DEPART	MENT OF HEALTH AN	ID HUMAN SERVICES			FORM APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES			OMB NO. 0938-0391
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345237	B. WING		C 04/13/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/13/2010
DADDOU				515 BARBOUR ROAD	
BARBOUI	R COURT NURSING ANL	REHABILITATION CENTER		SMITHFIELD, NC 27577	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 157 SS=D			F 15	7	5/6/16
	consult with the resid known, notify the resi or an interested famil accident involving the injury and has the po- intervention; a signific physical, mental, or p deterioration in health status in either life the clinical complications significantly (i.e., a ne existing form of treath consequences, or to treatment); or a decis				
	and, if known, the res or interested family m change in room or roo specified in §483.150 resident rights under	promptly notify the resident ident's legal representative nember when there is a commate assignment as (e)(2); or a change in Federal or State law or ed in paragraph (b)(1) of			
	the address and phor	rd and periodically update ne number of the resident's or interested family member.			
	This REQUIREMENT	is not met as evidenced			
	Based on observatio and staff interviews, t	n, record review, physician he facility failed to notify the ain for 1 of 3 sampled		Barbour Court Nursing and Rehabilit Center acknowledges receipt of the Statement of Deficiencies and propos	
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	RE	TITLE	(X6) DATE
	cally Signed				04/29/2016

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.

						0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE S COMPL	
			A. BUILDING		С	
		345237	B. WING			
	ROVIDER OR SUPPLIER	040201		STREET ADDRESS, CITY, STATE, ZIP CODE	04/1	3/2016
	NOVIDER OR SUIT LIER			515 BARBOUR ROAD		
BARBOUI	R COURT NURSING AND	REHABILITATION CENTER		SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	LD BE	(X5) COMPLETIO DATE
F 157	Continued From page	e 1	F 15	7		
	residents (Resident # Findings included: The undated Fall Pro	1) reviewed for falls. tocol included steps to call a		this Plan of Correction to the exten the summary of findings is factually correct and in order to maintain compliance with applicable rules ar	,	
	Code Green, to not m Charge Nurse had ma	nove the resident until the ade an assessment and to there was an injury or the		provisions of quality of care of resid The Plan of Correction is submitted written allegation of compliance.	lents.	
	Resident #1 had diag dementia, abnormal i	noses that included nvoluntary movements, and ne most recent Minimum		Barbour Court Nursing and Rehabi Center response to this Statement Deficiencies does not denote agree with the Statement of Deficiencies	of ement	
	Resident #1 had shor problems and had se	t and long term memory		does it constitute an admission tha deficiency is accurate. Further, Bar Court Nursing and Rehabilitation C	t any bour	
	ambulating in the roo indicated the resident	ne-person assistance for m and in the hallways and i's balance was not steady		reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispu-	ute	
	assistance. The MDS #1 was frequently inc not had any falls in at The Care Plan [most			Resolution, formal appeal procedur and/or any other administrative or I proceeding.		
	had an unsteady gait risk for falls. Approac footwear, ambulation	with staff supervision and		1) The physician was notified of Resident #1 complaint of pain post 4/5/16 by Nurse #2. New orders we	ere	
	Care Plan also includ	of urinary tract infections		 received for Norco 5/325mg and to resident to the ER on 4/5/16. 2) On 4/7/2016, 100% of Nurse and Risk Management Reports we 	s notes	
	hours and as needed An incident report dat	ed 4/5/2016 at 7:24 AM, and		reviewed for all residents to include resident #1 from 3/24/16-4/7/16 to all documented acute changes in condition to include pain poet fall b	ensure	
	CNA (Nursing Assista 0420 (4:20 AM), write	#1 included, "Notified by ant #1) that resident fell at er found resident sitting up plaining of) left knee pain.		condition, to include pain post fall h documentation of MD notification b Facility RN Nurse Consultants. All identified areas of concerns were		
		d socks ON. Resident		addressed by the DON with MD		

Facility ID: 923034

If continuation sheet Page 2 of 20

		MEDICAID SERVICES				IO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		E SURVEY
		345237	B. WING			C 4/13/2016
	ROVIDER OR SUPPLIER	0.020		STREET ADDRESS, CITY, STATE, ZIP CO		4/13/2016
	ROVIDER OR SUFFLIER				JDE	
BARBOUR	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI	ON SHOULD BE	(X5) COMPLETIC DATE
				DEFICIENC'	Y)	
F 157	Continued From page	e 2	F 15	7		
				notification on 4/8/16.		
		mands to stretch her leg, or ROM (range of motion)		3) 100% In-servicing to lic	anead nurses	
				to include Nurse #2, and Nu		
		npliant, No swelling noted ort included, "Resident		initiated on 4/8/2016 regard		
	-			notification for acute change		
		ain, X-ray ordered results in." esident was maintained in		to include pain post fall via		
		he lowest position and a bed		communication book by the		
		The vital signs included blood		-	Director or	
		se 84, respirations 16 and		Nursing/RN Supervisor/QI Nurse/Resource Nurse. All	nowly bired	
		-		employees will be in service		
	temperature was 98.	-				
		led a Progress Note dated		physician notification for act	-	
	4/5/2016 at 7:43 AM which included, "Resident fell in her room at 0420 (4:20 AM) while			condition to include pain po		
		who was in the room with		phone, not the communicat during the orientation proce		
		on her left side. Resident		Facilitator, ADON or DON.	iss by Stall	
	was C/O left knee pa			4) Nurses Notes and Risk	Managamont	
		sitive outcome, X-ray done		Reports will be reviewed for	-	
	results in No acute be			to include resident #1, 3 tim		
		dicated the Responsible		$X \square s$ 4 weeks, then weekly Z		
	Party (RP) had been	-		and then monthly X□s 1 mc		
		via consult book." The note		that the MD was notified tim		
	was signed by Nurse			changes in condition to incl	•	
		ated 4/5/2016, revealed an		fall using the QI Tool for Phy		
		of Resident #1's left knee. It		Notification by the RN Supe		
	revealed no fracture			Nurse or MDS Nurse. Any o		
		sident #1 's medical record		be addressed immediately		
		Progress Notes on 4/5/2016		reeducation of the license n		
		7-3 shift, Nurse #2. The		notification to the MD by RN		
		esident was given Tylenol at		QI Nurse or MDS Nurse. Th		
		ints of upper thigh and hip		review and initial the QI Toc		
		s seen by the attending		Notification weekly for 8 we	•	
		ed Norco5/325mg for the		monthly for 1 month for con		
		t was sent out to the hospital		ensure all areas of concern		
	-	he Norco at 1:30 PM.		addressed.		
	-	0:00 PM, on 4/5/2016 by		5) The DON will forward t	he Results of	
	-	ident #1 had been admitted		the QI Tool for Physician No		
		fracture to her left hip.		the Executive QI committee		
	-	al Radiology Report (dated		months to determine trends	-	
						1

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	S FOR MEDICARE &					0.0938-03
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	E CONSTRUCTION		E SURVEY PLETED
			A. BUILDING			С
		345237	B. WING		04	/13/2016
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP COD		
				515 BARBOUR ROAD		
BARBOUR	R COURT NURSING AND	OREHABILITATION CENTER		SMITHFIELD, NC 27577		
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO		(X5)
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)		COMPLETIO
F 157	Continued From page	e 3	F 15	7		
	minimally displaced l	eft femoral neck fracture.		place and to determine that n	eed for	
		An investigation was conducted by the facility		further and/or frequency of me		
	which included written statements from several staff members who worked on 4/5/2016. A statement from Nursing Assistant (NA) #1 on					
		he was the staff member				
		room when Resident #1 had				
	fallen. It indicated she had entered the resident's room to take her to the bathroom. The statement also included, "Once she was standing I took her					
		bk her with me to the closet to				
		nt brief) to put on her once				
		oom on the toilet." The NA's				
		et go of the resident's hand to				
	get the incontinent br	ief and when, "I turned back				
	around she (the resid	lent) had started walking				
		d she turned too quick and				
		Idn't catch her in time to stop				
		nent also said, "I got her up				
		he bed. She was complaining				
	-	tatement indicated the				
	nurse was called to the	back to the bed and then the				
		ed on 4/11/2016 at 4:18 PM.				
		s supposed to take the				
		oom every 2 hours. NA # 1				
		and got her to sit on the side				
	of the bed to make su	ure she was awake before				
	· ·	reiterated that she had				
		the closet and let go of the				
		t an incontinent brief from				
		aid she turned around to find				
	the resident had started to walk away and when the NA said the resident's name, the resident					
		ice and fell to the floor onto				
		aid, "We are supposed to				
	allow the nurse to ch	eck (the resident). I wasn't				
		eck (the resident). I wasn't just was thinking she was on				

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		ID HUMAN SERVICES MEDICAID SERVICES				FOF	D: 05/04/2016 MAPPROVED O. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DAT	E SURVEY IPLETED
		345237	B. WING			04	C I/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
				5'	15 BARBOUR ROAD		
BARBOUH	COURT NURSING AND	REHABILITATION CENTER		s	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETION DATE
F 157	so good." Nurse #1's statement 4/8/2016. The statement the resident's room I on the bed." In the st asked NA #1 why a c called but the NA did asked her how the re- the bed, (NA #1) state ambulated back to the The statement indicat the resident "from her was able to move her right leg but was not a The nurse instructed move the resident fro notice. The statemen supervisor (11-7 shift her Resident #1 had left knee pain. The st supervisor had asked been called and "I ex moved the resident fro the resident had amb was c/o left knee pain supervisor whether I for left knee x-ray. Su we are covered with i The statement said N standing orders, give pain, and called for a the x-ray was done a	the bed. She wasn't walking a was taken by the facility on bent included, "Upon entering found [the] resident sitting tatement Nurse #1 said she ode green had not been not respond. "Secondly I sident got from the floor to ed that the resident e bed without assistance." ted the nurse had examined ad to toe" and the resident r upper extremities and her able to move the left leg. the nursing assistants to not im the bed until further t said Nurse #1 called the Resource Nurse), informed fallen and had complained of atement indicated the d why a code green had not kplained that the aide had rom the floor to the bed and ulated back to the bed and ulated back to the bed and the resident Tylenol for n x-ray. The RP was notified, nd the results were put in the , "a consult form was filled to	F	157			
	PM. Nurse #1 said sh room and found her s	ewed on 4/12/2016 at 12:26 ne entered Resident #1's sitting on the side of the bed. the resident had fallen and					

Facility ID: 923034

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	· · · ·	
AND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COM	PLETED
		345237	B. WING		04	C / 13/2016
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 •	
BARBOUI	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETIO DATE
F 157	Continued From page	5	F 157			
	gotten back to the bed resident was able to a the bed. Nurse #1 sai about how she got off how she was able to a Nurse #1 said she chu head and ROM and th of knee pain. When a exam had taken place the side of the bed, an the resident to lie dow asymmetry, nor had s or redness on the leg. the resident some me ordered an x-ray to he signs were obtained. had been notified or a x-ray from the on-call indicated her method in the physician's corr stated she had not ca or the on-call physicia The 11-7 Resource N interviewed on 4/12/2 indicated, as Resource her role to assist the o and that she also had She stated that when was to call a Code Gr immediately and asse resident or ask if the p the Resource Nurse s (Nurse#1) needed he	of notification was to write it munication book. She lled the attending physician in. urse on 4/5/2016 was 016 at 8:30 AM. She we Nurse on night shift it was other nurses as necessary a unit of residents herself. a resident fell, the Protocol een so staff would respond ess for injury to see if the oved. The Fall Protocol also physician as necessary. d gone to assess the ohysician had been notified,				

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	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 05/04/20 FORM APPROVE OMB NO. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	CONSTRUCTION	(X3) DATE SURVEY COMPLETED C
		345237	B. WING		04/13/2016
	ROVIDER OR SUPPLIER	REHABILITATION CENTER	5	TREET ADDRESS, CITY, STATE, ZIP CODE 15 BARBOUR ROAD MITHFIELD, NC 27577	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 157 F 309 SS=D	10:00 AM, while bein physician, the Medica complain of pain and The Medical Director 4/12/2016 at 10:07 A injury with a fall then there is a suspected to be notified." During an interview of Administrator and DC expectation that a res be assessed while sti was pain or suspecte be notified. They both the on-call physician on 4/5/2016, immedia assessment. 483.25 PROVIDE CA HIGHEST WELL BEI Each resident must re provide the necessar or maintain the highe mental, and psychoso	erved in bed on 4/12/2016 at g examined by her attending al Director. She did not appeared comfortable. was interviewed on M. He stated, "If there is no we have a protocol but if injury or pain I would expect n 4/12/2016 at 5:58 PM, the DN indicated it was their sident who had fallen would ill on the floor and if there d injury the physician should n indicated for Resident #1, should have been contacted ately after the nurse's ARE/SERVICES FOR NG ecceive and the facility must y care and services to attain st practicable physical,	F 157		5/6/16
	by: Based on observatio and staff interviews, t an assessment at the it was safe for the res	is not met as evidenced n, record review, physician the facility failed to conduct time of a fall to determine if sident to ambulate, and failed ity Fall Protocol regarding for 1 of 3 residents		 The Physician assessed resident # post fall on 4/5/16 with new orders for Norco 5/325 mg and to send resident to the ER. 100% of Nurse □s notes and Risk Management Reports were reviewed fr 	

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CENTER	S FOR MEDICARE &	MEDICAID SERVICES					DRM APPROVE NO. 0938-03
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		ONSTRUCTION	· /	ATE SURVEY DMPLETED
		345237	B. WING				C 04/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				515	BARBOUR ROAD		
BARBOUR	R COURT NURSING AND	REHABILITATION CENTER		SM	ITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETIC DATE
F 309	Continued From page	7 د	F 30	na			
	Code Green, to not m Charge Nurse had ma notify the physician if resident complained of Resident #1 had diag dementia, abnormal i	tocol included steps to call a nove the resident until the ade an assessment and to there was an injury or the of pain.			3/24/16-4/7/16 to identify all residen had a fall to include Resident #1 to e that an assessment was conducted time of the fall and the fall protocol regarding assessment and pain was followed. This audit was completed Facility Consultants, on 4/7/2016. A identified areas of concerns were addressed by the DON by assessing resident to assure no acute changes	ensure at the by the ll g the s to	
	Data Set (MDS) date Resident #1 had shor problems and had se decision-making skills coded as requiring or ambulating in the roo indicated the resident	d 2/7/2016, revealed t and long term memory verely impaired s. The resident was also ne-person assistance for m and in the hallways and t's balance was not steady	Int Minimuminclude pain were observed by 4/16/1evealed3) 100% In-servicing was initiated ofrm memory4/8/2016 with all licensed nurses by theedDirector of Nursing/RNnt was alsoSupervisor/Resource Nurse/QI Nursesistance forregarding the fall protocol to includehallways andconducting a full head to toe assessmantas not steadyat the time of a fall to include full ROM	on the se sment DM,			
	assistance. The MDS #1 was frequently inc not had any falls in at The Care Plan [most 2/19/16] for Resident	#1 indicated the resident , lack of strength and was at			swelling, asymmetry, notifying the M phone of any findings from the assessment not the communication not moving or ambulating the reside sign and symptoms of a fracture to include pain are observed during the assessment, and calling code green	1D via book, ent if e	
	footwear, ambulation hand-held physical as Care Plan also includ and risk of urinary tra approaches that inclu and containment prog	with staff supervision and ssistance as necessary. The e a problem of incontinence			falls (code used to notify staff of a ref fall in the facility). All CNAs were in serviced regarding calling code gree falls, not to move or ambulate a resi post fall until the license nurse has performed a full head to toe assess	esident en for dent ment	
	completed by Nurse # CNA (Nursing Assista 0420 (4:20 AM), write on the bed C/O (com	ted 4/5/2016 at 7:24 AM, and #1 included, "Notified by ant #1) that resident fell at er found resident sitting up plaining of) left knee pain. d socks ON. Resident			to ensure the resident is able to safe ambulate, and notification to the nur any resident complaints of pain to in post fall. All newly hired license nur will be educated regarding conductin full head to toe assessment at the ti a fall to include full ROM, pain, obse	rse for include rses ng a me of	

Facility ID: 923034

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		ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 05/04/2010 M APPROVEI D. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345237	B. WING				C / 13/2016
NAME OF P	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BARBOU	R COURT NURSING AND	REHABILITATION CENTER			I5 BARBOUR ROAD MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 309	writer tried to check for resident was non-com Skin intact." The repu- medicated for C/O par It also indicated the m bed with the bed in the alarm was in place. T pressure 148/80, pulse temperature was 98. Record review reveal 4/5/2016 at 7:43 AM, fell in her room at 042 ambulating, per staff resident, resident fell was C/O left knee par administered with pos- results in No acute bo Progress note also in Party (RP) had been (Physician) consulted was signed by Nurse A Radiology report da x-ray had been taken revealed no fracture of Later Progress Notes by the 7-3 shift, Nurse the RP had arrived at the resident was give complaints of upper t of the pain, Nurse #2 suggested to the RP that Resident #1 be s evaluation. Resident attending physician, w for the pain, and the phospital after she was PM.	mands to stretch her leg, or ROM (range of motion) npliant, No swelling noted ort included, "Resident in, X-ray ordered results in." esident was maintained in the lowest position and a bed the vital signs included blood as 84, respirations 16 and 1 degrees. ed a Progress Note dated which included, "Resident 20 (4:20 AM) while who was in the room with on her left side. Resident in, Pain medication sitive outcome, X-ray done one pathology." The dicated the Responsible notified and, "MD I via consult book." The note #1. ated 4/5/2016, revealed an of Resident #1's left knee. It of the left knee. is on 4/5/2016 were entered e #2. The notes indicated is the facility at 7:50 AM, and n Tylenol at 10:30 AM for high and hip pain. Because documented that she had twice during the morning then to the hospital for further	F	309	 for bruising, redness, swelling, asymmetry, notifying the MD via phofindings from the assessment not the communication book, not moving or ambulating the resident if sign and symptoms of fracture to include pain observed during the assessment, and calling code green for falls in the orientation process by Staff Facilitate DON or ADON. All newly hired CNAss be in serviced regarding calling code green for falls, not to move or ambulate resident post fall until the license nur has performed a full head to toe assessment to ensure the resident is to safely ambulate, and notification to nurse for any resident complaints of to include post fall during orientation Staff Facilitator, ADON, DON. 4) Nurses Notes and Risk Manager Reports will be reviewed for all residet to include resident #1, 3 times per we X ≤ 4 weeks, then weekly X ≤ 4 we and then monthly X ≤ 1 month to ide all residents who had a fall to include Resident #1 to ensure that an assess was conducted at the time of the fall the fall protocol regarding assessment and pain was followed using the QI T for Falls by the QI Nurse or MDS Nur Any identified areas of concerns will addressed immediately with an assessment of the resident and reeducation of the staff member by th Nurse or MDS nurse. The DON will r and initial the QI Tool for Fall Protocol weekly for 8 weeks the monthly for 1 month for completion and to ensure a substance of the staff member by the completion and to ensure and the substance of the staff member by the completion and to ensure a substance of the staff member by the completion and to ensure and the substance of the staff member by the completion and to ensure and to ensure and the substance of the staff member by the completion and to ensure and to ensure and the completion and to ensure and to ensure and to ensure and to ensure and the substance of the staff member by the completion and to ensure and to ensure and the substance of the staff member by the completion and to ensure and to ensure and to ensure and to ensu	are d rr, will ate a se able o the pain by ment ents eek eks entify sment and nt ool se. be me QI eview	

Facility ID: 923034

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	OF DEFICIENCIES	MEDICAID SERVICES	(X2) MULTIP	LE CONSTRUCTION	OMB NO. 0938 (X3) DATE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· ,		COMPLETED
					С
		345237	B. WING		04/13/201
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
BARBOUR		REHABILITATION CENTER		515 BARBOUR ROAD	
BANDOOI		REHABIENATION GENTER		SMITHFIELD, NC 27577	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE AP DEFICIENCY)	HOULD BE COMPL
F 309	Continued From page	e 9	F 30	9	
		ident #1 had been admitted		areas of concern were addresse	ed.
	to the hospital with a fracture to her left hip.				
		al Radiology Report (dated		5) The DON will forward the R	
	,	esident #1 had sustained a		the QI Tool for Fall Protocol to th Executive QI committee monthly	-
		eft femoral neck fracture. conducted by the facility		months to determine trends and	
	•	n statements from several		that may need further interventio	
	staff members who w			place and to determine that nee	-
		rsing Assistant (NA) #1 on		further and/or frequency of moni	
		he was the staff member			-
		room when Resident #1 had			
		e had entered the resident's			
		e bathroom. The NA had side of the bed, "making			
		p and that she had on her			
		e statement also included,			
		ling I took her by the hand			
		to the closet to get her (an			
	<i>, , ,</i>	ut on her once she was in			
		toilet." The NA's statement			
	-	resident's hand to get the			
		when "I turned back around d started walking back			
		turned too quick and fell on			
		atch her in time to stop her			
		also said, "I got her up			
		e bed. She was complaining			
	-	statement indicated the			
		back to the bed and then the			
	nurse was called to the				
		ed on 4/11/2016 at 4:18 PM. s supposed to take the			
		oom every 2 hours. NA # 1			
		and got her to sit on the side			
		ure she was awake before			
	-	reiterated that she had			
		the closet and let go of the			
		t an incontinent brief from			
	the closet The NA se	aid she turned around to find			

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	S FOR MEDICARE &	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTII	PLE CONSTRUCTION		O. 0938-039
	CORRECTION	IDENTIFICATION NUMBER:		G	. ,	IPLETED
						С
		345237	B. WING		04	4/13/2016
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE	
BARBOUF	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD SMITHFIELD, NC 27577		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	-	AN OF CORRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIN CROSS-REFERENCE	/E ACTION SHOULD BE ED TO THE APPROPRIATE ICIENCY)	COMPLETIO
F 309	Continued From page	e 10	F 3	09		
		ted to walk away and when				
		ent's name, the resident				
		ice and fell to the floor onto				
		aid, "We are supposed to				
		eck (the resident). I wasn't				
	thinking about that. I	just was thinking she was on				
	the floor. So I picked	her up off the floor and				
		e bed. She wasn't walking				
	so good."					
		t was taken by the facility on				
		ent included, "Upon entering				
		found [the] resident sitting				
		tatement Nurse #1 said she ode green had not been				
		not respond. "Secondly I				
		sident got from the floor to				
	the bed, (NA #1) state	-				
	,	e bed without assistance."				
	The statement indica	ted the nurse had examined				
	the resident "from he	ad to toe" and the resident				
	was able to move her	r upper extremities and her				
		able to move the left leg.				
		the nursing assistants to not				
		m the bed until further				
		t said Nurse #1 called the				
		Resource Nurse), informed fallen and had complained of				
		atement indicated the				
		why a code green had not				
		kplained that the aide had				
		om the floor to the bed and				
		ulated back to the bed and				
	was c/o left knee pair	n." It also said, "I asked the				
	-	need to call the on-call MD				
		pervisor stated no and that				
		initiating the standing order."				
	The statement said N	lurse #1 had initiated the				
		n the resident Tylenol for				

Facility ID: 923034

If continuation sheet Page 11 of 20

		MEDICAID SERVICES		LE CONSTRUCTION		<u>D. 0938-03</u> E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	· · /			PLETED
			A. BOILDING			С
		345237	B. WING			
	ROVIDER OR SUPPLIER	545257		STREET ADDRESS, CITY, STATE, ZIP CO		/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			515 BARBOUR ROAD	JDE	
BARBOUR	R COURT NURSING AND	REHABILITATION CENTER		SMITHFIELD, NC 27577		
						0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETIO DATE
F 309	Continued From page	e 11	F 30	a		
			1 30			
		nd the results were put in the "a consult form was filled to				
	MD to (follow-up) and					
		ewed on 4/12/2016 at 12:26				
	PM. Nurse #1 said sh	ne entered Resident #1's				
	room and found her	sitting on the side of the bed.				
		the resident had fallen and				
	when asked by Nurse	e #1 how the resident had				
	gotten back to the be	d, the NA had said the				
		ambulate from the floor to				
		id, "I didn't get into details				
	-	f the floor. My concern was				
		ambulate back to her bed."				
		ecked the resident's face,				
		hat the resident complained				
		asked, Nurse #1 said the				
		e while the resident sat on Ind the nurse had not asked				
		wn on the bed to assess for				
		she looked for any bruising				
		J. Nurse #1 said she gave				
	-	edication for the pain and				
		er left knee, and a set of vital				
	-	When asked if the physician				
	-	an order obtained for the				
	x-ray from the on-cal	l physician, Nurse #1				
	indicated her method	of notification was to write it				
	in the physician's cor	nmunication book. Nurse #1				
		t called for a verbal order for				
	-	ed the supervisor right after				
		d and, "She advised me that				
		nding order to give her				
		nd to order the x-rays."				
		ne Physician's Standing				
		he front of the Medication				
		and on the computer. Nurse				
	TTI COLO COO DOD TOVIO		1	1		
		ewed the Standing Order had not looked for the				

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		MEDICAID SERVICES	(X2) MULTIPLE CONSTRUCTION			OMB NO. 0938-0	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		· · ·	E SURVEY	
			A. BUILDING	·		с	
		0.45007					
		345237	B. WING			4/13/2016	
NAME OF PF	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	DE		
BARBOUR	COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD			
				SMITHFIELD, NC 27577			
(X4) ID		ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)	
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	E APPROPRIATE	COMPLETIO DATE	
F 309	Continued From page	e 12	F 30	9			
		lurse on 4/5/2016 was					
	interviewed on 4/12/2						
		ce Nurse on night shift it was					
		other nurses as necessary					
		a unit of residents herself.					
	She stated that when	a resident fell, the Protocol					
		reen so staff would respond					
		ess for injury to see if the					
	resident should be m	oved. The Fall Protocol also					
	included notifying the	Responsible Party and the					
		urce Nurse stated Nurse #1					
	had called her a little	after 5AM to tell her					
	Resident #1 had falle	n. "I asked why a Code					
	Green had not been	called and she said they					
	were already getting	her up." When asked if she					
	had gone to assess t	he resident or ask if the					
	physician had been n	otified, the Resource Nurse					
	stated she had not go	one to assess the resident					
		urse #1 if the physician had					
		ource Nurse said, "I asked if					
	she needed help and						
		urce Nurse said Nurse #1					
		s the NA who had ambulated					
		source Nurse also said, "She					
		out standing orders for the					
		a standing order for x-ray."					
		ng (DON) was interviewed					
		AM. She indicated she had					
		the fall when she arrived in					
	-	00 AM but had not examined					
		N said, "I do remember that					
		e resident out a couple of					
		the RP wanted to wait and					
		o have lunch. When asked,					
		ad not followed the Fall					
	Protocol.						
		erved in bed on 4/12/2016 at g examined by her attending					

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	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MULTIPLE	CONSTRUCTION	OMB NO. 0938-03 (X3) DATE SURVEY
ID PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	. ,		COMPLETED
		345237	B. WING		04/13/2016
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
BARBOU	R COURT NURSING AND	D REHABILITATION CENTER	-	15 BARBOUR ROAD MITHFIELD, NC 27577	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 309	Continued From page	e 13	F 309		
F 510 SS=D	The Medical Director 4/12/2016 at 10:07 A was a fall with susper expect to be notified supervisor to have ex- resident, and have a can make a determin said, "We need to ma to do a thorough asse During an interview of Administrator and DO expectation that when code green would be would be done while floor. 483.75(k)(2)(i) RADIO ONLY WHEN ORDER	M. He stated that if there cted injury or pain, he would and said, "I expect the kamined and assessed the set of vitals also, so that I hation." The Medical Director ake sure the nurses get there essment." on 4/12/2016 at 5:58 PM, the DN indicated it was their n a resident had a fall, a called and an assessment the resident was still on the DLOGY/DIAGNOSTIC SVCS RED vide or obtain radiology and ices only when ordered by	F 510		5/6/16
	by: Based on observation and staff interviews, to order from the physic for 1 of 4 residents (F physician orders. Findings included: Resident #1 had diag dementia, abnormal in	involuntary movements, and he most recent Minimum		 The Physician assessed resident # post fall on 4/5/16 with new orders for Norco 5/325 mg and to send resident to the ER. 100% audit of all resident □s to include resident #1, diagnostic tests, to include x-rays, from 3/24/16 to 4/7/16, was completed by the Facility Consulta on 4/8/16 to ensure an order was obtain from the physician prior to obtaining the diagnostic test. All identified areas of 	nt ned

Event ID: 2DPN11

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		MEDICAID SERVICES			OMB NO. 093	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURV COMPLETED	
			A. BUILDING	<u> </u>		
		245927	B. WING		C	
		345237	B. WING		04/13/20)16
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	PCODE	
BARBOUI	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD		
	1			SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE COM TO THE APPROPRIATE	(X5) IPLETIO DATE
F 510	Continued From page	e 14	F 51	0		
	problems and had se			notification of the diagno	ostic test by the	
		s. The resident was also		DON on 4/8/16.		
	-	ne-person assistance for		3) 100% in servicing w	as initiated with all	
		m and in the hallways and		licensed nurses on 4/8/1		
		t's balance was not steady		standing orders, and ens		
		to stabilize without human		physician order is in place		
		further indicated Resident		obtaining any diagnostic		
		ontinent of bladder and had		x-rays by the DON/RN S		
		least the last 3 months.		nurse/Resource nurse. A	-	
	The Care Plan [most			license nurses will be ed		
	-	#1 indicated the resident		standing orders, and engoing physician order is in place		
	risk for falls. Approac	, lack of strength and was at		obtaining any diagnostic		
		with staff supervision and		x-rays in the orientation		
		ssistance as necessary. The		Facilitator, ADON or DO		
		le a problem of incontinence		 4) Physicians orders a 		
	and risk of urinary tra	-		testing manifest will be r		
	-	ided toileting assistance,		residents to include resid	dent #1 using the	
	and containment prog	gram every two hours and as		QI Tool for monitoring dia	agnostic test, 3	
	needed.			times per week X⊡s 4 w	eeks, then weekly	
	An incident report dat	ted 4/5/2016 at 7:24 AM, and		x 4 weeks and then mon	thly X⊡s 1 month	
		#1 included, "Notified by		to ensure a physician or		
		ant #1) that resident fell at		prior to obtaining the dia		
		er found resident sitting up		QI Nurse or MDS Nurse	-	
		plaining of) left knee pain.		will be addressed immed	-	
		d socks ON. Resident		notification and reeducation		
		mands to stretch her leg, or ROM (range of motion)		nurse regarding obtainin test without a physician		
		npliant, No swelling noted		Nurse or MDS Nurse. Th		
		ort included, "Resident		review and initial the QI		
		in, X-ray ordered results in."		monitoring diagnostic tes		
		esident was maintained in		weeks the monthly for 1		
		le lowest position and a bed		completion and to ensur		
		he vital signs included blood		concern were addressed		
	-	se 84, respirations 16 and				
	temperature was 98.2	-		5) The DON will forwa	rd the Results of	
		ed a Progress Note dated		the QI Tool for monitorin		
		which included, "Resident		to the Executive QI com	-	
	fell in her room at 042			months to determine tree		

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPL	E CONSTRUCTION	(X3) DATE		
AND PLAN OI	FCORRECTION	IDENTIFICATION NUMBER:	A. BUILDING		COMP		
		345237	B. WING		C 04/13/2016		
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	04/	13/2010	
BARBOU	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHOL CROSS-REFERENCED TO THE APPR DEFICIENCY)	JLD BE	(X5) COMPLETIO DATE	
F 510	ambulating, per staff resident, resident fell was C/O left knee pai administered with pos results in No acute bo Progress note also in Party (RP) had been (Physician) consulted was signed by Nurse A Radiology report da x-ray had been taken revealed no fracture of Later Progress Notes by the 7-3 shift, Nurse the RP had arrived at the resident was give complaints of upper ti #1 was seen by the a ordered Norco5/325n resident was sent out was given the Norco A Progress Note at 10 Nurse #3, stated Res to the hospital with a Review of the hospita 4/5/2016) revealed R minimally displaced le An investigation was which included written staff members who w A statement from Nur 4/6/2016, indicated she room to take her to the the resident sit on the	who was in the room with on her left side. Resident in, Pain medication sitive outcome, X-ray done one pathology." The dicated the Responsible notified and, "MD Via consult book." The note #1. ated 4/5/2016, revealed an of Resident #1's left knee. It of the left knee. on 4/5/2016 were entered #2. The notes indicated the facility at 7:50 AM, and n Tylenol at 10:30 AM for high and hip pain. Resident ttending physician, who ng for the pain, and the to the hospital after she at 1:30 PM. 0:00 PM, on 4/5/2016 by ident #1 had been admitted fracture to her left hip. I Radiology Report (dated esident #1 had sustained a eft femoral neck fracture. conducted by the facility n statements from several	F 510		or		

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	OF DEFICIENCIES	MEDICAID SERVICES		PLE CONSTRUCTION		10. 0938-03 FE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	` '		· · ·	MPLETED
						С
		345237	B. WING		0	4/13/2016
NAME OF P	ROVIDER OR SUPPLIER		•	STREET ADDRESS, CITY, STATE, ZIP C	CODE	
BARBOUI	R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD SMITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO 1 DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 510	Continued From page	e 16	F 5	10		
		to the closet to get her (an				
		but on her once she was in				
	, ,	toilet." The NA's statement				
		resident's hand to get the				
	-	when "I turned back around				
	she (the resident) had	d started walking back				
	towards her bed she	turned too quick and fell on				
		tch her in time to stop her				
		also said, "I got her up				
		he bed. She was complaining				
	•	statement indicated the				
		back to the bed and then the				
	nurse was called to the					
		ed on 4/11/2016 at 4:18 PM. supposed to allow the nurse				
		t). I wasn't thinking about				
		ng she was on the floor. So I				
	-	floor and walked her back to				
	the bed. She wasn't v					
		t was taken by the facility on				
		nent included, "Upon entering				
	the resident's room I	found [the] resident sitting				
		tatement Nurse #1 said she				
	-	ode green had not been				
		not respond. "Secondly I				
		sident got from the floor to				
	the bed, (NA #1) state					
		e bed without assistance."				
		ted the nurse had examined ad to toe" and the resident				
		r upper extremities and her				
		able to move the left leg.				
		the nursing assistants to not				
		om the bed until further				
		t said Nurse #1 called the				
		Resource Nurse), informed				
		fallen and had complained of				
	left knee pain. The st	-				
	explained that the aid	le had moved the resident				

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	S FOR MEDICARE &						NO. 0938-03	
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		INSTRUCTION	· · ·	TE SURVEY MPLETED	
			A. BUILDI	NG			С	
		345237	B. WING					
		545237	D. WING_				4/13/2016	
NAME OF PI	ROVIDER OR SUPPLIER				ET ADDRESS, CITY, STATE, ZIP CODE	1		
BARBOUF	R COURT NURSING AND	REHABILITATION CENTER			BARBOUR ROAD			
				SMI	THFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIC DATE	
F 510	Continued From page	e 17	E !	510				
		ed and the resident had						
		e bed and the resident had						
	pain." It also said, "I a							
	•	the on-call MD for left knee						
		ed no and that we are						
		the standing order." The						
	statement said Nurse							
		n the resident Tylenol for						
		n x-ray. The RP was notified,						
		nd the results were put in the						
	-	"a consult form was filled to						
	MD to (follow-up) and							
		ewed on 4/12/2016 at 12:26						
		ne entered Resident #1's						
		sitting on the side of the bed.						
		the resident had fallen and						
		#1 how the resident had						
	-	d, the NA had said the						
	•	ambulate from the floor to						
		id, "I didn't get into details						
		f the floor. My concern was						
	-	ambulate back to her bed."						
		ecked the resident's face,						
		hat the resident complained						
	of knee pain. When a	sked, Nurse #1 said the						
	exam had taken place	e while the resident sat on						
	the side of the bed, a	nd the nurse had not asked						
	the resident to lie dov	vn on the bed to assess for						
		she looked for any bruising						
		. Nurse #1 said she gave						
		edication for the pain and						
	•	er left knee, and a set of vital						
	-	When asked if the physician						
		an order obtained for the						
	x-ray from the on-call							
		of notification was to write it						
	the Alexandra in the second at a second		1				1	
		nmunication book. Nurse #1 t called for a verbal order for						

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/04/2016 / APPROVED). 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345237	B. WING				C 13/2016
NAME OF P	ROVIDER OR SUPPLIER	I		ST	REET ADDRESS, CITY, STATE, ZIP CODE		
BARBOUI	R COURT NURSING AND	REHABILITATION CENTER	515 BARBOUR ROAD		5 BARBOUR ROAD		
				SN	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 510	ROVIDER OR SUPPLIER R COURT NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	510			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM): 05/04/2016 APPROVED). 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		LETED
		345237	B. WING			C 04/13/2016	
NAME OF P	ROVIDER OR SUPPLIER		STREET ADDRESS, CITY, STATE, Z		TREET ADDRESS, CITY, STATE, ZIP CODE	1 0.	10.2010
BARBOU	R COURT NURSING AND	REHABILITATION CENTER			15 BARBOUR ROAD MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 510	should be ordering te During an interview o Administrator and DC expectation that if the		F	510			

Facility ID: 923034

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