

<b>STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTIONS</b>		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: <b>345237</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED <b>02/26/2026</b>
NAME OF PROVIDER OR SUPPLIER <b>Barbour Court Nursing and Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 Barbour Road , Smithfield, North Carolina, 27577</b>	
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E0000	Initial Comments  An unannounced recertification and complaint investigation survey was conducted on 2/23/26 through 2/26/26.  The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1E46C5-H1.	E0000		
F0000	INITIAL COMMENTS  A recertification and complaint investigation survey was conducted on 2/23/26 through 2/26/26. Event ID #1E46C5-H1.  The following intakes were investigated: 2670413, 2644395, and 2637460.  6 of 6 complaint allegations did not result in deficiency.	F0000		
F0576 SS = C	Right to Forms of Communication w/ Privacy  CFR(s): 483.10(g)(6)-(9)  §483.10(g)(6) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.  §483.10(g)(7) The facility must protect and facilitate that resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:  (i) A telephone, including TTY and TDD services;  (ii) The internet, to the extent available to the facility; and  (iii) Stationery, postage, writing implements and the ability to send mail.	F0576		

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 reverse for further 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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F0576 SS = C	<p>Continued from page 1</p> <p>§483.10(g)(8) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:</p> <p>(i) Privacy of such communications consistent with this section; and</p> <p>(ii) Access to stationery, postage, and writing implements at the resident's own expense.</p> <p>§483.10(g)(9) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.</p> <p>(i) If the access is available to the facility</p> <p>(ii) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.</p> <p>(iii) Such use must comply with State and Federal law.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and interviews with residents and staff, the facility failed to ensure the residents' right to receive mail delivered on Saturdays and on the date it was received. This had the potential to affect 136 of 136 residents in the facility.</p> <p>Findings included:</p> <p>During the Resident Council meeting on 2/25/26 at 2:08 PM Resident #26, Resident #39, Resident #54, Resident #73, Resident #94, Resident #95, and Resident #13 reported they did not get their regular mail delivered as the facility received the mail, including Saturdays. Resident #26, the Resident Council President, stated regular mail was delivered to Receptionist #1 Monday through Friday. Receptionist #1 sorted the mail and gave the residents' mail to the activities department to be delivered, but it was hit or miss how quickly the mail was delivered. The Resident Council President further stated Saturday's mail was held at the front desk and given to Receptionist #1 on Monday to sort and the residents' mail was then taken to activities to be delivered. The Resident Council President stated regular mail sometimes sat in the activities room for a week before it was delivered. The Resident Council</p>	F0576		

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F0576 SS = C	<p>Continued from page 2</p> <p>President stated he was aware of this issue because his trade/professional magazines, outdoor sporting magazines, and product catalogues had been in the activities room for a week before he collected them himself after Resident #39 informed him the magazines were in the activities room. Resident #39 then confirmed this by stating he often read Resident #26's outdoor sporting magazines in the activities room before he told Resident #26 his magazines were in the activities room. Resident #26 stated the times he was concerned his mail sat in the activities room were not when he was out of the facility or hospitalized and he usually had to collect his magazines from the activities room.</p> <p>During an interview on 2/26/26 at 9:40 AM Resident #95 stated she went to the activities room after lunch daily just to check in with them and color her coloring pages. She further stated most of the time she went into the activities room, the rack that held the sorted, regular mail for residents was often full. She stated the same mail, such as the Resident Council President's magazines, remained in the activities room for a week before it disappeared and she assumed it was delivered or the residents picked it up themselves. She stated the magazines were the easiest to identify as the same mail sitting for a long time because the magazine cover image was different for each issue, but the same cover sat in the activities room for many days. She stated there was not a set pattern or day that the mail was taken out of the activities room, but it was very obvious to her that the same items of mail sat in the activities room for multiple days before being delivered or picked up by the residents.</p> <p>During an interview on 2/26/26 at 7:58 AM Receptionist #1 stated each weekday, Monday through Friday between 1:00 PM and 1:30 PM, she got the mail from the mailbox and went to the post office to pick up the mail at the post office. She then returned to the facility and sorted the mail and put the residents' mail in the box in the activities room. She stated on Saturdays when she was not at the facility, the mail was put in her box at the front, and she sorted Saturday's mail on Mondays. She stated that most Mondays she sorted residents' mail that was delivered on Saturday and put the mail in the box in the activities room to be delivered to the residents on Monday.</p> <p>During an interview on 2/26/26 at 8:34 AM the Activities Director stated she worked some Saturdays and when she worked on Saturdays the mail was sorted and delivered to the residents. She stated someone from activities was in the facility every day and the mail</p>	F0576		

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F0576 SS = C	Continued from page 3 should be sorted and delivered on Saturdays by activities staff. The Activities Director stated she knew sometimes if there was a question of whether a resident should receive an item like a bill, activities staff would put it in Receptionist #1's box to be sorted Monday. So, there were times when Saturday's mail was not delivered until Monday if there were questions about whether it should go to the resident or another party. She concluded she was not aware of any time any resident's mail sat in the activities room and was not delivered for a week unless the resident was in the hospital and mail was held for them secured in an office belonging to activity staff.  During an interview on 2/26/26 at 8:07 AM the Administrator stated it was his expectation that mail was delivered daily to residents, including Saturdays. It was his understanding that regular mail was being distributed as it arrived by the activities department, including Saturdays. The Administrator stated he was not aware that the Receptionist sorted mail delivered on Saturday on most Mondays for residents or that residents had concerns with mail not being delivered daily throughout the week as no grievances had been completed about timely mail delivery.	F0576		
F0641 SS = E	Accuracy of Assessments  CFR(s): 483.20(g)(h)(i)(j)  §483.20(g) Accuracy of Assessments.  The assessment must accurately reflect the resident's status.  §483.20(h) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.  §483.20(i) Certification.  §483.20(i)(1) A registered nurse must sign and certify that the assessment is completed.  §483.20(i)(2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.  §483.20(j) Penalty for Falsification.  §483.20(j)(1) Under Medicare and Medicaid, an	F0641		

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F0641 SS = E	<p>Continued from page 4 individual who willfully and knowingly-</p> <p>(i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than \$1,000 for each assessment; or</p> <p>(ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than \$5,000 for each assessment.</p> <p>§483.20(j)(2) Clinical disagreement does not constitute a material and false statement.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications (Resident #8, Resident #4, and Resident #5) and Pneumococcal Vaccine (Resident #18). This was for 4 of 28 residents whose MDS assessments were reviewed.</p> <p>Findings included:</p> <p>a. Resident #8 was admitted to the facility on 10/23/18.</p> <p>Resident #8's physician orders included Novolog (a rapid acting insulin) injection solution 100 units/milliliter inject 10 units subcutaneously (beneath the skin) with meals. Hold for blood sugar less than 150 with a start date of 3/18/25.</p> <p>Resident #8's December 2025 Medication Administration Record (MAR) noted Novolog was administered subcutaneously to him on 12/25/25 at 11:30 AM, on 12/26/25 at 6:30 AM, on 12/27/25 at 6:30 AM, 11:30 AM, and 5:30 PM, on 12/28/25 at 6:30 AM and 11:30 AM, on 12/29/25 at 6:30 AM and 5:30 PM, on 12/30/25 at 11:30 AM and 5:30 PM, and on 12/31/25 at 6:30 AM and 5:30 PM.</p> <p>Resident #8's quarterly MDS assessment dated 12/31/25 revealed he received both injections and insulin injections on 5 of the 7 look back days of the assessment.</p> <p>On 2/25/26 at 10:50 AM during an interview MDS Nurse #1 stated she coded the medication section of Resident #8's MDS assessment dated 12/31/25. She reported she should have coded the section to indicate Resident #8 received both injections and insulin injections for 7 of the 7 look back days of the assessment period. She reported this was an error.</p>	F0641		

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F0641 SS = E	<p>Continued from page 5</p> <p>b. Resident #4 was admitted to the facility on 11/6/19.</p> <p>Resident #4's physician orders included Dulaglutide (non-insulin medication to improve blood sugar control) Solution Pen-injector 0.75 milligrams per 0.5 milliliter inject 0.75 mg subcutaneously one time a day every Saturday related to Type 2 Diabetes Mellitus with a start date of 12/6/25. There were no physician orders in December 2025 for Resident #4 to receive insulin.</p> <p>Resident #4's December 2025 Medication Administration Record (MAR) noted Dulaglutide was administered subcutaneously to him on 12/27/25.</p> <p>Resident #4's quarterly MDS assessment dated 1/1/26 revealed he received both an injection and an insulin injection on 1 of the 7 look back days of the assessment period.</p> <p>On 2/25/26 at 10:50 AM during an interview MDS Nurse #1 stated she coded the medication section of Resident #4's MDS assessment dated 1/1/26. She reported that she coded the section to indicate Resident #4 received both an injection and an insulin injection on 1 of the 7 look back days of the assessment period. She stated she coded this medication as an insulin because it was prescribed for Resident #4's diabetes.</p> <p>c. Resident #5 was admitted to the facility on 7/23/15.</p> <p>Resident #4's physician's orders for January and February 2026 did not reveal any orders for anticoagulant medication.</p> <p>Resident #4's January and February 2026 Medication Administration Records (MAR) did not reveal any documentation indicating anticoagulant medication had been administered.</p> <p>Resident #5's annual MDS assessment dated 2/3/26 noted she received anticoagulant medication during the 7 look back days of the assessment period.</p> <p>On 2/25/26 at 10:43 AM during an interview MDS Nurse #2 stated she coded the medications section of Resident #5's MDS assessment dated 2/3/26. She reported her coding that Resident #5 received anticoagulant medication was an error. She stated Resident #4 had not received any anticoagulant medication during the look back period of the assessment.</p> <p>d. Resident #18 was admitted to the facility on 6/29/17.</p>	F0641		

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F0641 SS = E	<p>Continued from page 6</p> <p>Resident #18's quarterly MDS assessment dated 11/15/25 revealed she was up to date with her pneumococcal vaccine.</p> <p>The immunization section of Resident #18's medical record revealed documentation indicating Resident #18 had historically received a single dose of Pneumovax (Pneumovax, also known as Pneumococcal Polysaccharide Vaccine or PPSV23) on 6/1/2014. There was no documentation discovered in Resident #18's medical record to indicate she received any further pneumococcal vaccines.</p> <p>On 2/26/26 at 10:07 AM during an interview MDS Nurse #1 stated she coded Resident #18's MDS assessment dated 11/15/25 to indicate Resident #18's pneumococcal vaccine was up to date. She reported this was not correct. She went on to explain she had just gone back to the Resident Assessment Instrument (RAI) manual and checked the most recent Centers for Disease Control and Prevention (CDC) guidelines and discovered a single historical dose of Pneumovax would not make Resident #18's pneumococcal vaccine up to date. MDS Nurse #1 reported she could not find a record indicating Resident #18 had received any other pneumococcal vaccines. She reported she must have looked at old CDC guidelines when she coded Resident #18's 11/15/25 MDS assessment.</p> <p>During an interview on 2/26/26 at 11:19 AM the Director of Nursing (DON) stated resident MDS assessments should be coded accurately.</p> <p>During an interview on 2/26/26 at 11:31 AM the Administrator stated resident MDS assessments should be coded accurately.</p>	F0641		
F0760 SS = D	<p>Residents are Free of Significant Med Errors</p> <p>CFR(s): 483.45(f)(2)</p> <p>The facility must ensure that its-</p> <p>§483.45(f)(2) Residents are free of any significant medication errors.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on observations, record review, and interviews with staff and the Nurse Practitioner (NP), the facility failed to ensure the resident's need for insulin (a hormone that regulates blood sugar levels) administration in accordance with the parameters</p>	F0760		

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F0760 SS = D	<p>Continued from page 7 provided by the physician before administering the insulin. This deficient practice affected 1 of 5 residents (Resident #8) reviewed for unnecessary medications.</p> <p>Findings included:</p> <p>Resident #8 was admitted to the facility on 10/23/2018 with a diagnosis of diabetes mellitus type 2 (DM II).</p> <p>A current active physician's order for Resident #8 with a start date of 3/18/25 revealed Novolog injection solution (a type of fast acting insulin)100 units per milliliter inject 10 units subcutaneously (SQ is beneath the skin) with meals and to hold (do not give) for blood sugar (BS) less than 150 (a normal adult BS before eating is between 70 to 99.</p> <p>A review of Resident #8's December 2025 Medication Administration Record (MAR) revealed documentation by Nurse #1 indicating that Resident #8's BS at 6:30 AM on 12/13/25 was 122 and she administered 10 units of Novolog insulin to Resident #8. Resident #8's BS at 11:30 AM on 12/13/25 was 236. On 12/15/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 122 and she administered 10 units SQ to Resident #8. Resident #8's BS at 11:30 AM on 12/15/25 was 205. On 12/27/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 122 and she administered 10 units SQ to Resident #8. Resident #8's BS at 11:30 AM on 12/27/25 was 134. On 12/29/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 106 and she administered 10 units SQ to Resident #8. Resident #8's refused to have his BS checked at 11:30 AM on 12/29/25.</p> <p>On 2/25/26 at 9:25 AM in a telephone interview Nurse #1 stated she was familiar with Resident #8. She reported she did not recall Resident #8 having any parameters for the administration of his Novolog insulin. She stated normally, if a resident had BS parameters for the administration of insulin, it would show on the resident's electronic MAR on her computer screen. She went on to say her documentation on Resident #8's December 2025 MAR on 12/13/25, 12/15/25, 12/27/25 and 12/29/25 would indicate she administered 10 units of Novolog insulin SQ to Resident #8 at 6:30 AM each of those days.</p> <p>Resident #8's quarterly Minimum Data Set (MDS) assessment dated 12/31/25 revealed he was cognitively intact. He had no behaviors or rejection of care. He received injections, and insulin injections on 5 of the 7 look back period days of the assessment.</p> <p>On 2/26/26 at 10:58 AM an interview with the NP</p>	F0760		

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F0760 SS = D	<p>Continued from page 8 indicated she was familiar with Resident #8. She reported he frequently refused his BS checks and his insulin despite many conversations with him on the importance of these for managing his DM II. She stated because of this, his BS tended to run on the higher side. She went on to say as a result the instances of administration of 10 units of Novolog insulin to Resident #8 when his BS was less than 150 had not caused Resident #8 any harm. She reported there was always the possibility of harm to a resident, which included an unsafe drop in BS level, if insulin was administered to them outside of the parameters of the physician's order as this insulin would not be needed. She stated nurses should always follow the parameters for administering insulin.</p> <p>On 2/25/26 at 1:53 PM in an interview the Director of Nursing stated she would consider the administration of insulin to a resident outside the parameters of the physician's order to be a serious medication error. She reported that the potential harm to a resident receiving insulin that was not indicated by their blood sugar level would be an unsafe lowering of their blood sugar.</p> <p>On 2/25/26 at 3:14 PM an interview with the Administrator indicated nurses should be adhering to the parameters in the physician's order when administering insulin. He stated the facility did not have a corrective action plan in place for this.</p>	F0760		
F0842 SS = A	<p>Resident Records - Identifiable Information</p> <p>CFR(s): 483.20(f)(5),483.70(h)(1)-(5)</p> <p>§483.20(f)(5) Resident-identifiable information.</p> <p>(i) A facility may not release information that is resident-identifiable to the public.</p> <p>(ii) The facility may release information that is resident-identifiable to an agent only in accordance with a contract under which the agent agrees not to use or disclose the information except to the extent the facility itself is permitted to do so.</p> <p>§483.70(h) Medical records.</p> <p>§483.70(h)(1) In accordance with accepted professional standards and practices, the facility must maintain medical records on each resident that are-</p> <p>(i) Complete;</p>	F0842		

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F0842 SS = A	<p>Continued from page 9</p> <p>(ii) Accurately documented;</p> <p>(iii) Readily accessible; and</p> <p>(iv) Systematically organized</p> <p>§483.70(h)(2) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is-</p> <p>(i) To the individual, or their resident representative where permitted by applicable law;</p> <p>(ii) Required by Law;</p> <p>(iii) For treatment, payment, or health care operations, as permitted by and in compliance with 45 CFR 164.506;</p> <p>(iv) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR 164.512.</p> <p>§483.70(h)(3) The facility must safeguard medical record information against loss, destruction, or unauthorized use.</p> <p>§483.70(h)(4) Medical records must be retained for-</p> <p>(i) The period of time required by State law; or</p> <p>(ii) Five years from the date of discharge when there is no requirement in State law; or</p> <p>(iii) For a minor, 3 years after a resident reaches legal age under State law.</p> <p>§483.70(h)(5) The medical record must contain-</p> <p>(i) Sufficient information to identify the resident;</p> <p>(ii) A record of the resident's assessments;</p>	F0842		

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NAME OF PROVIDER OR SUPPLIER <b>Barbour Court Nursing and Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 Barbour Road , Smithfield, North Carolina, 27577</b>	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F0842 SS = A	<p>Continued from page 10</p> <p>(iii) The comprehensive plan of care and services provided;</p> <p>(iv) The results of any preadmission screening and resident review evaluations and determinations conducted by the State;</p> <p>(v) Physician's, nurse's, and other licensed professional's progress notes; and</p> <p>(vi) Laboratory, radiology and other diagnostic services reports as required under §483.50.</p> <p>This REQUIREMENT is NOT MET as evidenced by:</p> <p>Based on record review and staff interviews, the facility failed to accurately document the administration of insulin (an essential hormone that manages blood sugar levels) for 1 of 5 residents reviewed for accurate medical records (Resident #8).</p> <p>Findings included:</p> <p>A current active physician's order for Resident #8 with a start date of 3/18/25 revealed Novolog injection solution (a type of fast acting insulin)100 units per milliliter inject 10 units subcutaneously (SQ is beneath the skin) with meals. Hold (do not give) for blood sugar (BS) less than 150 (a normal adult BS before eating is between 70 to 99.</p> <p>Resident #8's December 2025 Medication Administration Record (MAR) revealed documentation by Nurse #2 indicating that Resident #8's BS on 12/27/25 at 11:30 AM was 134 and she administered 10 units of Novolog insulin SQ to Resident #8. Resident #8's BS at 5:30 PM was 233. On 12/28/25 at 11:30 AM Nurse #2 documented Resident #8's BS was 125 and she administered 10 units of Novolog insulin SQ to Resident #8. Nurse #2's documentation on Resident #8's MAR indicated Resident #8's BS was not checked at 5:30 PM on 12/28/25 and to see the nursing progress note.</p> <p>Review of the medical record revealed no nursing progress note for Resident #8 written by Nurse #2 corresponding to the documentation on his MAR that his BS was not checked on 12/28/25 at 5:30 PM.</p> <p>On 2/25/26 at 9:50 AM in a telephone interview Nurse #2 stated she was familiar with Resident #8. She reported that she was aware that Resident #8 had parameters for the administration of his Novolog insulin that instructed for this insulin to be held if his BS was</p>	F0842		

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NAME OF PROVIDER OR SUPPLIER <b>Barbour Court Nursing and Rehabilitation Center</b>			STREET ADDRESS, CITY, STATE, ZIP CODE <b>515 Barbour Road , Smithfield, North Carolina, 27577</b>	
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F0842 SS = A	<p>Continued from page 11 less than 150. She went on to say she could see this on Resident #8's electronic MAR on her computer screen when she was administering his medications. Nurse #2 reported although her documentation on Resident #8's MAR on 12/27/25 at 11:30 AM that his BS was 134 and she administered 10 units SQ to Resident #8, and that on 12/28/25 at 11:30 AM Resident #8's BS was 125 and she administered 10 units SQ to Resident #8, this documentation had been in error. She stated she had not administered 10 units of Novolog insulin to Resident #8 on those dates because his BS had been below the parameter. She reported she could not say why her documentation had been inaccurate. Nurse #2 went on to say she thought she had written a progress note in Resident #8's medical record related to Resident #8 refusing his BS check on 12/28/25 at 5:30 PM.</p> <p>On 2/25/26 at 1:53 PM in an interview the Director of Nursing stated nurses' documentation on resident's MARs should be accurate.</p> <p>On 2/25/26 at 3:14 PM an interview with the Administrator indicated nurses' documentation on resident's MARs should be accurate.</p>	F0842		