiology report dated 03/14/24 revealed:
-There was no acute fracture.
-There was fragmentation of the distal phalanx of the 3rd toe with soft tissue swelling consistent with osteomyelitis.

Review of Resident #4's podiatry visit note dated 03/28/24 revealed:
-There was an ulcer on the distal aspect of the left 3rd toe with swelling.
-There was a radiology report of the left 3rd toe that reported positive for osteomyelitis (osteomyelitis is inflammation or infection of bone).
-Resident #4 was on doxycycline (an antibiotic used to treat infection) for 6 weeks with the last dose scheduled for 04/26/24.
-An Infectious Disease consult was needed for Resident #4 due to osteomyelitis.
-Resident #4 was to have a repeat x-ray of the left foot after completion of 6 weeks of antibiotics.

Review of Resident #4's podiatry visit note dated 05/02/24 revealed:
-Repeat x-ray of the left 3rd toe to be done at the

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 _____	05/30/2024

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 11	D 273		

next office visit.
-There was significant reduction in swelling of the left 3rd toe with no drainage noted.
-The ulcer measured 5 mm by 5 mm by 1 mm.

Review of Resident #4's record on 05/30/24 revealed there were no notes from an infectious disease provider.

Interview with the nurse from Resident #4's podiatry office on 05/30/24 at 12:04pm revealed:
-Resident #4 was seen on at the podiatry office on 03/28/24 and 05/02/24.
-An infectious disease consult was ordered for Resident #4 at the 03/28/24 office visit due to osteomyelitis noted on the resident's left foot x-ray.
-Resident #4's primary care provider (PCP) was responsible for sending the infectious disease consult due to insurance purposes.
-She was not aware that Resident #4 had not seen an infectious disease provider.
-Resident #4 was most recently seen on 05/02/24 and had significant improvement of the left 3rd toe ulcer and would have repeat x-rays at his 06/12/24 follow-up appointment.
-The podiatrist did want Resident #4 to see an infectious disease provider.
-It was important that Resident #4 see an infectious disease provider to make sure the osteomyelitis was improving.

Interview with a medication aide (MA) on 05/30/24 at 3:35pm revealed:
-The MAs could process pharmacy orders.
-The Resident Care Coordinator (RCC) reviewed and processed all referral orders.

Interview with the Executive Director (ED) on 05/30/24 at 3:48pm revealed:

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 _____	05/30/2024

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 12	D 273		

-When a resident had an outside appointment, the transporter gave the resident's paperwork to the RCC.
-The RCC was responsible for processing and completing referrals for the residents.
-The RCC had been out on leave for several weeks.
-The previous Administrator left suddenly on 05/21/24 and she took over the facility and the absent RCC's duties on 05/22/24.
-Resident #4's podiatry paperwork from the 03/28/24 visit should have been reviewed by the RCC.
-The RCC should have contacted the podiatry office to clarify who was to make the infectious disease referral.
-Resident #4's PCP should have been contacted regarding the podiatrist request for the infectious disease consult.
-Resident #4's podiatry notes should have been provided for his PCP to review.
-She did not know why the RCC did not contact Resident #4's podiatrist or PCP about the infectious disease referral.
-She did not know why the infectious disease consult was not made for Resident #4.

Interview with Resident #4's PCP on 05/30/24 at 3:24pm revealed:
-Resident #4 was an insulin dependent diabetic.
-She had been treating Resident #4 for an infection of the left 3rd toe and osteomyelitis since March 2024 and ordered an x-ray of the left foot at his 03/13/24 visit with her.
-The x-ray of the left foot reported osteomyelitis of the left 3rd toe.
-Resident #4 was followed by podiatry for routine foot care, the left 3rd toe ulcer, and osteomyelitis.
-She was not aware that Resident #4's podiatrist had requested an infectious disease consult.

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 _____	05/30/2024

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 13 -She had not been provided Resident #4's podiatry visit notes to review since 03/13/24. -She had asked that all provider correspondence be saved in a folder for her to review. -The facility should have provided all Resident #4's podiatry visit notes for her to review. -She last saw Resident #4 on 05/22/24 and his left 3rd toe was healing well with no drainage and closed over. -Osteomyelitis was an infection in the bone, and in someone with diabetes, can be a very serious infection that could lead to amputation. -She would reach out to the podiatrist regarding the infectious disease referral.	D 273		
D 315	10A NCAC 13F .0905 (a & b) Activities Program 10A NCAC 13F .0905 Activities Program (a) Each adult care home shall develop a program of activities designed to promote the residents' active involvement with each other, their families, and the community. (b) The program shall be designed to promote active involvement by all residents but is not to require any individual to participate in any activity against his or her will. If there is a question about a resident's ability to participate in an activity, the resident's physician shall be consulted to obtain a statement regarding the resident's capabilities. This Rule is not met as evidenced by: Based on interviews, record reviews and observations the facility failed to ensure residents were offered activities designed to promote the residents' active involvement. The findings are: Observation of the facility on 05/29/24 at 9:15am	D 315		

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 _____	05/30/2024

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 315	Continued From page 14	D 315		

revealed there was not an activities calendar posted within the facility.

Observation of the activities room on 05/29/24 at 9:01am revealed:
-There was a blank bulletin board on the wall.
-There was no activities calendar posted in the activities room.

Interview with a resident on 05/30/24 at 8:36am revealed:
-There were no activities for the residents for 1-2 months.
-There had not been an Activities Director at the facility for about 1-2 months.
-He enjoyed bingo but had been several months since bingo was offered.
-He went on outings with his family, the facility did not provide outings.

Interview with a second resident on 05/29/24 at 9:19am revealed:
-There residents were not offered activities daily because there was not an Activity Director.
-The last outing was over a month ago.
-There was only bible study on Tuesday and church every other Sunday from a volunteer.
-She had enjoyed playing bingo and other games with the residents when they were offered.

Interview with a third a resident on 05/29/24 at 9:27am revealed:
-Residents were not offered activities in the past two months.
-There was no longer an Activity Director at the facility.

Interview with a fourth resident on 05/29/24 at 9:31am revealed:
-There were no activities that he was aware of.

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 _____	05/30/2024

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 315	Continued From page 15	D 315		

-There were no outings provided by the facility.
-He would like to go out shopping.
-He was bored and did not want to watch television all day.
-He passed the time by sitting outside.

Interview with a fifth resident on 05/30/24 at 9:37am revealed:
-The facility had church services every other Sunday and bible study on Tuesday evenings.
-Someone would come to the facility and sing about one time per month.
-There used to be an activities calendar posted but it had been about 2 months since an activities calendar was posted.
-It had been about 3 months since the last outing from the facility.

Interview with a sixth resident on 05/30/24 at 9:38am revealed:
-The facility used to have monthly parties to celebrate birthdays, but it had been several months since the last birthday party or activity.
-She enjoyed bingo and crafts and would participate if these activities were offered.

Interview with a seventh resident on 05/29/24 at 9:55am revealed there were no activities because there was not an Activity Director.

Interview with a personal care aide (PCA) on 05/29/24 at 3:17pm revealed:
-Residents only had bible study once a week and church at least every other week.
-The facility no longer had an Activity Director.
-She had not been asked to assist with doing activities with the residents.

Interview with the Executive Director (ED) on 05/29/24 at 10:17am revealed:

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 _____	05/30/2024

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 315	Continued From page 16 -She learned on 05/22/24, her first day as the ED, the facility did not have an Activity Director. -No other staff had been assigned to complete activities with the residents. -The Activity Director position had been posted and she would be interviewing to fill the position soon. -Residents were informed an Activity Director would be hired soon and th residents would resumed their scheduled daily activities.	D 315		