

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>345237</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____  B. WING _____		(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/20/2015</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, NC 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	
F 241 SS=D	<p><b>483.15(a) DIGNITY AND RESPECT OF INDIVIDUALITY</b></p> <p>The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to treat a resident in a dignified manner for 1 of 2 sampled residents (resident #164) when the facility allowed a resident who requested to be put to bed to sit in their wheelchair for 5 to 6 hours without assistance.</p> <p>Findings included:</p> <p>Review of the clinical record of Resident #164 indicated the resident was admitted to facility on 1/24/2013.</p> <p>The annual Minimum Data Set (MDS) dated 1/4/2015 indicated the resident was cognitively intact with no deficits. The MDS also indicated the resident required extensive assistance of 2 persons for transfers, locomotion and toileting.</p> <p>The resident was interviewed in her room briefly on 5/19/2015 and completed the interview over the phone on 5/20/2015 at 10:30 AM. The resident stated on 5/1/2015, she was up in her wheelchair when second shift staff arrived around 3:00 PM. She stated she asked Nursing Assistant #1 (NA) to put her to bed as soon as the NA came on duty. The resident reported the NA told her she did not have anyone to help put</p>	F 241	<p>Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the Statement of Deficiencies and proposes this Plan of Correction to the extent that the summary of findings is factually correct and in order to maintain compliance with applicable rules and provisions of quality of care of residents. The Plan of Correction is submitted as a written allegation of compliance.</p> <p>Barbour Court Nursing and Rehabilitation Center's response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute an admission that any deficiency is accurate. Further, Wilson Pines Nursing and Rehabilitation Center reserves the right to refute any of the deficiencies on this Statement of Deficiencies through Informal Dispute Resolution, formal appeal procedure and/or any other administrative or legal proceeding.</p> <p>F241 Resident #164 will continue to be treated in a dignified manner and transferred to bed per resident's request.</p>	6/17/15	

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

TITLE

(X6) DATE

Electronically Signed

06/05/2015

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

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F 241	<p>Continued From page 1</p> <p>her to bed but would return as soon as another staff person was available to help. The resident also stated she asked other staff members during the next few hours to help her back to bed, and the resident stated staff replied there was no one to put her to bed. The resident stated she did not recall specific names of staff she asked. The resident also indicated she wheeled herself to the nurse's station around 7:30 PM and asked for help to go to bed and was told there was no one available to assist her. The resident further indicated she wore briefs and required staff to change her when she was soiled. The resident stated during those hours she had no choice but to soil herself. When asked how this event made her feel, the resident stated "It made me feel very bad. I missed my religious service that night. I have to be in my bed and connect to the service by phone to hear it at around 7:30 PM. The cord will not reach from my wheelchair, so I have to be in my bed to hear it. My religious services are very important to me. If I miss them, I feel very empty."</p> <p>Staff nurse #1 who cared for the resident on second shift on 5/1/2015 was interviewed on 5/19/2015 at 3:00 PM. The nurse did not recall the resident on 5/1/2015 having to wait to be put to bed when requested. The nurse did not recall anyone asking her to assist with putting the resident to bed.</p> <p>NA #1 who cared for the resident on second shift 5/1/2015 was interviewed on 5/19/2015 at 3:35 PM. The NA stated on 5/1/2015, she was assigned to resident #164 on the 3-11 shift. The NA reported the resident requested to be put to bed at 3:00 PM right after the NA arrived on duty.</p>	F 241	<p>A dignity questionnaire was completed with 100% of all alert and oriented resident's to include resident #164 to ensure residents feel treated in a dignified manner to include honoring preferences and being put to bed when requested by 6/17/15 by the Social Workers. The Administrator or Director of Nursing (DON) immediately addressed all identified areas of concerns from the resident dignity questionnaires by 6/17/15. Resident care observations were initiated on 6/5/15 by the MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors with 100% CNAs (Certified Nursing Assistances) to include NA # 1 and license nurses to include staff nurse #1 to ensure all CNAs and license nurses are treating residents in a dignified manner to include honoring preferences and transferring resident's to bed per their request. Retraining was immediately conducted during the observation by the MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors for any identified areas of concerns.</p> <p>An in-service was initiated on 6/5/15 by the MDS nurse, Director of Nursing, Staff Facilitator, and Nursing Supervisors with all staff to include NA #1, Staff nurse #1, all CNAs, all license nurses, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping, receptionist and social workers staff regarding dignity to include the definition of dignity and examples of dignity to include putting residents to bed upon request. All newly hired staff will be in-serviced regarding dignity to include the</p>		

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F 241	<p>Continued From page 2</p> <p>The NA stated she was the only NA on that end of the hall that evening, and she told the resident she would return as soon as she could and put her to bed, as she needed 2 people to do this. The NA stated that it was at least 8:00 or 8:30 PM or maybe even later before she got help to put her to bed. She stated there were other times she recalled resident #164 having to wait a long time to be put to bed when she requested, because there was not enough staff to help. The NA stated she did not ask any staff to assist her until late and further stated " they knew I needed help. "</p> <p>The facility Director of Nursing was interviewed on 5/20/2015 at 4:40 PM and stated the expectation was a resident's choices should be honored when reasonable, and she further stated no resident should have to wait for hours for assistance. The DON also stated a staff person should ask an NA on the other end of the unit or an NA from any other unit for assistance with a resident when assistance is required.</p> <p>The facility Administrator was interviewed on 5/20/2015 at 4:45 PM and stated the expectation was a resident's choices should be honored when reasonable. The Administrator also stated no resident should wait for hours to receive assistance.</p>	F 241	<p>definition of dignity and examples of dignity to include putting residents to bed upon request during orientation by the Staff Facilitator.</p> <p>A dignity questionnaire will be completed with 10% of all alert and oriented residents to include resident #164 by the social workers utilizing a QI Tool weekly x 8 weeks then monthly x 2 months to ensure residents feel treated in a dignified manner. The Administrator and DON will immediately address any identified areas of concern. Resident care observations will be completed with 10% of license nurses and CNAs on all shifts to include nights and weekends to observe license nurses to include staff nurse #1 and CNAs to include NA #1 to ensure staff are treating residents to include resident #164 in a dignified manner utilizing a resident care audit tool 3x per week times 4 weeks, then weekly x 4 weeks, then monthly x 2 months by the MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors. The Administrator or DON will review and initial the dignity questionnaires QI tools and the resident care audit tools weekly x 8 weeks then monthly x 2 months for completion and to ensure all areas of concern were addressed.</p> <p>The Quality Assurance committee will review the results of the Resident Dignity Questionnaires QI Tools and resident care audit tools at the monthly QI meeting for four months for the need to continue monitoring and the frequency of monitoring. The QI committee members consist of the QI nurse, DON, ADON,</p>		

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F 241	Continued From page 3	F 241	MDS Coordinator, Staff Facilitator, Business Manager, Therapy Manager, Medical Records Managers, Dietary Manager, and Administrator.		
F 242 SS=D	<p>483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES</p> <p>The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff and resident interviews, the facility failed to honor a resident's choice for 1 of 1 sampled residents (resident #164) when the facility allowed a resident who requested to be put to bed to sit in their wheelchair for 5 to 6 hours before putting the resident to bed.</p> <p>Findings included:</p> <p>Review of the clinical record of Resident #164 indicated the resident was admitted to facility on 1/24/2013.</p> <p>The annual Minimum Data Set (MDS) dated 1/4/2015 indicated the resident was cognitively intact with no deficits. The MDS also indicated the resident required extensive assistance of 2 persons for transfers, locomotion and toileting.</p>	F 242	<p>F242 Resident #164 will continue to have choices honored and be transferred to bed per resident's request. A resident choice questionnaire was completed with 100% of all alert and oriented residents to include resident #164 regarding preferences in care by the MDS nurses by 6/17/15. The MDS nurses immediately addressed all identified areas of concerns from the resident choice questionnaire by updating the resident care plan and care guide to reflect the resident's preference by 6/17/15. The Social Workers reviewed the federal resident rights with all alert and oriented residents and a copy of the federal resident's rights was given to the residents by 6/17/15. An in-service was initiated on 6/5/15 by</p>	6/17/15	

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F 242	<p>Continued From page 4</p> <p>The resident was interviewed in her room briefly on 5/19/2015 and completed the interview over the phone on 5/20/2015 at 10:30 AM. The resident stated on 5/1/2015, she was up in her wheelchair when second shift staff arrived around 3:00 PM. She stated she asked Nursing Assistant #1 (NA) to put her to bed as soon as the NA came on duty. The resident reported the NA told her she did not have anyone to help put her to bed but would return as soon as another staff person was available to help. The resident also stated she asked other staff members during the next few hours to help her back to bed, and the resident stated staff replied there was no one to put her to bed. The resident stated she did not recall specific names of staff she asked. The resident also indicated she wheeled herself to the nurse's station around 7:30 PM and asked for help to go to bed and was told there was no one available. The resident further indicated it was almost 9:00 PM before staff put her to bed that night.</p> <p>Staff nurse #1 who cared for the resident on second shift on 5/1/2015 was interviewed on 5/19/2015 at 3:00 PM. The nurse did not recall the resident on 5/1/2015 having to wait to be put to bed when requested. The nurse did not recall anyone asking her to assist with putting the resident to bed.</p> <p>NA #1 who cared for the resident on second shift 5/1/2015 was interviewed on 5/19/2015 at 3:35 PM. The NA stated on 5/1/2015, she was assigned to resident #164 on the 3-11 shift. The NA reported the resident requested to be put to bed at 3:00 PM right after the NA arrived on duty. The NA stated she was the only NA on that end of</p>	F 242	<p>the MDS nurse, Director of Nursing, Staff Facilitator, and Nursing Supervisors with all staff to include NA #1, Staff nurse #1, all CNAs, all license nurses, dietary staff, therapy staff, housekeeping staff, maintenance staff, activities, payroll, bookkeeping, receptionist and social workers staff regarding residents rights and right to make decisions. All newly hired staff will be in-serviced regarding resident's rights and right to make decisions during orientation by the Staff Facilitator.</p> <p>A resident choice questionnaire will be presented to all newly admitted residents upon admission regarding preferences in care by the MDS Nurses. The MDS nurses will immediately update the resident preferences on the resident care guide and resident care plan. A resident choice questionnaire will be completed with 10% of all alert and oriented residents to include resident #164 by MDS Nurses weekly x 8 weeks then monthly x 2 months to ensure residents preferences are being honored and for any changes in preferences utilizing a QI Tool. The MDS nurses will immediately address any identified areas of concern and update the resident care plan and resident care guide for any changes. Resident care observations will be completed with 10% of license nurses and CNAs on all shifts to include nights and weekends to observe license nurses to include staff nurse #1 and CNAs to include NA #1 to ensure resident preferences are being honored to include resident #164 utilizing a resident care audit tool 3x per week times 4</p>		

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F 242	Continued From page 5 the hall that evening, and she told the resident she would return as soon as she could and put her to bed, as she needed 2 people to do this. The NA stated that it was at least 8:00 or 8:30 PM or maybe even later before she got help to put her to bed. She stated there were other times she recalled resident #164 having to wait a long time to be put to bed when she requested, because there was not enough staff to help. The NA stated she did not ask any staff to assist her until late and further stated "they knew I needed help."  The facility Director of Nursing was interviewed on 5/20/2015 at 4:40 PM and stated the expectation was resident's choices should be honored when reasonable, and she further stated no resident should have to wait for hours for assistance. The DON also stated a staff person should ask an NA on the other end of the unit or an NA from any other unit for assistance with a resident.  The facility Administrator was interviewed on 5/20/2015 at 4:45 PM and stated the expectation was resident's choices should be honored when reasonable. The Administrator also stated no resident should wait for hours to receive assistance.	F 242	weeks, then weekly x 4 weeks, then monthly x 2 months by MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors. The Administrator or DON will review and initial the resident choice questionnaires QI audit tool and the resident care audit tools weekly x 8 weeks then monthly x 2 months for completion and to ensure all concerns were addressed. The Quality Assurance committee will review the results of the Resident Choice Questionnaires QI audit Tool and resident care audit tools at the monthly QI meeting for four months for the need to continue monitoring and the frequency of monitoring. The QI committee members consist of the QI nurse, DON, ADON, MDS Coordinator, Staff Facilitator, Business Manager, Therapy Manager, Medical Records Managers, Dietary Manager, and Administrator.		
F 312 SS=D	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS  A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.	F 312		6/17/15	

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F 312	Continued From page 6  This REQUIREMENT is not met as evidenced by: Based on record review and staff and resident interviews, the facility failed to transfer a resident from a wheel chair to bed following the resident 's request for of 1 of 1 sampled residents (resident #164). Findings included: Review of the clinical record of Resident #164 indicated the resident was admitted to facility on 1/24/2013. The annual Minimum Data Set (MDS) dated 1/4/2015 indicated the resident was cognitively intact with no deficits. The MDS also indicated the resident required extensive assistance of 2 persons for transfers, locomotion and toileting. The resident was interviewed in her room briefly on 5/19/2015 and completed the interview over the phone on 5/20/2015 at 10:30 AM. The resident stated on 5/1/2015, she was up in her wheelchair when second shift staff arrived around 3:00 PM. She stated she asked Nursing Assistant #1 (NA) to put her to bed as soon as the NA came on duty. The resident reported the NA told her she did not have anyone to help put her to bed but would return as soon as another staff person was available to help. The resident also stated she asked other staff members during the next few hours to help her back to bed, and the resident stated staff replied there was no one to put her to bed. The resident stated she did not recall specific names of staff she asked. The resident also indicated she wheeled herself to the nurse's station around 7:30 PM and asked for help to go to bed and was told there was no one available. The resident further indicated she wore briefs and required staff to change her when she was soiled. The resident stated during those	F 312	F312 Resident #164 will continue to have choices honored, treated in a dignified manner and be transferred to bed per resident's request. A resident choice questionnaire was completed with 100% of all alert and oriented residents to include resident #164 regarding preferences in care to include specific times to be transferred back to bed by the MDS Nurses by 6/17/15. The MDS nurses immediately addressed all identified areas of concerns from the resident choice questionnaire by updating the care plan and care guide to reflect the resident preference to include any preferences of specific times to be transferred back to bed by 6/17/15. An in-service was initiated on 6/5/15 by the MDS nurse, Director of Nursing, Staff Facilitator, and Nursing Supervisors with all Certified Nursing Assistances (CNAs) and license nurses to include NA #1, Staff nurse #1, regarding residents rights and right to make decisions to include ADL care and when to be transferred back to bed and to immediately notify the supervisor if a two person assist is needed for care and assistance cannot be found. All newly hired license nurses and CNAs will be in-serviced regarding resident's rights and right to make decisions to include ADL care and when to be transferred back to bed and to immediately notify the supervisor if a two person assist is needed for care and		

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F 312	<p>Continued From page 7</p> <p>hours she had no choice but to soil herself. The resident also stated how important it was for her to be in bed by 7:30 PM, as that was the time her religious program came on, and she could only access it by phone while on her bed.</p> <p>Staff nurse #1 who cared for the resident on second shift on 5/1/2015 was interviewed on 5/19/2015 at 3:00 PM. The nurse did not recall the resident on 5/1/2015 having to wait to be put to bed when requested. The nurse did not recall anyone asking her to assist with putting the resident to bed.</p> <p>NA #1 who cared for the resident on second shift 5/1/2015 was interviewed on 5/19/2015 at 3:35 PM. The NA stated on 5/1/2015, she was assigned to resident #164 on the 3-11 shift. The NA reported the resident requested to be put to bed at 3:00 PM right after the NA arrived on duty. The NA stated she was the only NA on that end of the hall that evening, and she told the resident she would return as soon as she could and put her to bed, as she needed 2 people to do this. The NA stated that it was at least 8:00 or 8:30 PM or maybe even later before she got help to put her to bed. She stated there were other times she recalled resident #164 having to wait a long time to be put to bed when she requested, because there was not enough staff to help. The NA stated she did not ask any staff to assist her until late and further stated " they knew I needed help. "</p> <p>The facility Director of Nursing was interviewed on 5/20/2015 at 4:40 PM and stated the expectation was residents should receive assistance with toileting and transfers when needed, and she further stated no resident should have to wait for hours for assistance. The DON also stated a staff person should ask an NA on the other end of the unit or an NA from any other</p>	F 312	<p>assistance cannot be found during orientation by the Staff facilitator. Resident care observations will be completed with 10% of license nurses and CNAs on all shifts to include nights and weekends to observe license nurses to include staff nurse #1 and CNAs to include NA #1 perform ADL care to include transfers to ensure residents to include resident #164 preferences are being honored per the resident care plan and care guide to include transfers utilizing a resident care audit tool 3x per week times 4 weeks, then weekly x 4 weeks, then monthly x 2 months by MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors. Retraining will be immediately conducted by the MDS nurses, Staff Facilitator, treatment nurses, and nursing supervisors for any identified areas of concern during the resident care observations. The Administrator or Director of Nursing will review and initial the resident care audit tools weekly x 8 weeks then monthly x 2 months for completion and to ensure all concerns were addressed.</p> <p>The Quality Assurance committee will review the results of the resident care audit tools at the monthly QI meeting for four months for the need to continue monitoring and the frequency of monitoring. The QI committee members consist of the QI nurse, DON, ADON, MDS Coordinator, Staff Facilitator, Business Manager, Therapy Manager, Medical Records Managers, Dietary Manager, and Administrator.</p>		



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

PRINTED: 06/15/2015  
FORM APPROVED  
OMB NO. 0938-0391

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F 312	Continued From page 8 unit for assistance with a resident when needed. The facility Administrator was interviewed on 5/20/2015 at 4:45 PM and stated the expectation was no resident should have to wait for hours to receive assistance.	F 312		