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	345237	A. BUILDING _____ B. WING _____	06/07/2012

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F 221 SS=D	483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews, and record reviews the facility failed to obtain a doctors order for a non-releasing seat belt and failed to monitor and document for one of one sampled residents (resident # 153). Findings include: Resident # 153 was admitted to the facility on 10/16/2008 with diagnoses which include Alzheimer ' s disease, and muscle weakness. The original order for the non-releasing seat belt restraint was written on 3/4/2009 for impaired gait. Upon further review of the resident record the last order for a physical restraint was dated 1/1/12 through 1/31/12. The most recent physician order for the restraint was signed by the physician on 1/24/12. The most recent physician orders dated 6/1/12 through 6/30/12 did not include an order for a physical restraint. Review of Resident #153 ' s clinical record revealed there were a total of three entries in the past five months. The entries were dated 1/28/12, 2/2/12 and 4/20/12. There was no indication in the three entries that the resident had any falls and there was no documentation to	F 221	Preface Statement Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other Administrative or legal proceeding. F221 The order for the Non Self Release Seat Belt Restraint for Resident #153 was obtained by the Director of Nursing on 6-7-12. 100 % audit of all Resident's currently utilizing restraints was completed on 6-26-12 with oversight by the Quality Improvement Nurse to ensure compliance with resident's right to be free of restraints unless an order is present for the restraint that includes the supporting medical symptom.	7-5-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bill Mullinix	Administrator	6-28-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 221	Continued From page 1 show there were any restorative programs in place for this resident during the period of 1/12 to 5/12. On 4/3/12 a Physical Restraint Evaluation was done for resident #153 and the evaluation indicated the medical symptom was unsafe movements which occurred multiple times during the day. The underlying cause for the medical symptom was an unsteady gait and balance. The least restrictive device for resident #153 was listed as a non-releasing seat belt because resident #153 fidgeted with self release devices and was able to release a lap buddy. Resident #153 was to wear the non-releasing seat belt when in a wheelchair and unattended. The benefits for resident #153 were listed as enhanced independence, dignity, prevented attempts to transfer without assistance. Risks for the restraint usage for resident #153 were listed as decline in mobility, increased agitation, or confusion. The Physical Restraint Evaluation to promote reduction of the restraint usage for resident #153 indicated that rehab, restorative dining and social activities were each attempted for 15 minutes on the day of the assessment and the resident exhibited unsafe movements. The Minimum Data Set (MDS) dated 5/14/12 revealed resident # 153 was severely cognitively impaired and was dependent on staff for all activities of daily living including bathing, feeding, and transfers. Resident # 153 used a wheelchair for mobility and was able to self propel. The MDS indicated a trunk restraint was used daily and there had been no falls that quarter. The MDS also indicated resident #153 had not received restorative nursing in the assessment period.	F 221	Resident Care Guides for all Residents utilizing Restraints have been updated to include the symptom /reason for the restraint use. The update was completed on 6-26-12. Restraint use will continue to be reviewed, monitored and documented for each Resident per facility policy during the evaluation, review and reduction attempt process. Nursing staff will continue to monitor restraint use during provision of routine care and daily rounds. The Quality Improvement Nurse was in-serviced on 6-26-12 by the Director of Nursing related to the documentation requirements and policy related to Restraint Use. In-servicing with all facility Nurses to include the Quality Improvement Nurse was completed by the Staff Development beginning on 6-14-12 related to allowing the resident to be free of the physical restraint unless a Physician's order with the supporting diagnosis was present to support the restraint use. Staff that have not received the in servicing as of 6-28-12 will receive the training prior to taking a Resident assignment. Restraints will be reviewed utilizing a QI audit tool by an Administrative Nurse weekly for 8 weeks then monthly for 2 months thereafter to ensure that restraints are not utilized unless Physician's orders are present and that monitoring and documentation are occurring as per policy.	

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F 221	Continued From page 2 The care plan dated 5/17/12 for resident #153 identified usage of a physical restraint device for prevention of injury due to a high risk for falls/ injury and impaired mobility related to impaired standing balance. The goal for resident # 153 was that the resident would not fall through next review period. Interventions included evaluation of activity and the device for least restriction, reduction, and or discomfort per facility protocol. Other interventions included; removal of the non-release seat belt restraint for resident #153 during supervised activities and meals. The non-releasing seat belt would be reapplied upon completion of the meal. During an observation on 6/5/12 at 2:45 PM resident # 153 was in her room with the non releasing seat belt in place. Resident #153 exhibited no signs of discomfort and did not attempt to get out of the chair. On 6/5/12 at 3:45 PM an interview with NA # 3 indicated she cared for resident #153 on a regular basis as part of her assignment. NA#3 indicated resident # 153 was dependent on staff for activities of daily living including feeding, dressing, and personal care. Resident # 153 was not able to make her needs known. NA# 3 indicated resident # 153 wore a non releasing seat belt at all times when the resident was out of bed in her scoot and go chair. NA#3 indicated resident #153 ate dinner in her room and the belt was not removed until bed time. NA# 3 indicated resident # 153 had not attempted to get up out of the chair. NA # 3 also indicated resident # 153 would slump down in her wheel chair and it helped keep resident #153 from sliding out of the	F 221	Audits will be reviewed weekly by the Quality Improvement Nurse with follow-up as deemed necessary for any identified concerns. The Quality Improvement Nurse will compile the results monthly and forward to the Quality Improvement Committee for monthly review and for the identification of trends, development of action plans as indicated, and to determine the need and/ or frequency of continuing QI monitoring.	

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F 221	Continued From page 3 chair to the floor. On 6/5/12 at 5:10 PM an interview with NA #4 revealed NA#4 was familiar with resident #153 and had been employed with the facility for more than 6 months. NA #4 indicated he worked with resident #153 on a regular basis as part of his assignment. NA #4 indicated resident #153 used a lap belt and it was on until resident #153 went to bed. NA#4 indicated resident #153 did not attempt to get out of the chair but the lap belt was used to prevent resident #153 from sliding down in the chair. During an interview on 6/5/12 at 5:15 PM Nurse #5 revealed resident #153 did not attempt to rise out of the chair and had not attempted to rise in the past year. Nurse #5 indicated resident #153 had slid down in the chair before and the lap restraint prevented resident #153 from sliding to the floor. Nurse #5 indicated resident #153 ate dinner in her room and the belt was kept on for that meal and only removed at bedtime. Nurse #5 reported that she monitored the restraint during random observations and did not document regarding the restraint usage on a regular basis. Nurse #5 was unable to provide any documentation of the monitoring of the seat belt restraint. Observation of resident #153 on 6/6/12 revealed the resident was in the main dining room at 8:20 AM waiting for breakfast to be served. Resident #153 made no attempts to get out of the chair. A staff member unfastened seat belt but kept it in place when the meal arrived. On 6/6/12 at 8:40 AM during an interview with	F 221		

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F 221	Continued From page 4 Nurse #4 it was revealed resident #153 wore the non-releasing seat belt restraint at all times except for meals during Nurse #4 ' s shift. Nurse #4 revealed she was unsure why resident #153 had the lap belt restraint in place. Nurse #4 also indicated resident #153 had made no attempts to rise out of the chair to her knowledge in the past year. Nurse #4 indicated resident #153 did not ambulate and had not had a fall in about one year. Nurse #4 indicated the MDS nurse determined if the restraint was needed and completed the quarterly assessments. Nurse #4 monitored the restraint during random observations and indicated she had not documented regularly on the restraint usage. Nurse #4 was unable to provide documentation of the observations and monitoring of the seat belt restraint. Review of resident #153 ' s care guide which was undated indicated a physical restraint called a non-releasing seat belt was used for resident #153. There were no instructions for staff regarding release or monitoring on the care guide. During an interview on 6/6/12 at 10:20 AM with Nurse #3 it was revealed the non-releasing lap belt restraint for resident #153 was in place because resident #153 would lean forward in her chair due to her poor cognition. Nurse #3 indicated sliding down in a chair would not be a reason to use a seat belt due to the risk of strangulation. Nurse #3 indicated there would have to be an in-service regarding the correct usage of the restraint for resident #153. Nurse #3 also revealed the assessments were done quarterly for the restraint usage by the Quality	F 221		

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F 221	Continued From page 5 Improvement Nurse (QI Nurse). Nurse #3 indicated she had been the QI nurse until very recently and had just moved to a new role. Nurse #3 indicated the usage and monitoring of the restraint for resident # 153 would be documented in the resident record by the nurses. During an interview on 6/6/12 at 11:20 AM with the MDS Coordinator and the MDS Nurse it was revealed a physical restraint was used for resident #153 for unsafe movements. The MDS nurse indicated she gathered information for her assessments and care plans from several sources which included observations of resident #153, interviews with staff, nurses ' notes, doctors ' orders, and the 24 hour report. The MDS nurse indicated that it was the QI nurses responsibility to add or take away any care areas that were no longer current. The MDS nurse was unable to provide documentation to show the restraint was monitored. An interview on 6/6/12 at 11:50 AM with the DON revealed two nurses would sign the orders as a double check system. The DON would expect the restraint order for resident #153 to be renewed on the monthly orders and expected the care guide to provide the necessary information such as removal and monitoring instructions. The DON indicated monitoring of the non-releasing seat belt restraint was done by staff but was unable to provide documentation of the monitoring for resident #153. The DON expected all staff to be knowledgeable of the reason why the restraint was used for resident #153 and the risks of using a restraint. An interview on 6/6/12 at 4:00 PM with the	F 221		

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F 221	Continued From page 6 physician revealed he signed orders for resident #153 every month and an order for a restraint should be obtained every month. He was unaware resident #153 did not have a current order for restraint use.	F 221		
F 244 SS=E	483.15(c)(6) LISTEN/ACT ON GROUP GRIEVANCE/RECOMMENDATION When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility. This REQUIREMENT is not met as evidenced by: Based on resident interviews, staff interviews, observation, and review of Resident Council minutes, the facility failed to respond to grievances related to water not being provided between meals for 4 of 4 sampled residents active in the Resident Council. Review of the Resident Council minutes dated May 2012 revealed the residents had included the lack of water in their pitchers as one of their concerns for that month. The social worker had attended. No documentation was found addressing how the concerns in regards to water would be handled. An interview was conducted with the Resident Council President (RCP) on 6/7/12 at 3:00PM. She stated the Resident Council met every month and concerns were discussed and relayed back to the facility administration by the Social Worker.	F 244	A Resident Council Meeting was held on 6-22-12. Residents in attendance included the Resident Council Vice President in the absence of the President, and the Facility Ombudsman. Residents in attendance for the group were given opportunity to express any outstanding concerns as of 6-22-12. The follow up was completed by the Director of Nursing on 6-26-12 as appropriate according to the concern expressed. The Resident Council President is currently out of the facility and will be informed of the action taken upon return by the Social Worker. Action taken will also be reviewed at the next Resident Council meeting for those in attendance. Action taken to address the reported failure of staff to pass ice and water on each shift was also shared with the group at the Resident Council Meeting on 6-22-12 by the Social Worker. The residents present were satisfied with the response and plan given to address the concern. This plan included staff in servicing and monitoring of ice and water pass by the Administrative Nurses. Residents will be questioned regarding change in opinion related to the concern at the next scheduled Resident Council Meeting.	7-5-12

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F 244	Continued From page 7 The RCP stated that the concerns were not always addressed and if they were, the response did not provide a solution to the problem. She stated that if any action was taken at all, it rarely solved the issue. The most important problem to her has been the staff not filling the water pitchers in the residents' rooms. The RCP stated one resident had gone without water in her pitcher for three days. A group interview was held on 6/8/12 at 10:30AM. Four of four alert and oriented residents who were Resident Council members attended. Each member stated the water pitchers in their rooms were not filled every shift. One resident stated she had not had water put in her pitcher for three days at one point in time. When asked about the hydration carts observed being used, the residents agreed they were not used all the time in a consistent manner. When asked if they had discussed the concern at their meetings, they stated they had and had not received an acceptable response from the facility. Observations on 6/7/12 at 9:00AM and 6/8/12 at 4:00PM revealed that 4 out of 4 residents' water pitchers were full with ice and water. On 6/8/12 at 12:30PM the Director of Nursing (DON) was interviewed. She stated that the social worker attended the monthly Resident Council meeting and relayed concerns to the appropriate staff. It is her expectation that the residents felt their concerns were taken seriously and the facility gave them a response they felt addressed the issue. She also stated it is expected that the problems were corrected and change was implemented to ensure the residents' well being.	F 244	The Social Workers responsible for Resident Council Meetings and generating concern follow up were in serviced on 6-14-12 by the Facility Consultant related to the policy for addressing concerns received during routine Resident Council Meetings. Administrative Staff to include the Activity Director, Dietary Manager, Housekeeping Supervisor, Maintenance Director and the Director of Nursing were in serviced on 6-14-12 by the Facility Consultant related to promptly responding to concerns to include those submitted to them for follow up from the Resident Council Meetings. Resident Council Meetings will continue to occur at a minimum of monthly. Residents will continue to have any concerns voiced forwarded to the appropriate department head for follow up. The follow up will include informing the resident voicing the concern of the action taken. The action taken will be discussed at the next scheduled Resident Council Meeting as appropriate. A QI Tool will be utilized to record those concerns and subsequent follow up. The Facility Administrator will review and sign the completed QI tools received at each Resident Council Meeting upon completion of follow up to the concern voiced and then forward the QI form back to the Social Worker. The Quality Improvement Nurse will review the Completed QI Tools monthly for a minimum of 3 months to monitor the receipt and timely follow up any concerns voiced during the Resident Council Meeting. Results will be forwarded to the Monthly Quality Improvement Committee for monthly reviews. The Quality Improvement Committee will identify any trends, development of action plans as indicated, and determine the need and/ or frequency of continuing QI monitoring.	

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F 244	Continued From page 8 She stated she expected the residents to have their water pitchers filled each shift and more if needed. The hydration carts were implemented to ensure residents were provided water and snacks in between meals. On 6/8/12 at 12:40PM the Administrator was interviewed regarding the Resident Council concerns. He stated it was his expectation that the council's concerns were addressed and that the members felt their concerns were important and would be addressed. His plan was to meet with the RCP the following day and discuss any concerns she and the council had and ensure the chain of communication was effective. An interview with the Social Worker responsible for relaying concerns from residents was held on 6/15/12 at 10:36AM. She stated two social workers attended the monthly Resident Council meetings, but she was the primary one responsible for taking concerns to the appropriate administrative personnel. The social worker stated once concerns were relayed to the facility administration, she was given a response and relayed that to the Resident Council at the next meeting. She stated ice and water being available to residents had been a recurring concern and that she shared that concern with the Director of Nursing.	F 244		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.	F 323	Interventions in place for Resident #186 to aide with fall prevention were reviewed by the Director of Nursing on 6-7-12. The Mechanical Recliner in use for Resident #186 was removed and placed in storage for pickup as arranged with the family by the Administrator on 6-6-12.	7-5-12

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F 323	Continued From page 9 This REQUIREMENT is not met as evidenced by: Based upon observations, record reviews and staff interviews the facility failed to implement a fall prevention intervention for a mechanical recliner that resulted in an injury for 1 of 2 sampled Resident ' s (Resident #186) at risk for falls. Findings include: Resident #186 had diagnoses of dementia, chronic back pain and parkinson's disease. The 5-day Minimum Data Set (MDS) dated 3/21/12 indicated he required extensive to total assistance with his activities of daily living and had poor balance. The care area assessment dated 3/21/12 revealed he had triggered for falls due his poor balance skills, decline in cognition and incontinence. The care plan dated 3/26/12 revealed he was at risk for fall due to the history of falls, actual falls, injury and multiple risk factors. The interventions for this fall risk were the following: 1. assist during transfer and mobility, 2. place his bed in the lowest position, 3. have his call bell pinned to his gown when in bed and 4. have commonly used articles within easy reach. A record review of the facility incident report dated 2/16/12 revealed Resident #186 was on the floor in front of his mechanical recliner. The mechanical recliner was in the upright position. There was a skin tear noted to the left arm. The	F 323	All Residents utilizing Mechanical Recliners were evaluated for the appropriateness and safety of the recliner by the Facility Quality Improvement Nurse and the Therapy Manager. The review and any needed follow up were completed on 6-22-12. Interventions currently in use for Residents determined to be at Risk for Falls were reviewed by the Quality Improvement Nurse and the Therapy Manager to ensure fall prevention interventions were implemented as needed based on Resident condition. The review and any needed follow up to any concerns identified were completed on 6-22-12. Care Guides were updated as needed to reflect interventions determined for communication to the nursing staff. A second review was completed by the QI Nurse and was completed on 6-29-12. The Quality Improvement Nurse was in serviced by the Director of Nursing and the Facility Consultant on 6-26-12 related to the responsibility of the QI Nurse to ensure Residents identified at risk for falls have interventions in place to aide with falls prevention as warranted based on their condition and individual needs. The QI Nurse will review Falls Risk Assessments as completed per policy on an ongoing basis upon completion to aide with ensuring interventions are in place as warranted.	

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F 323	Continued From page 10 immediate action was to have Resident #186 placed back into the mechanical lift recliner and the remote control for the mechanical recliner to be placed out of reach. The call light was to be placed within reach. The predisposing environmental factor to the fall was deemed the mechanical recliner. The predisposing physiological factors were decreased functional status, safety awareness and mobility and cognitive status. The predisposing situation factor was that Resident #186 was in the mechanical recliner at the bedside. The Nursing Assistant (NA) did not know not to leave the controls within reach due to Resident #186 was playing with controls. The NA was educated. Resident #186 was able to push the lift button until it lifted enough to slide him out of the chair. The NA ' s were educated not to have controls in reach of Resident #186 due to him playing with the buttons while seated in the mechanical recliner. A record review of the facility incident report dated 5/19/12 revealed Resident#186 had an unobserved fall. Resident #186 was found on the floor in front of the mechanical recliner by Nurse #2. Resident #186 had pushed up the chair with the remote control. He had the recliner at a high level. The immediate action taken was for Resident #186 to be assessed for injuries and contact the physician and supervisor. There were no found injuries at the time of the assessment. The predisposing environmental factor was the mechanical recliner. The predisposing physiological factors were an unsteady gait, muscle weakness, impaired vision, decreased mobility and safety awareness and alzheimer ' s disease. The predisposing situation factor was	F 323	In-services were initiated with all nursing staff by the Staff Development Coordinator on 6-14-12 related to ensuring interventions are in place to aide with accident / fall prevention as needed and as indicated on the Resident Care Guide. Staff that have not received the in servicing as of 6-28-12 will receive the training prior to taking a Resident assignment. Residents are being monitored by staff for appropriate interventions to include during routine care and on daily rounds. Audits of interventions in use will be conducted by an Administrative Nurse to include the Director of Nursing, Assistant Director of Nursing, Quality Improvement Nurse and the Staff Development Coordinator. The audits will be completed 3 x weekly for 4 weeks, then once weekly for 4 weeks then monthly for a minimum of 2 months or as directed by the QI Committee utilizing a QI tool. The QI Nurse will review, compile and forward the results to the Quality Improvement Committee for monthly reviews. The Quality Improvement Committee will identify any trends, development action plans as indicated, and determine the need and/ or frequency of continuing QI monitoring.	

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	06/07/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR RD SMITHFIELD, NC 27577

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F 323	Continued From page 11 Resident #186 sitting in the mechanical recliner that had a remote to rise for easy standing. The notations were to apply a dycen to the mechanical chair per therapy recommendations on 5/23/12. The staff was educated to use the dycen in the mechanical recliner. A record review of the facility physician notes was conducted. The note dated 5/22/12 indicated Resident #186 had a fall over weekend with pain in the left elbow and increased pain in the left rib with respiration. The note dated 5/29/12 indicated the Nurse Practitioner was called to see Resident#186 wound. The wound was initially treated with cipro and switched to augmentin on 5/28/12. There was a large amount of purulent bloody drainage from the elbow. It was reddened and painful. Resident #186 was sent to the Emergency Room (ER) to be evaluated for a septic elbow. A record review of the May 2012 MAR revealed ultram medication 50mg was given to Resident #186 on 5/21/12 for complaints of pain in his side. A record review of the hospital ER history and physical dated 5/29/12 indicated a fracture of the elbow was reported on the CT scan. The left elbow was weeping with red skin. There was an elevated white blood cell count. He was admitted to the hospital on 5/29/12. The orthopedic consult wanted to treat for bursitis and provide intravenous antibiotics. A record review of the hospital radiology report dated 5/29/12 revealed the following: 1.probable humeral fracture of the left arm and 2. possible radial fracture of the left arm versus old trauma.	F 323		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
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F 323	Continued From page 12 A record review of the facility physician orders indicated Resident #186 was readmitted back to the facility on 6/2/12 with fall precautions after completing intravenous antibiotic treatment at the hospital. An interview with Nurse #2 on 6/4/12 at 3:45 pm revealed Resident#186 had a recent fall from his mechanical recliner by the bed and sustained an arm fracture. He had used the remote to rise up the recliner and slid onto the floor. The mechanical recliner was still in his room. The remote was taken away. An interview with Nurse#1 on 6/6/12 at 11:53 am revealed Resident #186 had a fall on Friday, May 19th evening around 5:00 pm after she left for her shift earlier that day. When she came back to work on Monday, she saw his elbow was swollen and red. His left side had some red spotted areas. It was reported to her that he complained of pain over weekend in his arm. He was on an as needed pain medication. He was started on cipro that Monday. She had x-rays ordered for his ribs and elbow. The x-rays were negative. The Treatment Nurse was wrapping up his arm for that week due to some drainage. She had not recalled him complaining of pain that week. By end of week, the Treatment Nurse indicated the arm did not look better. The arm had increased swelling and drainage. They did attempt to change the antibiotic based upon the Responsible Party (RP) said the cipro made him feel loopy. The antibiotic was changed to augmentum. By the following Monday, they had called the physician about the arm. The	F 323		

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F 323	Continued From page 13 physician wanted him sent out for further evaluation. The CT scan at the hospital indicated a small fracture. Nurse #2 has indicated she has seen him sitting in the mechanical recliner in the evening ' s at times watching television. After incident, they did not like having mechanical recliner remain in his room. Nurse#2 had told the RP about the mechanical recliner and wanted the RP to get the mechanical recliner from Resident #186 room. The mechanical recliner remained in his room. An observation with Nurse #1 on 6/6/12 at 12:04 pm in Resident #186 room revealed the mechanical recliner chair was located beside his bed. The recliner remote was connected to the recliner by a cord. The remote was placed in the open pocket on the right side of the recliner. The mechanical recliner was plugged into the wall. Nurse #1 demonstrated how to push the button up with her hand to raise the mechanical recliner. The mechanical recliner rose at an angle and to the height of about 2 feet from the ground. An Interview with the PT on 6/6/12 at 1:00 pm revealed Resident #186 revealed she knew that Resident #186 liked to be put into the mechanical recliner. She recalled the Nurse told the family about not have the mechanical recliner in the room but the family really wanted him to have the mechanical recliner. She did not know the mechanical recliner was still in his room. She would not recommend a mechanical recliner chair for a non-ambulatory resident. An interview with Nurse #2 on 6/6/12 at 3:35 pm revealed she worked the evening of Resident#186 fall on 5/19/12. Nurse#2 was at	F 323		

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F 323	Continued From page 14 the end of the hall when she heard Resident#186 had yelled for help. She came to his room and found him on the floor between the recliner and his roommate ' s bed. She saw the mechanical recliner elevated in the air. She asked Resident #186 what had happened. He indicated he had pushed the remote on the mechanical recliner. Resident #186 indicated he liked to be high. Nurse#2 assessed Resident #186. He did not complain of pain. She did not see any injuries. She assessed him throughout her shift and did not see any changes in his elbow. She thought the remote was to be kept somewhere at the nurse station area. She had seen him before in the recliner but he has not been in it since the fall. She could not recall him falling prior to this fall on 5/19/12. An interview with NA#2 on 6/6/12 at 3:35 pm revealed she was working the evening of Resident #186 fall on 5/19/12. She indicated Resident #186 liked to play with buttons. NA#4 assumed the remote was kept at the side of the chair. They would place him in the recliner using the mechanical lift. Before the fall on 5/19/12, NA#4 could not recall any instruction about not being in his mechanical recliner or placement of the remote. After his fall on 5/19/12, she has not placed him in the mechanical recliner. An observation on 6/6/12 at 3:40 pm with Nurse #2 revealed the mechanical recliner beside Resident #186 bed. The remote was attached to the chair with a cord. The mechanical recliner was plugged into the wall. The remote was located in the open pocket on the right side of the chair.	F 323		

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F 323	Continued From page 15 An interview with the prior Quality Improvement (QI), Nurse#3 and new QI Nurse was conducted on 6/6/12 at 4:09 pm. Nurse #3 indicated they have monthly and quarterly meetings for falls. The monthly meetings were for the discussion of falls and interventions. The quarterly meetings were for the number of falls and trends. Resident #186 was discussed in the monthly meetings. The 5/19/12 was related to him using the remote on the mechanical recliner. The intervention was for the dycen pad to be used in the mechanical recliner. They thought the dycen pad would help him from sliding from the recliner. They thought it was the best intervention at that time. Typically Nurse#3 indicated she has only seen residents with mechanical recliners in the rehabilitation unit or if the resident was incapable of the use of buttons. The 2/16/12 fall intervention was to put the remote in the pocket of the mechanical recliner so it could be out of reach of Resident #186. An interview with the Director of Nursing on 6/7/12 at 1:46pm revealed they think they should have either unplugged the mechanical recliner remote or kept the remote out of Resident #186 reach.	F 323		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control	F 441	Facility staff is maintaining Infection Control practices to prevent the spread of infection by not eating while feeding Residents including Resident #136, and while in areas where there is a reasonable likelihood of potential exposure as .indicated by accepted professional practice.	7-5-12

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F 441	Continued From page 16 Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based upon observations, record review and staff interviews the facility failed to follow infection control guidelines when a staff member had eaten food and fed 1 of 6 sampled Residents (Resident #136) dependent for feeding without washing their hands.	F 441	Facility staff was in serviced related to aiding with the prevention of the spread of infection by not eating in Resident care areas by the Staff Development Coordinator. The in-servicing was initiated on 6-14-12. The in servicing was initiated a second time by the Staff Development Coordinator beginning on 6-22-12 with Nursing Staff and included addressing the need for staff to conduct proper hand washing between eating and feeding of a Resident. Staff that have not received the in servicing as of 6-28-12 will receive the training prior to taking a Resident assignment. The DON or Administrative Nurse will monitor Staff during feeding of Residents to ensure that Staff is not eating while providing meal service and that Staff are washing their hands if eating and feeding of a Resident is occurring. This monitoring will be reflected on a QI audit tool that will be completed 3 x weekly for 4 weeks, then weekly for 4 weeks, and then monthly for minimum of 2 months. Audits will be reviewed weekly by the Quality Improvement Nurse or the Director of Nursing with follow-up as deemed necessary for any identified concerns. Results of the review will be compiled monthly by the Quality Improvement Nurse and will be forwarded to the Quality Improvement Committee for monthly reviews and for the identification of trends, development of action plans as indicated, and to determine the need and/ or frequency of continuing QI monitoring.	

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F 441	Continued From page 17 Findings Include: An observation on 6/6/12 at 9:05 am revealed Nursing Assistant (NA) 1# was in Resident #136 room and standing next to his bed. Resident #136 was in his bed. The bedside table was located next to his bed. The meal tray was sitting on top of the bed side table. NA#1 was standing next to the bedside table also. NA#1 had a piece of sausage on a fork and was eating a portion of the sausage. She then placed the fork with sausage back onto the side of the resident ' s tray. An interview with NA#1 on 6/6/12 at 9:08am revealed she was almost finished feeding the resident. She knew it was wrong to eat while feeding a resident. An observation of NA#1 on 6/6/12 at 9:10am revealed her continuing to feed Resident #136 with a beverage from his meal tray without washing her hands. An Interview with the Infection Control Nurse on 6/7/12 at 9:14am revealed the Staff Development Coordinator (SDC) does training with NA ' s and feeding. The NA ' s would not be allowed to eat while feeding residents. An interview with former SDC, Nurse #1 and new SDC on 6/712 at 9:53am revealed NAs were not allowed to eat while in the room with another resident or while feeding a resident. Nurse#1 indicated that for newly hired NA ' s would receive a policy booklet that had information on feeding residents such as eating from resident trays and	F 441		

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F 441	Continued From page 18 eating while feeding residents related to infection control. A record review of the facility infection control policy dated August 2005 indicated that eating and drinking in work areas were reasonable likelihood for potential exposure. An Interview with the Director of Nursing on 6/7/12 at 1:46pm revealed she would not have NA ' s eating while feeding residents. They were trained upon hire not to do this.	F 441		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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	345237	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	

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CONSTRUCTION SECTION

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BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR RD SMITHFIELD, NC 27577

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K 018 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1¾ inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3 Roller latches are prohibited by CMS regulations in all health care facilities. This STANDARD is not met as evidenced by: A. Based on observation on 06/21/2012 the inside door release device for the freezer and the cooler were not operable . One was broken and the other one was blocked by a storage rack.	K 018	**Preface Statement** Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other Administrative or legal proceeding. **K 018** Roller latches were removed from 2 doors with Secure Care Key Pads on 6/25/12. The third roller latch will be removed by August 3, 2012. The broken inside freezer door release device will be replaced by August 3, 2012. The cooler door will not be blocked by storage racks. Dietary staff was re-trained to keep area free of obstacles by Dietary Manager on July 5, 2012.	8-3-12
K 062 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5	K 062	**F062** Contracted Sprinkler Company will complete dry sprinkler flow test on July 11, 2012. Dry sprinkler flow will be no more than 60 seconds. Quarterly and Annual inspections by the outside contractor will monitor compliance.	7-11-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bill Mullinax	Regional VP Operations	7-5-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See Instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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K 062	Continued From page 1 This STANDARD is not met as evidenced by: A. Based on observation on 06/21/2012 the flow test done on 04/27/2011 for the dry sprinkler showed flow in 90 sec. . This time must be no more than sixty (60)sec.	K 062		

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	345237	A. BUILDING 02 - BUILDING 02 B. WING _____	06/21/2012

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K 012 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following. 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/21/2012 the riser room ceiling had unprotected PVC penetrating the ceiling. 42 CFR 483.70 (a)	K 012	**K 012** PVC pipes penetrating the ceiling in the riser room serving 800 wing will be sealed by building contractor by August 3, 2012.	8-3-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bill Mullinax	Regional VP Operations	7-5-12

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K 038 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: A. Based on observation on 06/21/2012 the Exit door across from the smoking area and the door into the smoking area had latching devices that exceeded the maximum of forty-eight (48) inches from the floor. 42 CFR 483.70 (a)	K 038	F 038 The latching device on the exit door across from smoking area on 200 hallway was removed June 25, 2012.	6-25-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Bill Mallard	Regional VP Operations	7-5-12

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