	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,	LE CONSTRUCTION		TE SURVEY MPLETED
	oonneonon	IDENTIFICATION NOMBER.	A. BUILDING	i		C
		345237	B. WING		1	2/13/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CC		
				515 BARBOUR ROAD		
BARBOUI		ND REHABILITATION CENTER		SMITHFIELD, NC 27577		
(X4) ID		STATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF C		(X5)
PREFIX TAG		NCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	IE APPROPRIATE	COMPLETIO DATE
F 000	INITIAL COMMEN	TS	F 00	o		
	The survevor ente	ered the facility on 12/7/21 to				
	-	nd complaint investigation and				
	•	n 12/8/21. Additional				
		ptained on 12/13/21 and				
		date was changed to 12/13/21.				
	One of one compla substantiated. Eve					
E 580		(Injury/Decline/Room, etc.)	F 58	o		1/11/22
SS=D	CFR(s): 483.10(g)		1 30			1/ 11/22
	8483 10(a)(14) No	tification of Changes.				
		nmediately inform the resident;				
	.,	sident's physician; and notify,				
		or her authority, the resident				
	representative(s) v					
		volving the resident which				
	physician intervent	d has the potential for requiring				
		ange in the resident's physical,				
		social status (that is, a				
	deterioration in he	alth, mental, or psychosocial				
		-threatening conditions or				
	clinical complicatio					
		treatment significantly (that is,				
		nue an existing form of dverse consequences, or to				
		form of treatment); or				
		ansfer or discharge the				
	resident from the f	acility as specified in				
	§483.15(c)(1)(ii).					
		notification under paragraph (g)				
		on, the facility must ensure that ation specified in §483.15(c)(2)				
	is available and pr	ovided upon request to the				
	physician. (iii) The facility mu	st also promptly notify the				
		esident representative, if any,				

Electronically Signed

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.

12/22/2021

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/202 FORM APPROVE OMB NO. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345237	B. WING _		C 12/13/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	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 O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE COMPLETION THE APPROPRIATE DATE
F 580	as specified in §483.4 (B) A change in resid State law or regulatio (e)(10) of this section (iv) The facility must r update the address (r phone number of the representative(s). §483.10(g)(15) Admission to a comp that is a composite di §483.5) must disclose its physical configura locations that compris part, and must specif room changes betwe under §483.15(c)(9). This REQUIREMENT by: Based on record rev interviews, Nurse Pra Physician interview, f sampled resident in the facility failed to effect Physician or Nurse Pra intravenous placement experiencing a changed dry mouth and low un been written for Intrav- by facility staff to star failed and 4) the resp that intravenous inter The facility also failed resident's blood press	 a or roommate assignment 10(e)(6); or ent rights under Federal or ins as specified in paragraph i. record and periodically mailing and email) and resident osite distinct part. A facility stinct part (as defined in e in its admission agreement tion, including the various se the composite distinct y the policies that apply to en its different locations a is not met as evidenced iew, family interviews, staff actitioner interview, and for one (Resident # 2) of one he end stages of life, the ively communicate with the ractitioner regarding midline in tafter 1) the resident was ge in condition with signs of ine output 2) orders had venous fluids 3) six attempts t intravenous fluids had onsible party's wishes were ventions be part of his care. It to communicate when the sure would not register and to closer to a hypothermic 	F 5	80 Barbour Court Nursing an Center acknowledges rec Statement of Deficiencies this Plan of Correction to the summary of findings is correct and in order to ma compliance with applicabl provisions of quality of ca The Plan of Correction is written allegation of comp Barbour Court Nursing an Center response to this S Deficiencies does not der with the Statement of Defi does it constitute and adn deficiency is accurate. Fu	eipt of the and proposes the extent that s factually aintain le rules and re of residents. submitted as a diance. ad Rehabilitation tatement of note agreement iciencies nor nission that any urther, Barbour

Facility ID: 923034

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				PRINTED: 01/12/2022 FORM APPROVED OMB NO. 0938-0391
DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED
	345237	B. WING		C 12/13/2021
ROVIDER OR SUPPLIER	•	5	STREET ADDRESS, CITY, STATE, ZIP CODE	•
		5	15 BARBOUR ROAD	
R COURT NURSING AND	REHABILITATION CENTER	5	SMITHFIELD, NC 27577	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOUL	D BE COMPLETION
Continued From page	e 2	F 580		
Record review revealed Resident # 2 resided at the facility from 10/5/15 until his death on 11/9/21. According to the record the resident had a neurological disorder which resulted in spastic quadriplegia and was initially admitted to the facility in 2015 with a diagnosis of failure to thrive. Additionally, the resident had diagnoses of dysphagia, atherosclerosis, contractures, and profound intellectual disability. Review of Resident # 2's minimum data set assessment, dated 11/6/21, revealed Resident # 2 was coded as needing total staff assistance with his activities of daily living and as incontinent			reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispur Resolution, formal appeal procedure and/or any other administrative or lee proceeding. F 580 Notify of Changes Resident #2 no longer resides at this facility thus no other corrective action be completed for this resident. Nurses #2 and #3, who failed to state IV and Nurses #4 and Unit Manager who were unable to obtain a blood pressure and failed to notify the practitioner, were in-serviced by Dire	te gal s n can t the #1
for Do Not Resuscitat On 8/10/21 NP (Nurs routinely saw the resi be considered due to she talked to the Res party) about the resid the resident's RP war IVs, diagnostic test, a indicated for an acute failed, then she would care only. NP # 2 was interview and reported the follo Resident # 2's RP, w	te in the event of his death. e Practitioner) # 2, who ident, noted hospice might his weight. NP # 2 noted ident's RP (responsible lent's lack of function, and need the resident to have and hospitalization if ever e condition. If treatment d make the resident comfort ed on 12/13/21 at 3:15 PM owing. She had talked to ho resided in the same room		 include but not limited to changes in signs, inability to obtain vital signs, changes in oral intake, changes in u output, changes in lab values. 3. Notifying the physician by telep when a change in condition is obser prior to starting another task. 4. Communicating a full assessme report to the provider of a resident's change in condition. 5. Following physician's orders an 	vital rine ction, hone ved ent d unable
	S FOR MEDICARE & DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER COURT NURSING ANE SUMMARY ST (EACH DEFICIENC REGULATORY OR Continued From page Record review reveal the facility from 10/5/ According to the reco neurological disorder quadriplegia and was facility in 2015 with a Additionally, the resic dysphagia, atheroscle profound intellectual Review of Resident # assessment, dated 1 2 was coded as need with his activities of d of bowel and bladder Record review reveal for Do Not Resuscitat On 8/10/21 NP (Nurs routinely saw the resid be considered due to she talked to the Res party) about the resid the resident's RP war IVs, diagnostic test, a indicated for an acute failed, then she would care only. NP # 2 was interview and reported the follor Resident # 2's RP, w	CORRECTION IDENTIFICATION NUMBER: IDENTIFICATION NUMBER: Additional provided in the state of the stat	S FOR MEDICARE & MEDICAID SERVICES DF DEFICIENCIES CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLI A BUILDING 345237 B. WING ROVIDER OR SUPPLIER 345237 ROVIDER OR SUPPLIER ID COURT NURSING AND REHABILITATION CENTER ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 2 F 580 Record review revealed Resident # 2 resided at the facility from 10/5/15 until his death on 11/9/21. According to the record the resident had a neurological disorder which resulted in spastic quadriplegia and was initially admitted to the facility in 2015 with a diagnosis of failure to thrive. Additionally, the resident had diagnoses of dysphagia, atherosclerosis, contractures, and profound intellectual disability. Review of Resident # 2's minimum data set assessment, dated 11/6/21, revealed Resident # 2 was coded as needing total staff assistance with his activities of daily living and as incontinent of bowel and bladder. Record review revealed Resident # 2 had orders for Do Not Resuscitate in the event of his death. On 8/10/21 NP (Nurse Practitioner) # 2, who routinely saw the resident, noted hospice might be considered due to his weight. NP # 2 noted she talked to the Resident's RP (responsible party) about the resident's lack of function, and the resident's RP wanted the resident to have IVs, diagnostic test, and hospitalization if ever indicated for an acute condition. If treatment failed, then she woul	S FOR MEDICARE & MEDICAID SERVICES OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A BUILDING A BUILDING SCORECTION IDENTIFICATION NUMBER: A BUILDING STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE STREET ADDRESS, CITY, STATE, ZIP CODE SUMMARY STATEMENT OF DEFICIENCES IDENTIFYING INFORMATION) RECORT RVIEW revealed Resident # 2 resided at the facility from 10/5/15 until his death on 11/12/21. Deficiencies on this Statement of Deficiencies on this Statement of proceeding, and was initially admitted to the facility in 2015 with a diagnosis of failure to thrive. Additionally, the resident had a neurological disorder which resulted na diagnoses of dysphagia, atherosclerosis, contractures, and profound intellectual disability. F 580 Review of Resident # 2's minimum data set assessment, dated 11/6/21, revealed Resident # 2 was coded as needing total staff assistance with his activities of daily living and as incontinent of Dowel and bladder. 1. How to complete a Nursing assessment. Record review revealed Resident # 2 had orders for Do NR Resuscitate in the event of his death. 1. How to complete a Nursing assessment. On 3/10/21 NP (Nurse Practitioner) # 2, who routiney saw the resident, NP 4 2 noted she talked to the Resident # 2 had o

Facility ID: 923034

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		ND HUMAN SERVICES MEDICAID SERVICES			FORM	: 01/12/202 APPROVE . 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE : COMPL	LETED
		345237	B. WING		12/1	; 13/2021
NAME OF PF	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP COD		
			4	515 BARBOUR ROAD		
BARBOUR	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 CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 580	Continued From page	2	F 580			
1 300			F 580			
		c tests, and hospitalization if remained her choice up until		physician.		
	the resident's death.	·		On 12/11/21, the Director of N	lursing	
				(DON), Assistant Director of N	•	
		M nursing notes reflected the		(ADON), Unit Managers and		
	0	e in condition as evidenced		Data Set (MDS) Nurses asse		
	by vomiting and shive	ering.		of all current residents for cha		
	A			condition to include worsening		
	ordered in addition to	ord diagnostic tests were		signs, diaphoresis, dry mouth	-	
		antiemetics.		symptoms of dehydration, and shaking/shivering. The DON,		
	Nurse # 1 had cared	for Resident # 2 on the 7:00		nurse notified the physician d		
	AM to 3:00 PM shift of			audit for any changes observe	-	
	interviewed on 12/7/2	21 at 2:20 PM. The nurse		worsening of vital signs or the		
	reported the following	g. The resident had thrown		obtain vital signs. All noted ch	anges and	
		ich had clumps in it. It ran		notification to the physician w	as	
		lid talk to the on-call NP (NP		documented in the resident's	clinical	
	, ,	y another NP (NP #2) came		records.		
		. Around the time of NP #2's		On 12/11/21, the Director of N		
		the resident was shivering		(DON), Assistant Director of N	-	
	-	more of something coming		(ADON), Unit Managers and Consultant audited 100% of a	-	
	-	; "but not like before." He did n her shift and he did not		residents' progress notes, 24-		
	urinate.			communication sheets, and v		
				report logs from 11/1/21-12/1	•	
	NA # 1 had cared for	Resident # 2 on the 7:00		audit is to ensure that all doc		
	AM to 3:00 PM shift of			changes in condition had bee		
	interviewed on 12/7/2	21 at 2:50 PM. The NA		communicated to the physicia		
	-	did not drink anything that		worsening in vital signs and/o	-	
	day nor did he urinate	e on her shift.		obtain vital signs. The Directo	-	
				(DON), Assistant Director of N	•	
	•	s nursing entry of 11/8/21 at		(ADON), and Unit Managers		
		try into the record was made		the resident and notified the p	•	
	by NP #2 at 6:21 PM	seen the resident and		all identified areas of concern		
	evaluated some of his			during the audit. Audit was co 12/12/21.	mpleted by	
		ed an ileus had been noted		On 12/11/21, the Director of N	lursing	
	on one of his diagnos			(DON), Assistant Director of N	-	

Facility ID: 923034

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		ID HUMAN SERVICES MEDICAID SERVICES				F	ITED: 01/12/202 ORM APPROVEI NO. 0938-039
STATEMENT C	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` <i>`</i>		ONSTRUCTION		DATE SURVEY
		345237	B. WING				C 12/13/2021
NAME OF PR	ROVIDER OR SUPPLIER			STR	REET ADDRESS, CITY, STATE, ZIP CODE		
				515	BARBOUR ROAD		
BARBOUR	COURT NURSING ANL	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 CORRECTIO (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE
F 580	Continued From page	a /	ES	20			
F 580	going to order intrave enema and Dulcolax repeated on 11/10/21 On 11/8/21 orders we have normal saline at centimers/ hour) after normal saline bolus. If order was never carri no written orders to d hold. Nurse # 2 had cared 3:00-11:00 PM shift of interviewed on 12/8/2 reported the following the beginning of her s intravenous fluids (IV IV in three times but of the nursing supervised attempts and passed Following the NP's er the next entry was may by the night shift nurs following. Attempts w again but were unsuce documentation the pf Practitioner was notifi attempts were unsuce Nurse # 3 was intervi	e to dehydration." She was mous fluids, and that a fleets be given. The labs would be ere written that the resident to 60 cc/hour (cubic administering a 500 cc of Record review revealed this ed out and there had been iscontinue it or place it on for Resident # 2 on the f 11/8/21 and was at a 10:50 AM. Nurse # 2 g. The NP came a little after shift and left orders for). She attempted to get the was unsuccessful. She told or about the unsuccessful IV it along to the next nurse. http on 11/8/21 at 6:21 PM, ade on 11/9/21 at 5:03 AM se (Nurse # 3) who noted the ere made to insert the IV ccessful. There was no hysician or Nurse ied by Nurse # 2 that IV	F 5		Consultant audited 100% of physicia orders for all residents identified acu changes through residents' progress notes, 24-hour report communication sheets, and vital sign report logs from 11/1/21-12/11/21. This audit is to en- orders were completed and followed physician's order to include midline intravenous placement. Also, to ensi- the physician was notified of any ord that were unable to be carried out. T Director of Nursing (DON), Assistant Director of Nursing (ADON), and Un Managers reassessed the resident a notified the physician for all orders th were not completed or carried out. A was completed by 12/12/21. On 12/11/21, the Activity Director po bright colored sign at each nursing s regarding guidelines of things to communicate to the physician by ph- include but not limited to changes in condition, inability to carry out orders any reason, inability to obtain vital si and/or inability to obtain labs. Signs posted by 12/12/21. On 12/11/21, an in-service was initia the Director of Nursing with 100% of nurses regarding: 1. How to complete a Nursing assessment. 2. Examples of changes in condition	te m sure per ure ers he it udit sted a tation one to s for gns, were ted by all	
	attempts were made	to insert the IV, but the able. He passed along to the			include but not limited to changes in signs, inability to obtain vital signs, changes in oral intake, changes in u	vital rine	
	Unit Manager # 1 was	s interviewed on 12/8/21 at			output, changes in normal body function and changes in lab values.	uon,	

Facility ID: 923034

			0.00				O. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	· /	E SURVEY IPLETED
			A. BOILDI				С
		345237	B. WING			12	2/13/2021
NAME OF P	ROVIDER OR SUPPLIER	•		S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
		D REHABILITATION CENTER		5	15 BARBOUR ROAD		
BARBOUI	COURT NORSING AND	CREMABILITATION CENTER		S	MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES SY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETIO DATE
F 580	Continued From page	~ F		-00			
F 300			Ft	580	2 Notificanthe abusician butcleaks		
		d the following. She had not			3. Notifying the physician by telepho		
		orders which had been given /8/21) but if IV access was			when a change in condition is observe prior to starting another task.	u	
	not able to be obtained			4. Communicating a full assessment			
		ider company who could			report to the provider of a resident's		
		procedure was to notify the			change in condition.		
		mission to use the company.			5. Following physician's orders and		
		. ,			notifying the physician if orders are un	able	
	According to Resider	nt # 2's record, no orders			to be carried out.		
	were obtained from t	he physician or the NP in			6. What to do when a blood pressure	Э	
		contract company to start an			monitor is not reading to include		
		vealed the facility did have a			rechecking, checking to see if the cuff	is	
		ide company for midline			too loose or too tight, taking the blood		
	placement.				pressure manually, and notifying the		
					physician.		
		2 on 12/13/21 3:15 PM			la comise will be completed by		
		ad called the on- call			In-service will be completed by 12/12/2021. After 12/12/2021, the		
		uring the night shift which en an order would have been			Administrator will ensure the remaining		
	given to contact the c				in-services for staff who have not work		
		ad not been done. NP # 2			or have not received the in-services ar		
		nt she recalled talking to a			mailed with instructions to review, sign		
		placement but did not recall if			in-service, and return to the staff facilit		
	that was before or af				and/or director of nursing prior to next		
					scheduled work shift.		
	Following Nurse # 4's	s nursing entry on 11/9/21 at			The Unit Managers and Assistant Dire	ctor	
		e was entered on 11/9/21 at			of Nursing will audit all 24- hour		
	12:00 PM by Nurse #	4. The nurse noted around			communication reports and progress		
		temperature was 95; his			notes 5 x per week x 4 weeks then		
		s respirations were 30, and			monthly x 1 month utilizing an Acute		
		ould not be obtained. The			Change in Condition Audit Tool. This a		
		rmed two supervisors and			is to ensure that the nurse has identified		
	-	heck his blood pressure.			and documented all changes in condit	on	
		nentation the resident's			to include inability to obtain a blood	20	
	-	ractitioner were notified the			pressure and communicated the change	Je	
		sure was not registering or had fallen to 95 degrees.			to the physician with follow up actions taken.		
		nau lalleli lo 30 degrees.			The Unit Managers and Assistant Dire	ctor	
		iewed on 12/8/21 at 11:10			of Nursing will audit physician orders f		

Facility ID: 923034

	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	IPLE	CONSTRUCTION		D. 0938-039 SURVEY
ND PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDIN	۱G		COM	PLETED
							С
		345237	B. WING			12	/13/2021
NAME OF P	ROVIDER OR SUPPLIER				TREET ADDRESS, CITY, STATE, ZIP CODE		
BARBOUI	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 PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETIO DATE
F 580		2.6	E	200			
F 580	AM and again on 12/ reported the following and let her know the could not get the IV in sent to the hospital. checked his vitals ag blood pressure to reg got a cuff and tried to could not auscultate if two unit managers ar resident. She went to When she came back the NP had called an Manager # 2 for Resi antibiotics. Nurse # 4 directly to the NP or g the resident's blood p auscultated. Unit Manager # 1 was 9:30 AM and reported Nurse # 4 telling her doing well and the nu call back from the NF him. She tried to get a to the resident's move distress. She had not she could not get a b NP # 2 was interview and again on 12/13/2 following. She had set	8/21 at 3:10 PM and g. She had talked to the NP resident was drinking, they n, and the family wanted him Before 12:30 PM she had ain and could not get his gister on the machine. She manually auscultate it and t. She had reported this to nd asked them to check the lunch around 12:30 PM. K from lunch, she learned d left orders with Unit dent # 2 which included 4 stated she never talked gave the NP an update after pressure could not be s interviewed on 12/8/21 at d the following. She recalled that Resident # 2 was not urse was waiting on a phone P. She went into check on his blood pressure and could . The nurse stated it was blood pressure reading due ements but he did not look in a reported to the physician	F 5	580	all residents identified for acute change through residents' progress notes, 24-hour report communication sheets and vital sign report logs 5 times per v x 4 weeks then monthly x 1 month util Orders Audit Tool. This audit is to ens orders were completed and followed p physician's order. The DON will present the findings of t Change in Condition Audit Tool and Orders Audit Tool to the Executive Qu Assurance (QA) committee monthly for months. The Executive QA Committee will meet monthly for 2 months and re the Change in Condition Audit Tool an Orders Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequent of monitoring.	, veek izing ure ber he ality or 2 e view d	
	having hiccoughs. Hi him again on the eve shown an ileus and s	s vitals were stable other than ning of 11/8/21. His KUB had he had left orders to address On the morning of 11/9/21					

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		D HUMAN SERVICES MEDICAID SERVICES				FORM	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED
		345237	B. WING				C / 13/2021
NAME OF PI	ROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE		
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 PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Nurse # 4 had alerted family member wante hospital. At the time, I resident was starting longer vomiting. She was high and therefor Rocephin for him bec brewing." She had tal member, who was ag at the facility. She als he wanted to add Flag called the staff and le did not see the reside conversations she wa resident seemed to be did they tell her that th pressure on the reside unaware the resident" to 95 degrees. She w that. The resident see quickly. The resident's physici 12/8/21 at 3:27 PM ar The physician felt the not concerning for def were drawn on 11/8/2 starting to take oral flu 11/9/21 and the nurse times to insert an IV, continue with trying to resident was continuin According to the physit to know when two nurse to know when two hor two	I her that the resident's d the resident sent to the Nurse # 4 had indicated the to drink fluids and was no was aware his heart rate re she had ordered some ause something "could be ked to the resident's family reeable to treat the resident o talked to the physician and gyl also to the orders. She t them know that also. She int on 11/9/21 and from the is having with the staff, the e getting better. At no time hey could not get a blood ent, and she had been is temperature had dropped yould have wanted to know emed to have declined	F	580			

Facility ID: 923034

If continuation sheet Page 8 of 20

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		STRUCTION	(X3) DATE SURVEY COMPLETED	
							С
		345237	B. WING			1	2/13/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREE	T ADDRESS, CITY, STATE, ZIP CODE		
BARBOUR	R COURT NURSING AND	REHABILITATION CENTER		515 BA	RBOUR ROAD		
				SMITH	IFIELD, 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 CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 580	Continued From page	2 8	F 5	580			
		ransferred sooner to the					
		n felt the resident would					
	have been placed on						
F 684	Quality of Care	Paman	F6	684			1/11/22
SS=D	CFR(s): 483.25						.,=
	§ 483.25 Quality of ca						
	-	ndamental principle that					
		nt and care provided to					
	-	ed on the comprehensive					
		dent, the facility must ensure					
		e treatment and care in essional standards of					
		nensive person-centered					
	care plan, and the res						
		is not met as evidenced					
	by:						
	-	iew, family interviews, staff		F	684 Quality of Care		
		actitioner interview, and			esident #2 no longer resides at this		
	Physician interview, f	or one (Resident # 2) of one		fac	cility thus no other corrective action	can	
	sampled resident in the	he end stages of life, the		be	completed for this resident.		
		ntravenous fluids, obtain a			urses #2 and #3, who failed to start		
	-	unicate effectively with the			and Nurses #4 and Unit Manager #	ŧ1	
		t he be hospitalized per the			no were unable to obtain a blood		
	-	e and Responsible Party's			essure and failed to notify the		
	wishes. The findings	included.			actitioner, were in-serviced by Direc Nursing on 12/11/2021 regarding:	lor	
	Record review reveal	ed Resident # 2 resided at					
		15 until his death on $11/9/21$.		7	How to complete a Nursing		
	According to the reco				sessment.		
	-	which resulted in spastic			Examples of changes in condition	n to	
		initially admitted to the			clude but not limited to changes in v		
		diagnosis of failure to thrive.			gns, inability to obtain vital signs,		
		lent had diagnoses of			anges in oral intake, changes in uri		
		erosis, contractures, and			tput, changes in normal body functi	on,	
	profound intellectual	disability.		an	d changes in lab values.		
				9.	Notifying the physician by telephonen a change in condition is observe		
	Review of Resident #						

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/2 FORM APPROV OMB NO. 0938-03	
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345237	B. WING		C 12/13/2021	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP 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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETI	
F 684	2 was coded as need with his activities of d of bowel and bladder Resident # 2's care p 10/27/21, revealed th never weighing over a Responsible party ha tube, but would want intervention if indicate resident's weight fluct have a slow steady d resident's goal that he weight was discontine would adhere to his of puree diet. Part of the current until the resid resident was at risk for that staff were to mor which included dry sk increased pulse rate; decreased pulse volu mental status; and de care plan also directe as ordered with notifier results. Review of Resident # following: 6/10/21-75 7/10/21-74 8/9/21-74 9/10/21-73 Record review reveal	1/6/21, revealed Resident # ling total staff assistance aily living and as incontinent lan, last reviewed on e resident reportedly had 82 pounds and in 2018 the d decided against a feeding	F 68	 prior to starting another task. 10. Communicating a full assess report to the provider of a residen change in condition. 11. Following physician's orders notifying the physician if orders ar to be carried out. 12. What to do when a blood pre monitor is not reading to include rechecking, checking to see if the too loose or too tight, taking the b pressure manually, and notifying physician. On 12/11/21, the Director of Nursi (DON), Assistant Director of Nursi (DON), Unit Managers and Mini Data Set (MDS) Nurses assessed of all current residents for change condition to include worsening of signs, diaphoresis, dry mouth, sig symptoms of dehydration, and shaking/shivering. The DON, ADC nurse notified the physician during audit for any changes observed to worsening of vital signs or the ina obtain vital signs. All noted chang notification to the physician was documented in the resident's clini records. On 12/11/21, the Director of Nursi (DON), Assistant Director of Nursi (DON), Unit Managers and Faci Consultant audited 100% of all cur residents' progress notes, 24-hou communication sheets, and vital si report logs from 11/1/21-12/11/21 audit is to ensure that all docume changes in condition had been 	t's and re unable ssure cuff is lood the ing ing mum d 100% ss in vital ins and DN, MDS g the b include bility to les and cal ing ing lity urrent r report sign . This	

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	S FOR MEDICARE &				
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
			A. BUILDING		
		245007			С
		345237	B. WING		12/13/2021
NAME OF PI	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	
BARBOUR	R COURT NURSING ANI	D REHABILITATION CENTER		15 BARBOUR ROAD	
				MITHFIELD, NC 27577	
(X4) ID			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL	. ,
PREFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROF DEFICIENCY)	DATE
F 684	Continued From pag	e 10	F 684		
	On 8/10/21 NP (Nurs	se Practitioner) # 2, who		communicated to the physician to in	clude
	routinely saw the res	ident, noted hospice might		worsening in vital signs and/or inabi	
		his weight. NP # 2 noted		obtain vital signs. The Director of Nu	
		sident's RP (responsible		(DON), Assistant Director of Nursing	-
	,	dent's lack of function, and		(ADON), and Unit Managers reasse	
		nted the resident to have		the resident and notified the physicia	an for
		and hospitalization if ever		all identified areas of concern noted	
		e condition. If treatment		during the audit. Audit was complete	ed by
	care only.	d make the resident comfort		12/12/21. On 12/11/21, the Director of Nursing	
	care only.			(DON), Assistant Director of Nursing	
	NP # 2 was interview	ved on 12/13/21 at 3:15 PM		(ADON), Unit Managers and Facility	-
		owing. She had talked to		Consultant audited 100% of physicia	
		ho resided in the same room		orders for all residents identified acu	
	as Resident # 2, abo			changes through residents' progress	
		nt's weight was declining, and		notes, 24-hour report communicatio	
	the RP did not want	a feeding tube. The RP had		sheets, and vital sign report logs fro	m
		lent # 2 had exceeded his life		11/1/21-12/11/21. This audit is to en	
		still wanted him to have IV's,		orders were completed and followed	l per
	-	c tests, and hospitalization if		physician's order to include midline	
		remained her choice up until		intravenous placement. Also, to ens	
	the resident's death.			the physician was notified of any or	
	On 11/9/21 at 9.00 A	M Nurse # 1 made a nursing		that were unable to be carried out. T Director of Nursing (DON), Assistan	
		wing. The resident had		Director of Nursing (DON), Assistan	
		ostance and was shivering.		Managers reassessed the resident a	
		igns were temperature: 97.0;		notified the physician for all orders t	
		s 18; and blood pressure		were not completed or carried out. A	
		alled the on call NP (NP # 1)		was completed by 12/12/21.	
		for 1) antiemetics (nausea		On 12/11/21, the Activity Director po	osted a
	medication); 2) labs	which included stat (right		bright colored sign at each nursing s	
		d count, stat complete		regarding guidelines of things to	
	•	l a urinalysis and culture and		communicate to the physician by ph	
		est x-ray; 4) stat KUB; 5)		include but not limited to changes in	
		ours; 6) vitals to be done		condition, inability to carry out order	
	every four hours for t	the next 24 hours.		any reason, inability to obtain vital s	-
	Device (1.1			and/or inability to obtain labs. Signs	were
	Review of lab results	revealed the urinalysis was		posted by 12/12/21.	

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	S FOR MEDICARE &	MEDICAID SERVICES	(X2) MUU		CONSTRUCTION	OMB N	MAPPROVE O. 0938-039 E SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING			C 12/13/2021	
		345237					
NAME OF PI	ROVIDER OR SUPPLIER			ST	IREET ADDRESS, CITY, STATE, ZIP CODE		
BARBOUR	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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	D BE	(X5) COMPLETIOI DATE
F 684		ecord. The CMP, completed	F	684	On 12/11/21, an in-service was initia		
	BUN and Creatinine (of hydration status) w resident's white blood	M, showed the resident's (which can be an indication vere within normal limits. The d count was 11.8 (normal			the Director of Nursing with 100% o nurses regarding:7. How to complete a Nursing	fall	
	13.2-17.1) and his he 38.5-50). The resider	noglobin was 17.2 (normal matocrit was 50 (normal nt's chest x-ray, completed no acute findings or infiltrate.			 assessment. 8. Examples of changes in conditiinclude but not limited to changes in signs, inability to obtain vital signs, 		
	The resident's KUB, of showed he had a mild bowel's ability to mov	completed on 11/8/21, d ileus (a disruption in the re material) and marked			changes in oral intake, changes in u output, changes in normal body fun- and changes in lab values.	ction,	
	- -	s suspected but the stomach ualized. The radiologist noted up upper GI study is			 Notifying the physician by telep when a change in condition is obser prior to starting another task. Communicating a full assessme report to the provider of a resident's 	rved ent	
	shift before the day s NA # 3 on 12/8/21 at	Resident # 2 on the night hift of 11/8/21. Interview with 2:28 PM revealed Resident e and sweating that night to			 change in condition. 11. Following physician's orders ar notifying the physician if orders are to be carried out. 	ıd	
	the point that the NA He could not tell if it v	changed his clothing twice. vas emesis or phlegm but ething coming from his			 12. What to do when a blood press monitor is not reading to include rechecking, checking to see if the car 		
		got on his collar. He did urse. He did not give any			too loose or too tight, taking the bloo pressure manually, and notifying the physician.		
	who had worked on the dayshift of 11/8/21, re	at 4:20 PM with Nurse # 3, he night shift before the evealed he did not recall t shift prior to 11/8/21.			On 12/11/21, the Assistant Director Nursing, Minimum Data Set Nurse (and/or RN Consultant will complete quizzes with all nurses regarding	MDS)	
	AM to 3:00 PM shift o on 12/7/21 at 2:20 PM	for Resident # 2 on the 7:00 of 11/8/21, was interviewed /, and reported the nt had thrown up yellow			Recognizing Acute Changes and Physician Notification. This quiz is to validate staff knowledge of recogniz and communicating when to notify to physician to include but not limited to	ing he	
		imps in it. It ran down his the on-call NP (NP # 1) and			changes in condition. The Assistant Director of Nursing, Minimum Data		

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		ID HUMAN SERVICES				APPROVE
TATEMENT C	S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		OMB NO. (X3) DATE S COMPLI	URVEY
			A. BUILDING	G	C	
		345237	B. WING		_	3/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, Z	P CODE	
BARBOUR COURT NURSING AND REHABILITATION CENTER			515 BARBOUR ROAD			
2/11/2001				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 / CROSS-REFERENCED T DEFICII	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIO DATE
F 684	Continued From page	e 12	F 68	34		
		NP (NP #2) came in to see	1.00	Nurse (MDS) and/or RN	Consultant will	
		the time of NP #2's visit the		reeducate and re-admin		
		ent was shivering again and		any nurse who does not		
		omething coming from his		demonstrate competence	3	
	mouth again; "but not	t like before." He did not take		Nurses will not be allowed	ed to work until	
		ft and he did not urinate.		successful demonstratio	-	
	-	rine specimen and she		The In-service and quiz		
	reported this to the ne	ext nurse and the NP.		by 12/12/2021. After 12	-	
	NA # 1 had cared for	Resident # 2 on the 7:00		Administrator will ensure	-	
	AM to 3:00 PM shift of			in-services and or quiz for not worked or have not r		
		21 at 2:50 PM. The NA		in-services and/or quiz a		
		did not drink anything that		instructions to review, co		
	day nor did he urinate			return to the Human Res		
				Coordinator and/or DON	I prior to next	
		s nursing entry of 11/8/21 at		scheduled work shift.		
		try into the record was made		The Unit Managers and		
		I on 11/8/21. The NP noted		of Nursing will audit all 2		
	the following. She wa	is seeing the resident ited twice. The UA had not		communication reports a		
		urine output. He appeared		notes 5 x per week x 4 v monthly x 1 month utilizi		
		eus had been noted on the		Change in Condition Au		
		elevated white count and		is to ensure that the nur		
		atocrit were "likely due to		and documented all cha		
		is going to order intravenous		to include inability to obt	ain a blood	
		ts enema and Dulcolax be		pressure and communic	Ū	
	given. The labs would	d be repeated on 11/10/21.		to the physician with foll taken.	ow up actions	
	Review of orders reve	ealed NP # 2 wrote orders		The Unit Managers and	Assistant Director	
		and for the administration of		of Nursing will audit phy		
		ax. According the record, the		all residents identified fo	<u> </u>	
		re never administered and		through residents' progr		
	the order was never p			24-hour report communi		
	discontinued in the re			and vital sign report logs x 4 weeks then monthly		
	There was no nursing	g note for the 3:00 PM to		Orders Audit Tool. This a	-	
		B/21. Nurse # 2 had cared for		orders were completed a		
		shift and was interviewed on		physician's order.		
		Nurse # 2 reported the		The DON will present th	e findings of the	

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		ID HUMAN SERVICES				FORM	D: 01/12/2022 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CC	(X3) DATE SURVEY COMPLETED		
		345237	B. WING _				C 1 3/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STRE	ET ADDRESS, CITY, STATE, ZIP CODE		
BARBOUR COURT NURSING AND REHABILITATION CENTER			515 E	BARBOUR ROAD			
BARBOON				SMI	THFIELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPF DEFICIENCY)	BE	(X5) COMPLETION DATE
F 684	of her shift and left or (IV). She attempted to but was unsuccessful thought with each IV resident's vein but go thought this could hav dehydrated. She tried the resident to drink p centimeter) cup of flu the urine specimen a nursing supervisor at attempts and passed Following the NP's er the next entry was may by the night shift nurs following. Attempts w again but were unsucce encouraged with app given. The resident h fleets and Dulcolax, w pain/discomfort. Nurse # 3 was intervi and reported the follo were stable although them. Three unsucce insert the IV, but the following being done. Following. The resident on 11/9/21 at 9:06 AM following. The resident temperature 96.3; put blood pressure 111/8	me a little after the beginning ders for intravenous fluids o get the IV in three times I. The nurse stated she attempt she was in the t no flashback of blood. She we been because he was d to give him fluids and got bart of a 240 cc (cubic id. She did not know about nd did not get it. She told the bout the unsuccessful IV it along to the next nurse. htry on 11/8/21 at 6:21 PM, ade on 11/9/21 at 5:03 AM se (Nurse # 3) who noted the tere made to insert the IV ccessful. Fluids were roximately 100 ml of water ad good results from the was afebrile, and with ewed on 12/7/21 at 4:20 PM twing. The resident's vitals he had not documented ssful attempts were made to resident appeared stable. He g about the urinalysis not	F	(// r v t (/ a ii	Change in Condition Audit Tool and Orders Audit Tool to the Executive Qu Assurance (QA) committee monthly for nonths. The Executive QA Committee will meet monthly for 2 months and re- he Change in Condition Audit Tool ar Orders Audit Tool to determine trends and/or issues that may need further nterventions put into place and to determine the need for further freque of monitoring.	or 2 ee view nd	

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 01/12/2022 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345237	B. WING _		C 12/13/2021
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, 2	· · · · · · · · · · · · · · · · · · ·
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	X (EACH CORRECTIVE CROSS-REFERENCED	N OF CORRECTION (X5) ACTION SHOULD BE COMPLETION TO THE APPROPRIATE DATE IENCY)
F 684	without difficulty. The resident's family men emergency contact # for the resident to be 4 noted NP # 2 instru- that time and she wor- member. Resident # 2's RP wa 9:58 AM. The RP star- had not been eating a The facility staff had s they had trouble getti contact # 2 was interv AM and reported that 11/9/21 and it had be resident would receiv- if he grew worse then resident sent to the h Contact # 2's underst been established the be done that day. Acc Contact # 2 if it had b not going to be estab would have wanted th hospital. Following Nurse # 4's 9:06 AM the next not 12:00 PM by Nurse # following. "Around 10 resident VS, 95, 93, 3 received call from NF dose, which was give AM with diff (different told NP nurse will be requested nurse give	and the resident had taken it nurse also noted the ober, who was listed as 2, had called and requested sent to the hospital. Nurse # cted not to do anything at uld talk to the family as interviewed on 12/8/21 at ted she knew Resident # 2 and had been concerned. said they would do an IV but ng one started. Emergency viewed on 12/7/21 at 11:24 the had talked to the NP on en established that the te treatment at the facility but the and the RP wanted the ospital. It was Emergency veen decided that an IV had not previous day, but one would cording to Emergency eeen decided that an IV was lished, then he and the RP he resident sent to the a nursing entry on 11/9/21 at e was entered on 11/9/21 at e w	F	584	

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
				TIPLE	(X3) DATE SURVEY COMPLETED C		
		345237	B. WING				
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BARBOUR COURT NURSING AND REHABILITATION CENTER					15 BARBOUR ROAD MITHFIELD, NC 27577		
(X4) ID PREFIX TAG	((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX				PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 684	resident was on clear whole time nurse gav resident drank all toga at that time" The nur- resident's RP was con- eating. The nurse end documenting, "Nurse lunch, saw nurse two asked if they can che heart rate and respiral could not get the BP, the hall from lunch, re- nurse was busy to tra (medication administr everything ready, did (RP)." Following Nurse # 4's PM, the next note wa PM by the NP. She nu- changed that morning rate and increased re pressure had been st had ordered the Roce consulted with the ph Flagyl (another antibie KUB would be done of family had been cons agreed to attempt treat Review of the record signs after Nurse # 4' blood pressure could Review of the NP ord received by Nurse # 4'	ve can change the diet, liquid diet currently, the e resident only the juice, ether about 360 ml (milliters) urse further documented the ncerned because he was not ded the nursing note by went to break room for supervisors and nurse ck resident out because his tion stay high, and nurse when nurse came back to eceived the order from NP, inscribe on the MAR ration record) and get not hear any complain from a entry on 11/9/21 at 12:00 s entered on 11/9/21 at 1:00 oted the resident's vitals had g with an increased heart spirations and his blood able that am at 111/83. She ephin (an antibiotic), ysician, and was adding otic). Repeat labs and a on 11/10/21. The resident's ulted that morning and had atment in place. revealed no further vital s notation that the resident's	F	684			

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STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE (CONSTRUCTION	(X3) DAT	E SURVEY	
IDENTIFICATION NUMBER:		A. BUILDING		COMPLETED			
		245007	B. WING			С	
				REET ADDRESS, CITY, STATE, ZIP CODE		2/13/2021	
NAME OF PROVIDER OR SUPPLIER BARBOUR COURT NURSING AND REHABILITATION CENTER			5 BARBOUR ROAD				
BARBOU	R COURT NURSING AND	REHABILITATION CENTER	SN				
(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 COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE	
F 684	AM and again on 12/4 reported the following Resident # 1's emerg and wanted the resid knew the night shift h getting the IV in, but s resident to drink som she was able to get th cc. The resident had and his vitals were of heart rate was high. S let her know the resid not get the IV in, and to the hospital. Befor checked his vitals again blood pressure to reg got a cuff and tried to could not auscultate it two unit managers an	8/21 at 3:10 PM and g. On the morning of 11/9/21 lency contact # 2 had called ent sent to the hospital. She ad been unsuccessful in she had been able to get the e fluids. The total for the day he resident to drink was 360 looked better after drinking kay in the morning except his She had talked to the NP and lent was drinking, they could the family wanted him sent	F 684				
	the NP had called an Manager # 2 for Resi she never talked dire NP an update after th could not be ausculta her supplies and tran # 2. The nurse confir one IM dose of Roce transcribing the resid a call for help for the breathing. Unit Manager # 1 was 9:30 AM and reported Nurse # 4 telling her t	k from lunch, she learned d left orders with Unit dent # 2. Nurse # 4 stated ctly to the NP or gave the he resident's blood pressure tted. She started gathering scribing orders for Resident med the resident received phin. As she was working on ent's other orders she heard resident because he was not s interviewed on 12/8/21 at d the following. She recalled that Resident # 2 was not urse was waiting on a phone					

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		ID HUMAN SERVICES MEDICAID SERVICES					FOR	D: 01/12/2022 MAPPROVED D. 0938-0391
		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345237		B. WING			C 12/13/2021		
	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 PREFI TAG		PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD B		(X5) COMPLETION DATE
F 684	his blood pressure ar machine. She did not pressure. The nurse s get a blood pressure movements but he di regards to the IV not Manager stated she h orders which had bee (11/8/21) but if IV acc obtained then the fac outsider company wh procedure was to not permission to use the According to Residen provider was contacte Resident # 2 prior to facility's contract with midlines revealed the typically between 3 to during business hour The contract also stat adjusted based on ne Unit Manager # 2 was 12:20 PM and reporte called around 1:00 Pl antibiotics for the resi type of physical asse day and therefore she type of physical asse orders and gave then NP # 2 was interview and again on 12/13/2 following. She had se morning of 11/8/21. H	cc of fluid. She tried to get ad could not with the try auscultating a blood stated it was always hard to reading due to the resident's d not look in distress. In being done, the Unit had not been involved in the en given the previous day wess was not able to be ility had a contract with an to could place a midline. The ify the provider and get e company. At # 2's record, no outside ed to try to start an IV for his death. Review of the the company which places if response time was to 6 hours when notified s; which began at 8:00 AM. ted priority might be eed. s interviewed on 12/8/21 at ed the following. The NP had M and given orders for ident. She had not done any ssment for Resident # 2 that e did not give the NP any ssment update. She took the	F	684				

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		ND HUMAN SERVICES				F	TED: 01/12/2022 ORM APPROVED NO. 0938-0391
AND PLAN OF CORRECTION		ICIENCIES (X1) PROVIDER/SUPPLIER/CLIA		TIPLE CONST	(X3) DATE SURVEY COMPLETED C 12/13/2021		
		345237	345237 B. WING				
NAME OF P	ROVIDER OR SUPPLIER	•	•	STREET	ADDRESS, CITY, STATE, ZIP CODE		
BARBOUR COURT NURSING AND REHABILITATION CENTER				515 BAR	BOUR ROAD		
BARBOUI	COURT NURSING AND	REHABILITATION CENTER		SMITHF	IELD, NC 27577		
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFI TAG	x	PROVIDER'S PLAN OF CORI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 684	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F	584			

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULT	FIPLE (CONSTRUCTION	(X3) DATE	SURVEY
AND PLAN OF CORRECTION		ECTION IDENTIFICATION NUMBER:		NG			
		345237	B. WING _				C 13/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	· · - /	
BARBOUR COURT NURSING AND REHABILITATION CENTER					5 BARBOUR ROAD		
	SMITHFIEL				AITHFIELD, NC 27577		0(5)
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 684	continue with trying to resident was continui According to the phys to know when two nu a blood pressure on t made aware of that, t resident out for further feel this would have of resident. The resident even if he had been t	he felt it had been fine not to o insert the IV as long as the ng to take fluids by mouth. sician he would have wanted rses could not have obtained the resident. If he had been then he would have sent the er evaluation but he did not changed the outcome for the nt's weight was very low and ransferred sooner to the n felt the resident would	F	684			

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