PRINTED: 10/12/2021 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:		TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345237	B. WING _			C 09/09/2021	
	ROVIDER OR SUPPLIER R COURT NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, Z 515 BARBOUR ROAD SMITHFIELD, NC 27577	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED DEFICI	ACTION SHOULD BE TO THE APPROPRIAT	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS	;	F	000			
		ation survey was conducted h 09/09/21. Event ID#					
	10 of the 30 complair substantiated resulting						
F 550 SS=D	Resident Rights/Exer CFR(s): 483.10(a)(1)	-	F t	550		10/7/21	
	self-determination, ar	Rights. ght to a dignified existence, nd communication with and nd services inside and cluding those specified in					
	with respect and dign resident in a manner promotes maintenand	and in an environment that be or enhancement of his or ognizing each resident's lity must protect and					
	access to quality care severity of condition, must establish and m practices regarding tr	cility must provide equal e regardless of diagnosis, or payment source. A facility laintain identical policies and ransfer, discharge, and the under the State plan for all of payment source.					
		right to exercise his or her fthe facility and as a citizen					
ABORATORY	 DIRECTOR'S OR PROVIDER/:	SUPPLIER REPRESENTATIVE'S SIGNATU	RE	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE

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.

Electronically Signed

09/27/2021

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345237	B. WING		C 09/09/2021
NAME OF P	ROVIDER OR SUPPLIER	0.020		STREET ADDRESS, CITY, STATE, ZIP CODE	09/09/2021
				515 BARBOUR ROAD	
BARBOUF	R COURT NURSING AND	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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 550	Continued From page	e 1	F 550		
	resident can exercise	cility must ensure that the his or her rights without h, discrimination, or reprisal			
	free of interference, or reprisal from the facility rights and to be supplexercise of his or her subpart. This REQUIREMENT by: Based on observation interviews, and record treat residents in a dight the door open and the position while he was resident's exposed by hall (Resident #10) at which resulted in sleet	sident has the right to be oercion, discrimination, and ty in exercising his or her orted by the facility in the rights as required under this is not met as evidenced ans, staff and resident direview the facility failed to gnified manner by leaving a privacy curtain in the open undressed resulting in the ody being visible from the and by the use of profanity of disturbances (Resident 3 of 4 residents reviewed for		Barbour Court Nursing and Rehabilitat Center acknowledges receipt of the Statement of Deficiencies and propose 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 resident The Plan of Correction is submitted as written allegation of compliance. Barbour Court Nursing and Rehabilitati	s ut s. a
	1.Resident #10 was r 8/14/2021 with diagnounspecified demential disturbances. The Minimum Data S revealed Resident #1 required extensive as no behaviors, and was bowel and bladder. A continuous observa	et (MDS) dated 8/20/2021 0 was cognitively intact. He sistance with dressing, had s always incontinent of		Center response to this Statement of Deficiencies does not denote agreeme with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Barbou Court Nursing and Rehabilitation Centereserves 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 lega proceeding.	nt y r er
		of Resident #10 's room on		F550 Resident Rights/Exercise of Righ	ts

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BUILDI	NG _		Ι,	•	
		345237	B. WING				09/2021	
NAME OF P	ROVIDER OR SUPPLIER	•	•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	-		
DADDOU	S COURT NUIDOING AN	UD DELLA DIL ITATION OFNITED		5′	15 BARBOUR ROAD			
BARBOU	R COURT NURSING AF	ND REHABILITATION CENTER		s	MITHFIELD, NC 27577			
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	,	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 550	Continued From pa	ne 2	F	550				
	· ·	-		000				
		ne was laying on the bed on ocovering, adult brief, or			On 9/9/21, the Unit Manager assisted			
	_	d was positioned near the			resident #10 with donning clothes and			
		lent #14 was sitting on the			pulled privacy curtain to provide privacy	,		
	•	and faced the front of			for resident.	<i>'</i>		
		dy. The back of Resident #10 '			10.100.00.11			
		d from the shoulders down to			On 9/23/21, the Unit Managers comple	ted		
		visible through the opened			an audit of all residents to ensure			
	door. Nurse Aide (N	IA) #7 and Laundry worker #1			residents were dressed appropriately			
	were observed to p	ass by Resident #10 ' s open			and/or provided privacy when dressing	or		
	door while he was ι	uncovered and exposed.			during care. The hall nurse, Unit			
	On 0/0/2021 at 0:46	3 am an interview and			Managers and/or nursing assistant will address all concerns/preferences			
		dent #10 were conducted with			identified during the audit to include			
		irmed Resident #10 ' s			pulling privacy curtain, closing			
		s visible from the hallway			doors/blinds or assisting residents with			
		oor. NA #7 then closed the			care as indicated.			
		uring the interview NA #7						
		would not keep his clothing			On 9/27/21, the Unit managers initiated	t		
	on. She said he has	s been taking his clothing off			100% resident care interactions with al	ı		
	for months. NA #7 s	said she normally closed his			nurses, nursing assistants (NA) to inclu	ıde		
	door or pulled the c	urtain, and she did not know			NA # 1 and #7, therapy staff,			
	why the curtain was	s not pulled or door closed.			housekeeping/laundry staff to include			
					laundry aide #1, accounts receivable,			
		with Nurse #3 on 9/9/2021 at			accounts payable, social worker, dietar	-		
		Resident #10 took his			staff, medical records, maintenance sta			
		tly. She stated it was not a			Human Resource Coordinator, Admiss	ion		
		day that he disrobed. Nurse #3			Coordinator and activity staff. This			
		des have been told to keep the e door closed when he was			interaction is to ensure resident rights a followed to include the right to privacy	ile.		
	undressed.	e door closed when he was			during care/dressing and the right to be			
	unui 03300.				treated with dignity and respect. This	•		
	On 9/9/2021 at 10·0	00 am during an interview with			includes but not limited to not using			
		ated he took his clothing off all			profanity in the presence of residents,			
		he did not want people to be			directed at residents, or within hearing			
		nout his clothing on. Resident			distance of residents and maintaining a	1		
		swer any more questions.			quiet environment during resident⊡s			
		•			hours of sleep. The Unit Managers and	i		
	An interview with R	esident #10 ' s roommate on			Charge Nurse will address all concerns			

NAME OF PROVIDER OR SUPPLIER STREET ADDRESS.CITY, STATE, ZIP CODE 95 BARBOUR COURT NURSING AND REHABILITATION CENTER STREET ADDRESS.CITY, STATE, ZIP CODE 95 BARBOUR ROAD SMITHFIELD, NC 27577 SMITHFI	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		' IDENTIFICATION NUMBER: '		ΓIPLI NG _	(X3) DATE SURVEY COMPLETED		
STREET ADDRESS. CITY, STATE, 2P CODE \$15 BARBOUR COURT NURSING AND REHABILITATION CENTER CALL			345237	B. WING _			1	
### SARBOUR COURT NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES PREFIX TAG	NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS CITY STATE ZIP CODE	1 03/	09/2021
MITHFIELD, NC 27577						, , ,		
F 550 Continued From page 3 g/9/2021 at 10:07 am revealed Resident #10 took off his clothing as soon as the staff put the clothing on him. He stated the curtain was not always pulled or the door closed when Resident #10 had no clothing on. An interview with the Director of Nursing (DON) on 9/9/2021 at 12:10 pm revealed staff should have been doing regular checks to make sure Resident #10 was clothed, his door was closed, and/or the privacy curtain was pulled to ensure his unclothed body was not visible from the hall to maintain his dignity. During an interview with the Administrator on 9/9/2021 at 12:42 pm she stated Resident #10 's door should have been closed or the privacy curtain pulled to ensure his unclothed body was not visible from the hall to maintain his dignity. 2. Resident #3 was readmitted to the facility on 1/28/2021 with diagnoses that include diabetes mellitus. The Minimum Data Set dated 7/28/2021 revealed Resident #3 was cognitively intact with adequate hearing without a hearing device. During an interview on 9/7/2021 at 10:30 am Resident #3 stated the nurse aides (NAs) on third shift made a lot of noise when they entered the unit. He stated he was awakened three to four times a week from his skep from the loud use of profanily by the NAs. He stated this was a regular occurrence since April 2021 and last occurred the last weekend of August 2021. Resident #3 further stated he had trouble going to skeep and did not want to be awakened by the noise. He	BARBOUF	R COURT NURSING AND	REHABILITATION CENTER					
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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345237	B. WING				C	
	DOLUBER OF OURDLUE	343237	D. WING _			09	/09/2021	
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE			
BARBOU	R COURT NURSING	AND REHABILITATION CENTER		51	15 BARBOUR ROAD			
_,				S	MITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 550	Continued From p	page 4	F t	550				
	multiple times to d	different nurses. Resident #3			review the Resident Rights Audit Tool			
		d to agency nurses and they			weekly x 4 weeks then monthly x 1 mo	onth		
	changed all the tir				to ensure all concerns were addressed			
	J							
	During an intervie	w with NA #1 on 9/9/2021 at			The Social Worker will complete five (5)		
	_	ed she worked third shift mainly			resident interviews with alert and orien	•		
	on the weekends.	She said the NAs used loud			residents to include resident #3 and #9)		
		ne on the weekends. She			utilizing Resident Questionnaire-Resid	ent		
		sed the loud profanity within the			Rights. This interview is to identify any			
	, ,	st 2021). NA #1 stated the loud			concerns related to the noise level dur	-		
		curred at the 100-hall nursing			hours of sleep and/or staff use of profa	inity		
	station. She said	she did not report it to anyone.			in the facility. The Social Workers will			
	During an intensio	wwith the Director of Nursing			address all areas of concern identified			
		w with the Director of Nursing :10 pm she stated she was not			during the interviews. The Administrate will review all resident interviews to en			
		I profanity was used on third			all concerns were addressed.	Suie		
		residents should not have			all concerns were addressed.			
		profanity while sleeping.			The Administrator will present the findi	nas		
		presently trime electricity.			of the Resident Rights Audit Tool and	90		
	On 9/9/2021 at 12	2:42 pm during an interview the			Resident Questionnaire-Resident Righ	ıts		
		stated the nurse management			to the Executive Quality Assurance			
	team should have	observed and educated the			Performance Improvement (QAPI)			
	staff about conver	sations with coworkers. She			committee monthly for 2 months. The			
		ed that leadership would come			Executive QAPI Committee will meet			
	in on third shift an	d do spot checks.			monthly for 2 months and review the			
					Resident Rights Audit Tool and Reside	nt		
		as readmitted to the facility on			Questionnaire-Resident Rights to			
		agnoses that included anxiety			determine trends and/or issues that m			
	disorder.				need further interventions put into place and to determine the need for further	.e		
	The Minimum Dat	a Set dated 7/25/2021 revealed			frequency of monitoring.			
		cognitively intact with adequate			requericy of monitoring.			
	hearing without a	- ·						
	, , , , , , , , , , , , , , , , , , ,							
	An interview cond	ucted on 9/8/2021 at 10:00 am						
	revealed she was	often awakened by the NAs						
	loud use of profar	nity on the third shift. She stated						
	she was awakene	d by the noise at least two to						
	three times a wee	k. Resident #9 said she knew it						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED		
		345237	B. WING _				09/2021
	ROVIDER OR SUPPLIER R COURT NURSING AND	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZI 515 BARBOUR ROAD SMITHFIELD, NC 27577	IP CODE		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFII TAG	PROVIDER'S PLAN (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIA		(X5) COMPLETION DATE
F 550	but the loud profanity Resident #9 said it or did not try to keep up the foul language rea she did not use that k use to it. During an interview will 1:00 am she stated on the weekends. Ship profanity all the time stated she witnessed last month (August 20 conversations occurre station. She said she During an interview will on 9/9/2021 at 12:10 informed that loud profits the four profits and the said she will be said she will	esident council in April 2021,	F	550			
F 677 SS=D	On 9/9/2021 at 12:42 Administrator she stateam should have obstaff about conversation on third shift and distance of the conversation on third shift and distance of the conversation of t	while sleeping. pm during an interview the ted the nurse management served and educated the fons with coworkers. She that leadership would come to spot checks or Dependent Residents ent who is unable to carry iving receives the necessary good nutrition, grooming, and	F	677			10/7/21

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING				(X3) DATE SURVEY COMPLETED	
		345237	B. WING _				09/ 2021	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				5	15 BARBOUR ROAD			
BARBOUF	R COURT NURSING AND	REHABILITATION CENTER			MITHFIELD, NC 27577			
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F 677	Continued From page	e 6	F 6	677				
	facility failed to provid	iews and record review the le incontinence care for 2 of for activities of daily living			F677 ADL Care Provided for Depende Residents			
	care (Resident #1, and Resident #2). Findings included: 1. Resident #1 was admitted to the facility on 7/20/16. Her active diagnoses included myocardial infarction, anemia, coronary artery disease, hypertension, hyperlipidemia, and dementia.				On 9/22/21, the Unit Managers assess resident #1 and resident #2 to ensure incontinent care had been provided tim			
					There were no concerns identified. On 9/22/21, the Unit Managers initiated audit of all incontinent resident to ensure residents were provided incontinent catimely. The Unit Managers addressed at timely.	re re		
	assessed as moderat	ly minimum data set 1/21 revealed she was sely cognitively impaired. s and required extensive two			concerns identified during the audit to include providing incontinent care and education of the staff. Audit will be completed by 10/7/21.			
	She required extension with personal hygiene on two staff for transf	th bed mobility and dressing. ve one person assistance e. She was totally dependent ers, toilet use, and bathing. ntinent of bowel and bladder. ulcers.	sing. On 9/24/21, the Unit Managers initiated an in-service with all nurses and nursing dent assistants in regards to Incontinent Care with emphasis on providing incontinent care timely. In-service will be completed by 10/7/21. All newly hired nurses and		re			
	she was care planned activities of daily living	sident #1's care plan dated 7/17/21 revealed e was care planned to require assistance with tivities of daily living. The interventions included use incontinent products and provide frequent eting.			nursing assistants will be in-serviced during orientation in regards to Incontin Care. The Unit Managers and Charge Nurses will complete 15 Resident Care	5		
	#1 stated Resident #' morning and when he brief, pad, and bedsh Nurse Aide #2 was th assisting with morning care for Resident #1.	n 9/7/21 at 9:37 AM Nurse 1 needed help with a bath in e entered, he saw that her eets were soaked with urine. e nurse aide who was g activities of daily living Nurse #1 stated he could te, but it was a few weeks			Incontinent Audits on residents who are incontinent to include resident #1 week 4 weeks then monthly x 1 month. (Resident #2 no longer resides in facilit Audits will include all shifts and all days the week. This audit is to ensure all residents with incontinence are provide incontinent care timely. The Unit Managers and the Charge Nurses will	tly x ty). s of		

Facility ID: 923034

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345237	B. WING _			C 9/09/2021	
	ROVIDER OR SUPPLIER	ND REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 BARBOUR ROAD SMITHFIELD, NC 27577		370072021	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 677	Aide #1 stated she care of all the reside unit one night shift a not remember the e they knew it was just their rounds, and it is AM to complete the was unable to providiving care to all resimany residents on to could not remember working that night be and they did not hele assistance when the were short of help. So nurse aide started whave a chance to castated she was sure were soaked throug time to get to them and because she did know who she had been residents who daily living care. Shonight and was just in all the residents. Shoremember the exact approximately 148 rof them and they rosome residents need with activities of dail staffing on night shift and she did not know the same time to get to them and they rosome residents need with activities of dail staffing on night shift and she did not know the same time to get the same time time to get the same time time time time time time time ti	on 9/7/21 at 10:52 AM Nurse and Nurse Aide #5 had to take ents except for the Alzheimer's a week or two ago but could exact date. She stated once at the two of them, they started took from about 11:30 AM to 4 in first round. She stated she de timely activities of daily idents because they had so their shift. She stated she if the nurses who were ut believed they were agency, it is portable for each of the point of the	F 6	address all concerns identified audit to include providing inco when indicated and re-educati staff. The Director of Nursing of the Resident Care Incontinent ensure all areas of concern we addressed. The Administrator will present of the Resident Care Incontine the Executive Quality Assuran Performance Improvement (Quemittee monthly for 2 mont Executive QAPI Committee with monthly for 2 months and review Resident Care Incontinent Auditermine trends and/or issue need further interventions put and to determine the need for frequency of monitoring.	ntinent care ion of the will review Audits to ere the findings ent Audits to ce API) hs. The ill meet ew the dits to s that may into place		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	TIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345237	B. WING			С	
NAME OF D		343237	B. WING _	OTDEET ADDRESS SITY STATE		9/09/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE	E, ZIP CODE		
BARBOUE	R COURT NURSING A	ND REHABILITATION CENTER		515 BARBOUR ROAD			
27.11.12.001	t cook! Notionio/!	NO NEW COLON		SMITHFIELD, NC 27577			
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFII TAG	(EACH CORRECTIVE CROSS-REFERENCE	AN OF CORRECTION VE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY)	(X5) COMPLETION DATE	
F 677	Continued From pa	age 8	F	577			
F 677	During an interview Aide #2 stated staff the facility and was stated she remember the facility and Resided brief, pad, gown, a help her with the m stated this had occ few months, but she particular and who also sometimes who found the resident stated she had spout the concern at night due to staff told her she would Nursing and they we buring an interview Manager #1 stated exact date, but she made aware that N #5 had been the on sparks unit and the adequate care. She Nurse Aide #2 carrabout residents be shift and she told the	on 9/7/21 at 12:10 PM Nurse fing had been going down in an ongoing problem. She bered one morning but could date, when she came to the not #1 was soaked through her and sheets. Nurse #1 had to corning care that day. She could remember this time in the resident was. She stated then she came in to work, she had double briefs on. She oken with Unit Manager #1 for residents not receiving care fing and Unit Manager #1 had speak with the Director of would see what they could do. If on 9/7/21 at 4:20 PM Unit she could not remember the exame in the next day and was larse Aide #1 and Nurse Aide for the extended the provide the staff were unable to provide the staff were unable to provide the staff that the night shift was the to staff not showing up for	F	577			
	Director of Nursing the administrator to nurse aides who w unit for the night. S what the date was	on 9/8/21 at 9:18 AM the stated she knew at one point old her there were only two orked outside of the locked the stated she was unsure of and the nurses were agency taff members notified anyone					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	FIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
		345237	B. WING _			C 09/09/2021		
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 515 BARBOUR ROAD SMITHFIELD, NC 27577		03/03/2021		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE		
F 677	She stated when she would be made aware been enough staff in to provide activities of the worst night this honly Nurse Aide #1 anight shift. She state staff were not notifying shortages and was a care not being provide from call outs and not be a care not being provided from call outs and not be a care not being provided from call outs and not be a care not being provided from call outs and not be a care not being provided she was informed that hourse aides in the bulk of the bulk of the state	e so few staff in the building. E arrived in the morning, she re by staff that there had not the building the night before of daily living care. She stated rappened was the night when and Nurse Aide #5 worked the d she had no answer for why ring administration of staff riware activities of daily living ded due to staff being short of call no shows was an issue. On 9/8/21 at 9:45 AM the it was not until the next day at there had been only three wilding during one 11 PM to 7 as ago. She could not thappened. She stated 1 a locked unit and the other accare of the rest of the aree nurse aides for the 7 AM shift did not meet her and was not adequate staff of daily living care. On 9/9/21 at 8:59 AM Nurse id not remember the exact at two weeks ago when her ad the entire facility except eir workload during the 11 e stated she was unable to	F	677				
	probably around fifty residents for Nurse A	e exact census, but it was residents for her and fifty Aide #1. She stated that was nts to be able to get to						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED		
		345237	B. WING			1	C 09/2021
	ROVIDER OR SUPPLIER	D REHABILITATION CENTER	1	515 E	BARBOUR ROAD THFIELD, NC 27577	1 00.	00/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHO			(X5) COMPLETION DATE
F 677	care, so she was sur who did not receive a stated because she weveryone, she did not which residents did cated they notified the nurses, and she coult were, but the nurses get any help and did care. She further stating the building on 11 common problem. Stiliving care would be must be picked up by continuing staffing is: 2. Resident #2 was a 8/14/2020. Her active failure, hypertension. Resident #2's annual assessment dated 7/ assessed a severely had no behaviors and two staff for bed mobile personal hygiene. She assistance from two always incontinent of no pressure ulcer. Resident #2's care poshe was care planne.	e activities of daily living e that there were residents any care that night. She was unable to get to t remember specifically or did not receive care. She ne nurses, who were agency d not remember who they did not call administration to not help the nurse aides with ted not having enough staff PM to 7 AM shift was a ne stated activities of daily missed on night shift and or the morning shift due to sues. Idmitted to the facility on the diagnoses included heart and chronic pain. I minimum data set 15/21 revealed she was cognitively impaired. She d was totally dependent on ility, transfers, toilet use, and	F	677			
	to provide pericare a episode. Per the facility asses	•					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI	IULTIPLE CONSTRUCTION LDING			(X3) DATE SURVEY COMPLETED	
		345237	B. WING _				09/2021	
	ROVIDER OR SUPPLIER R COURT NURSING AND	O REHABILITATION CENTER		515 BARBO	DRESS, CITY, STATE, ZIP CODE UR ROAD LD, NC 27577	,		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	-	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE	
F 677	#2 stated staffing for challenge. She stated week but could not rewent to help Nurse A Resident #2's morning gown, and the brief of with urine. She stated everything to clean the the mattress. She staurine, the resident had aily living care through 11 PM to 7 AM. She happened because the about fifty residents of her shift that day. The aides in the entire but only in the locked unit he other had the oth unit. She concluded staffing issues. During an interview of Aide #1 stated she at care of all the resident unit one night shift at not remember the extension the could not remember to the could not remember the interview of the providing care to all resident and residents on the could not remember the extension of the could not remember the extension of the could not remember the could not rem	on 9/7/21 at 9:44 AM Nurse the night shift had been a d she believed it was last emember the date, that she ide #6 on first shift with a g care and the pad, bed, of Resident #2 was soaked d they had to change he resident and wipe down ated based on the amount of ad not received activities of agh the entire night shift from stated she believed this here was one nurse aide for during the night shift prior to here were only three nurse hilding that night, but one was at so one had one side and her side of the skilled nursing heveryone was aware of the sweek or two ago but could act date. She stated once the two of them, they started book from about 11:30 AM to 4 first round. She stated she he timely activities of daily lents because they had so heir shift. She stated she the nurses who were	F	677				
	and they did not help	t believed they were agency, or call anyone for y let the nurses know they						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
	345237 B.V		B. WING		C 09/09/2021		
NAME OF PROVIDER OR SUPPLIER BARBOUR COURT NURSING AND REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 515 BARBOUR ROAD SMITHFIELD, NC 27577	1 03/03/2021			
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		
F 677	nurse aide started wo have a chance to call stated she was sure to were soaked through time to get to them do and because she did know who she had mobeen residents who would daily living care. She night and was just im all the residents. She remember the exact capproximately 148 resofthem and they rour some residents need with activities of daily on night shift was a codid not know why the and why staff would some nights. During an interview of Aide #6 stated the facility and were one night she remem did come to the facilit to 3 PM and there had working that night. She exact date or the cen remembered Resider urine soaked through soaked the pad, gower #2. She stated the nurse aides on the skeduring the night shift,	ne stated her and the other ork right away and did not for help either. She further here were residents who as she did not have enough uring the entirety of her shift not get to them, she did not issed but knew there had were missed for activities of stated it was a devastating possible to provide care to concluded she could not bensus number, but it was sidents split between the two need together because ed two person assistance living. She concluded staff continual problem and she by were unable to keep staff cimply not show up for work on 9/7/21 at 12:00 PM Nurse collity had issues with staffing the short staffed. She stated bered a few weeks ago she by for her day shift from 7 AM do only been two nurse aides the could not remember the	F 67	7			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		DNSTRUCTION	(X3) DATE SURVEY COMPLETED		
345237		345237	B. WING				C 09/2021	
NAME OF PROVIDER OR SUPPLIER BARBOUR COURT NURSING AND REHABILITATION CENTER				515 E	BARBOUR ROAD THFIELD, NC 27577	,		
(X4) ID PREFIX TAG			ID PREFI TAG	PREFIX (EACH CORRECTIVE ACTION SHOUL			(X5) COMPLETION DATE	
F 677		ing issue in the facility, but mple that stuck out which	F	677				
	Manager #1 stated sexact date, but she commade aware that Nu #5 had been the only sparks unit and the sadequate care. She Nurse Aide #2 came about residents bein shift and she told the	on 9/7/21 at 4:20 PM Unit the could not remember the came in the next day and was rese Aide #1 and Nurse Aide y nurse aides outside of the staff were unable to provide stated she remembered to her and spoke to her g left soaked from the night e staff that the night shift was to staff not showing up for se.						
	Director of Nursing sethe administrator told nurse aides who wounit for the night. She what the date was a that night and no star of the fact there were She stated when she would be made awabeen enough staff in to provide activities of the worst night this honly Nurse Aide #1 anight shift. She states staff were not notify is shortages and was a care not being provide from call outs and not buring an interview of	on 9/8/21 at 9:18 AM the stated she knew at one point do her there were only two riked outside of the locked se stated she was unsure of and the nurses were agency off members notified anyone se so few staff in the building. Se arrived in the morning, she are by staff that there had not the building the night before of daily living care. She stated appened was the night when and Nurse Aide #5 worked the do she had no answer why and administration of staff aware activities of daily living ded due to staff being short of call no shows was an issue.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345237		345237	B. WING			C 09/09/2021		
NAME OF PI	ROVIDER OR SUPPLIER		-	STREET ADDRESS, CITY, STATE, ZIP CODE	<u></u>	00,00,		
				515 BARBOUR ROAD				
BARBOU	R COURT NURSING AND	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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE		(X5) OMPLETION DATE	
F 677	Continued From page	e 14	F6	77				
F 677	she was informed that nurse aides in the built shift a few weeks ago the date it happened. Was in the locked unit aides took care of the stated three nurse aid to 7 AM shift did not respectations and was provide activities of did activities of did date, but it was about and Nurse Aide #1 hat the locked unit on the AM shift. She stated activities of daily living because there were justificate for on their shift. remember the exact of around fifty residents Nurse Aide #1. She seriodents to be able to provide activities of districtions of daily living because there were provide activities of districtions of districtions of districtions of districtions of districtions activities activi	t there had been only three Iding one 11 PM to 7 AM She could not remember She stated 1 nurse aide and the other two nurse rest of the facility. She les for the building on 11 PM meet her staffing anot adequate staff to aily living care. In 9/9/21 at 8:59 AM Nurse do not remember the exact two weeks ago when her ad the entire facility except in workload from 11 PM to 7 she was unable to provide go care to all residents ust too many residents to She stated she did not be stated that was just too many to get to everyone and aily living care, so she was residents who did not night. She stated because to everyone, she did not which residents did or did stated they notified the ncy nurses, and she could be were, but the nurses did not get any help and did not	F 6	77				
	not having enough sta to 7 AM shift was a co activities of daily living	with care. She further stated aff in the building on 11 PM pmmon problem. She stated g care would be missed on e picked up by the morning g staffing issues.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G		E SURVEY IPLETED	
	345237		B. WING _		C 09/09/2021		
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		5/05/2021	
BARBOUR COURT NURSING AND REHABILITATION CENTER			515 BARBOUR ROAD				
				SMITHFIELD, NC 27577		_	
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 687 SS=D	and care to maintain health, the facility mu (i) Provide foot care a with professional star to prevent complication medical condition(s) a (ii) If necessary, assist appointments with a carranging for transpot appointments. This REQUIREMENT by: Based on observation interviews the facility arrange podiatry serve (Resident #12) review Findings included: Resident #12 was ad 08/18/2020 with diagratic diabetes mellitus and	are. Ints receive proper treatment mobility and good foot st: Ind treatment, in accordance indured of practice, including ons from the resident's and st the resident in making qualified person, and retation to and from such is not met as evidenced ins, record review and staff failed to provide nail care or ices for 1 of 3 residents are done for foot care.	F6	F687 Foot Care Resident #12 was scheduled an appointment with Podiatry on 9/3: 2:15 pm. On 9/22/21, the Unit Managers in 100% audit of resident nails to incresident #12. This audit is to ensucare to include toenails was provincesident preference and/ or podial services consult initiated when in The Unit Managers addressed all	nitiated a clude ure nail ided per ntry dicated.	10/7/21	
	07/27/2021 revealed for daily decision make behaviors or rejection assessment period. So of one person for bath	she was severely impaired king. Resident #12 had no of care during the She required total assistance		concerns identified during the audinclude trimming nails per resider preference and initiating podiatry when indicated. Audit will be com 10/7/21. On 9/24/21, the Unit Managers in	dit to nt services apleted by		
	on 08/19/2020 of acti	a for Resident #12 initiated vities of daily living and ed a goal of activities of daily		in-service with all nurses to include #3 and nursing assistants (NA) to NA #7 in regards to Nail Care. En	de nurse include		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345237		B. WING _	B. WING		C 09/09/2021		
NAME OF PROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS	S, CITY, STATE, ZIP CODE	1 00/0	0/2021	
			515 BARBOUR R	ROAD			
BARBOUR COURT NURSING	AND REHABILITATION CENTER		SMITHFIELD, N				
PREFIX (EACH DEFIC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)			(X5) COMPLETION DATE			
F 687 Continued From p	page 16	F 6	87				
living and personal staff support as a achieve highest per through the next raid with bathing, personal control of the persona	al care will be completed with propriate to maintain or ractical level of functioning review. Interventions included personal hygiene, and grooming. 10:13 AM during a bathing #12's toenails on both feet were ick and long, extending inch beyond the nail bed. The toes were observed to be to ½ inch long, thick, and curved to ½ inch long, thick, and curved tending approximately ¼ inch ed. She stated they were tending approximately ¼ inch ed. She stated they were further indicated Resident re too thick to be cut by staff and ald need to see a podiatrist. She rrsing assistants (NA) were pping resident's toenails during lurse #3 stated if NA's were sidents toenails, they were the nurse. She stated no one her of any issues with Resident 10:44 PM an interview with point worker (SW) indicated a the facility quarterly. He stated sited the facility in July 2021. He rrses would let him know which to be seen and he would send atrist. He stated he had never to any podiatry list because the him know Resident #12	F 6	on providing preference consult who completed nurses and in-serviced Nail Care. The Unit M Charge Nuresident scare for resident services of the month Care Audit nail care to per resider services of the Unit M concerns it include tring preference when indic will review x 4 weeks ensure all of the Admir findings of Executive of Improvement for 2 month Committee and review determine and to determ	and initiating podiatry service in indicated. In-service will by 10/7/21. All newly hired in nursing assistants will be diduring orientation in regard did nursing assistants will be diduring orientation in regard diduring the naudit of an ail/foot care to include nail sident #12 weekly x 4 weeks hely x 1 month utilizing the Nail Tool. This audit is to ensure to include toenails was provident preference and/or podiatry onsult initiated when indicated dianagers will address all dentified during the audit to mming nails per resident e and initiating podiatry service and initiating podiatry service and initiating podiatry service the Nail Care Audit Tool week then monthly x 1 month to concerns are addressed. Inistrator will present the the Nail Care Audit Tool to the Quality Assurance Performance (QAPI) committee month his. The Executive QAPI e will meet monthly for 2 more of the Nail Care Audit Tool to the Nail Care Audit	be Is to and f 15 I s hill e ded y ed. ces g ekly he nnce nly nths		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG	(X:	(X3) DATE SURVEY COMPLETED	
	345237 B. WING			C 09/09/2021			
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		STREET ADDRESS, CITY, STATE 515 BARBOUR ROAD SMITHFIELD, NC 27577	, ZIP CODE	03/03/2021	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	((EACH CORRECTIV CROSS-REFERENCE	AN OF CORRECTION 'E ACTION SHOULD BE D TO THE APPROPRIATE CIENCY)	(X5) COMPLETION DATE	
F 687	Continued From page	e 17	F 6	587			
		podiatry list for July 2021 2 was not on the list and					
		#12's medical record she had been seen by a dmission to the facility.					
	with NA #7 indicated with a full bath on 08, noticed Resident #12 thick and needed cut	58 PM a telephone interview she provided Resident #12 /31/2021. She stated she 's toenails were long and ting, but she had not been went on to say she thought to Nurse #4.					
	with Nurse #4 indicat	9 PM a telephone interview ed he did not recall anyone Resident #12's toenails or could not be cut.					
F 725 SS=D	director of nursing (D #12's toenails were to the facility to be able Resident #12 was a composite been added to the position to the facility and there was receiving any podiatr Sufficient Nursing Sta	ity. She stated Resident #12 to the list of residents vices on her admission to the no record of Resident #12 y services.	F 7	725		10/7/21	
	§483.35(a) Sufficient The facility must have	Staff. e sufficient nursing staff with					

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		(X3) DATE SURVEY COMPLETED		
	345237	B. WING			C 09/09/2021	
ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
R COURT NURSING AND	REHABILITATION CENTER		515 BARBOUR ROAD			
			SMITHFIELD, NC 27577			
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION	SHOULD BE	D 4.T.E.	
Continued From page	e 18	F 7	25			
provide nursing and r resident safety and a practicable physical, well-being of each resident assessments and considering the r diagnoses of the facil accordance with the fat §483.70(e). §483.35(a)(1) The facil by sufficient numbers types of personnel or nursing care to all resident care plans: (i) Except when waive this section, licensed	elated services to assure ttain or maintain the highest mental, and psychosocial sident, as determined by s and individual plans of care number, acuity and ity's resident population in facility assessment required cility must provide services of each of the following a 24-hour basis to provide sidents in accordance with ed under paragraph (e) of nurses; and					
paragraph (e) of this designate a licensed nurse on each tour of This REQUIREMENT by: Based on record revifacility failed to provide incontinence soiled with urine (Resfor 2 of 5 residents refindings included: This tag is cross reference.	section, the facility must nurse to serve as a charge duty. is not met as evidenced sew and staff interviews the le sufficient nursing staff to care to residents who were sident #1 and Resident #2) eviewed for staffing.		assignments sheets for the up- days to ensure there are adeq nursing assistant staff schedul- the staffing requirements and r residents. The Administrator an	coming 3 uate ed to med needs of a	et	
	COURT NURSING AND SUMMARY ST. (EACH DEFICIENC REGULATORY OR I Continued From page the appropriate comp provide nursing and r resident safety and at practicable physical, i well-being of each res resident assessments and considering the r diagnoses of the facil accordance with the f at §483.70(e). §483.35(a)(1) The facil accordance with the f at §483.70(e). §483.35(a)(1) The facil president care plans: (i) Except when waive this section, licensed (ii) Other nursing pers limited to nurse aides §483.35(a)(2) Except paragraph (e) of this s designate a licensed nurse on each tour of This REQUIREMENT by: Based on record revi facility failed to provice provide incontinence soiled with urine (Res for 2 of 5 residents re Findings included: This tag is cross reference.	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) Continued From page 18 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment required at §483.70(e). §483.35(a)(1) The facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. §483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide sufficient nursing staff to provide incontinence care to residents who were soiled with urine (Resident #1 and Resident #2) for 2 of 5 residents reviewed for staffing.	A BUILDIN 345237 B. WING	ROWDER OR SUPPLIER RECOURT NURSING AND REHABILITATION CENTER RECOURT NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY PULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population in accordance with the facility must provide services by sufficient numbers of each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. \$483.35(a)(2) Except when waived under paragraph (e) of this section, the facility must designate a licensed nurse to serve as a charge nurse on each tour of duty. 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A BUILDING 345237 345237 STREET ADDRESS, CITY, STATE, ZIP CODE STORE RABBULTATION CENTER COURT NURSING AND REHABILITATION CENTER SUMMARY STATEMENT OF DEPTICENCIES EACH DEPTICENCY WILL SEE PRECEDED BY PILL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 18 The appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, aculty and diagnoses of the facility's resident population in accordance with the facility's resident population in accordance with resident care plans: (i) Except when waived under paragraph (e) of this section, licensed nurses; and (ii) Other nursing personnel, including but not limited to nurse aides. \$483.35(a)(2) Except when waived under paragraph (e) of this section, licensed nurse to serve as a charge nurse on each tour of duty. This RECOUREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to provide sufficient nursing staff to provide incontinence care to residents who were soiled with urine (Resident #1 and Resident #2) for 2 of 5 residents reviewed for staffing. This tag is cross referenced to: This tag is cross referenced to: Tag F677 - Based on staff interviews and record Tag F677 - Based on staff interviews and record Tag F677 - Based on staff interviews and record	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
						(
		345237	B. WING _	B. WING		09/09/2021		
NAME OF PR	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE			
				51	15 BARBOUR ROAD			
BARBOUF	R COURT NURSING AND	REHABILITATION CENTER		S	MITHFIELD, NC 27577			
(X4) ID	SUMMARY ST	FATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD E REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)				COMPLÉTION DATE			
F 725	Continued From pag	e 19	F 7	725				
	care for 2 of 5 reside	nts reviewed for activities of			On 9/27/21, The administrator reviewed	d		
		ident #1, and Resident #2).			agency contracts to ensure the facility l			
	, , ,	,			multiple agencies to choose from durin			
	During an interview of	on 9/7/21 at 4:20 PM Unit			staff concerns. The purpose of the			
		he was aware there had			agency service is to fill open on duty ai	de		
	been issues with 11	to 7 staffing in general. She			positions to meet staffing requirements			
	stated they would ha	ve the schedule staffed fully			and meet the needs of the residents. T	he		
	according to the paper	erwork and then some of the			facility is utilizing Florence, Favorite,			
		nd no show. She further			Excel, Allegiance, Cornerstone and			
	_	entionally staffed only three			Maxim. To ensure availability of			
		tire building, but it did			contracted staff, the facility has			
		uts or staff no call no shows.			additionally reviewed contract staff			
	•	shifted from agency to			assignments in place of prn agency			
		urse aides with the waiver.			staffing when available.			
		equired to be evaluated at a re skills check offs before			The facility has consistently been placi	20		
	_	care, however the students			ads on Indeed for posting of job opening			
	_	ot showing up for their			The advertisements for nursing assista			
	_	e stated this meant on paper			and/or nurse assistant trainees have	1113		
		taffed, but there had been			consistently been running since Februa	arv		
		here only three nurse aides			2021. The ads are re-initiated every 14			
		ent in the building. She			days.			
		nly three nurse aides in the			•			
	building from 11 PM	to 7 AM, which is the shift			On 10/4/21, the scheduler will begin			
	these issues were ha	appening on, the staff were			validating nursing assistant staff sched	ule		
	unable to provide ad-	equate care. She stated her			24 hours prior to schedule shift to ensu	re		
	and the Director of N	ursing had spoken about the			staff schedule is accurate and to confin	m		
	_	nd the Administrator had			staff attendance. The scheduler will no	tify		
		never be only three nurse			the Director of Nursing and/or			
		ht shift alone. She stated she			Administrator of all staffing concerns.			
		irrent budget there should be			0 40/4/04 # 11 ## 5			
		n night shift from 11 to 7. She			On 10/4/21, the Unit Managers and/or			
		ue has been ongoing and			Assistant Director of Nursing will confin			
		ed. She further stated staff			staff attendance each shift to ensure th	е		
		day, Saturday, and Sunday			facility has at least the minimum			
	•	ited the nurses and nurse			requirements to provide personal care			
		led the Director of Nursing to			and supervision according to local state			
		fing issues but was not			and federal regulations and codes. The			
	aware or arryone call	ing. She concluded there			Unit Manager and/or Assistant Director	UI		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345237		345237	B. WING			C 09/09/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00.		
				51	5 BARBOUR ROAD			
BARBOUF	R COURT NURSING AND	REHABILITATION CENTER		SI	MITHFIELD, NC 27577			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHOU TAG CROSS-REFERENCED TO THE APPRO DEFICIENCY)			(X5) COMPLETION DATE	
F 725	Continued From page	e 20	F 7	725				
	had been no education to call when their start	on to her knowledge of staff ffing was short.			Nursing will immediately notify the Director of Nursing and/or Administrate all staffing concerns.	or of		
	Director of Nursing sistaffing across the both 7 AM shift had been shows. The staff in the shows happened were administration about not enough staff in the she arrived in the more aware by staff that the staff in the building the timely activities of darken had no answer wadministration of staff this was an ongoing activities of daily living due to staff being shown on shows. She stated warning for not notify they could not cover member continued to terminate the staff. Si	the concern that there was e building. She stated when rning, she would be made ere had not been enough he night before to provide illy living care. She stated why staff were not notifying f shortages and was aware ssue with staffing as well as g care not being provided ort from call outs and no call d they would give staff a ing the facility timely that			On 9/24/21, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants in regard to the new Attendance Policy. Emphas on expectations on attendance and polyiolations. In-service will be completed 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Attendance Policy. On 9/24/21, the Assistant Director of Nursing initiated an in-service with all nurses and nursing assistants in regard to Staffing with emphasis on notification Manager on Duty, Assistant Director of Nursing, Director of Nursing (DON) and Administrator when the facility does no have adequate staff to meet the needs the residents. In-service will be completely 10/7/21. All newly hired nurses and nursing assistants will be in-serviced during orientation in regards to Staffing	is licy by ds n of f d/or t of		
	Administrator stated building on 11 PM to staffing expectations notified until the next informed of staffing creach out to administ stated the nurse aide could and followed cl notified the nurses of	on 9/8/21 at 9:45 AM the other on urse aides for the 7 AM shift did not meet her and she was not morning. She stated once oncerns, the nurse should ration for assistance. She is were doing everything they main of command and of the lack of staff. She stated tration was made aware of			The Assistant Director of Nursing, DON and scheduler will review the upcoming schedule and staffing assignment sheef or staffing needs weekly x 4 weeks the monthly x 1 month utilizing the Staffing Audit Tool to ensure the facility has minimum requirements to provide personal care and supervision according to local state and federal regulations are codes. The scheduler will ensure that of duty staff and/or agency are contacted	g ets en ng nd		

STATEMENT OF DEFICIENCIES (X1) AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345237	B. WING	B. WING			00/2024
	ROVIDER OR SUPPLIER	REHABILITATION CENTER		51	TREET ADDRESS, CITY, STATE, ZIP CODE 15 BARBOUR ROAD MITHFIELD, NC 27577	USA	09/2021
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 725	explain why staff did rabout the concern. She phone numbers in the contact because ager and she had not beer educate them to contact staffing concerns. She told them not to rely of follow facility notification they might not be fully. She told her permane aides can contact adrof any concerns and of the two nurse aides we stated they could ever from the copy machine requested the administrated they acould requested the facility number of staff on pashows were a continuate because they would rewere scheduled were. On night shift, accord assessment and cens scheduled for the 11 I unfortunately with call no shows from staff and services and staff and shows from staff and services and services and staff and shows from staff and services and services and staff and shows from staff and services are services and services	axt day and she could not not contact administration he stated they reposted a facility for administration not cy staff changed regularly, in able to consistently act administration with the then met with her staff and on the agency nurses to ion procedures because y aware of the procedures. Bent staff that even the nurse ministration to inform them gave her personal number to who worked that night. She are direct scan something the to her email that the strator come to the facility. If was scheduling the correct per; however, no call no ual issue with staffing not know that the staff who a not showing up for work. It ing to their facility saus, they have 8 nurse aides	F 7	725	when an assignment needs filling. The Administrator will review the Staffing At Tool weekly x4 weeks then monthly x 1 month to ensure all concerns addresse. The Administrator will forward the result of the staffing assignment sheets to the Executive Quality Assurance Performal Improvement (QAPI) committee month for 2 months. The Executive Quality Assurance Performance Improvement (QAPI) committee will meet will meet monthly for 2 months and review the Staffing Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequence of monitoring.	ts e nce ly	