| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
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| BARBOUR COURT NURSING AND REHABILITATION CENTER | 515 BARBOUR ROAD SMITHFIELD, NC 27577 |

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| F 000 | INITIAL COMMENTS<br><br>The surveyor entered the facility on 12/7/21 to conduct a revisit and complaint investigation and exited the facility on 12/8/21. Additional information was obtained on 12/13/21 and therefore the exit date was changed to 12/13/21. One of one complaint allegation was substantiated. Event 1MT911. | F 000 | | |
| F 580 SS=D | Notify of Changes (Injury/Decline/Room, etc.)<br>CFR(s): 483.10(g)(14)(i)-(iv)(15)<br><br>§483.10(g)(14) Notification of Changes.<br>(i) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is-<br>(A) An accident involving the resident which results in injury and has the potential for requiring physician intervention;<br>(B) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);<br>(C) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or<br>(D) A decision to transfer or discharge the resident from the facility as specified in §483.15(c)(1)(ii).<br>(ii) When making notification under paragraph (g)(14)(i) of this section, the facility must ensure that all pertinent information specified in §483.15(c)(2) is available and provided upon request to the physician.<br>(iii) The facility must also promptly notify the resident and the resident representative, if any, | F 580 | | 1/11/22 |

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 12/22/2021

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| F 580 | Continued From page 1<br>when there is-<br>(A) A change in room or roommate assignment as specified in §483.10(e)(6); or<br>(B) A change in resident rights under Federal or State law or regulations as specified in paragraph (e)(10) of this section.<br>(iv) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).<br><br>§483.10(g)(15)<br>Admission to a composite distinct part. A facility that is a composite distinct part (as defined in §483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations under §483.15(c)(9).<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, family interviews, staff interviews, Nurse Practitioner interview, and Physician interview, for one (Resident # 2) of one sampled resident in the end stages of life, the facility failed to effectively communicate with the Physician or Nurse Practitioner regarding midline intravenous placement after 1) the resident was experiencing a change in condition with signs of dry mouth and low urine output 2) orders had been written for Intravenous fluids 3) six attempts by facility staff to start intravenous fluids had failed and 4) the responsible party's wishes were that intravenous interventions be part of his care. The facility also failed to communicate when the resident's blood pressure would not register and his temperature grew closer to a hypothermic reading. The findings included. | F 580 | 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.<br>Barbour Court Nursing and Rehabilitation Center response to this Statement of Deficiencies does not denote agreement with the Statement of Deficiencies nor does it constitute and admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center | |

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| F 580 | Continued From page 2<br><br>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.<br><br>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.<br><br>Record review revealed Resident # 2 had orders for Do Not Resuscitate in the event of his death.<br><br>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 would make the resident comfort care only.<br><br>NP # 2 was interviewed on 12/13/21 at 3:15 PM and reported the following. She had talked to Resident # 2's RP, who resided in the same room as Resident # 2, about care goals for the resident. The resident's weight was declining, and the RP did not want a feeding tube. The RP had acknowledged Resident # 2 had exceeded his life expectancy, but she still wanted him to have IV's, | F 580 | 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.<br>F 580 Notify of Changes<br>Resident #2 no longer resides at this facility thus no other corrective action can be completed for this resident.<br>Nurses #2 and #3, who failed to start the IV and Nurses #4 and Unit Manager #1 who were unable to obtain a blood pressure and failed to notify the practitioner, were in-serviced by Director of Nursing on 12/11/2021 regarding:<br><br>1. How to complete a Nursing assessment.<br>2. Examples of changes in condition to include but not limited to changes in vital signs, inability to obtain vital signs, changes in oral intake, changes in urine output, changes in normal body function, and changes in lab values.<br>3. Notifying the physician by telephone when a change in condition is observed prior to starting another task.<br>4. Communicating a full assessment report to the provider of a resident's change in condition.<br>5. Following physician's orders and notifying the physician if orders are unable to be carried out.<br>6. What to do when a blood pressure monitor is not reading to include rechecking, checking to see if the cuff is too loose or too tight, taking the blood pressure manually, and notifying the | |

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| F 580 | Continued From page 3 | F 580 | | |

antibiotics, diagnostic tests, and hospitalization if ever warranted. This remained her choice up until the resident's death.

On 11/8/21 at 8:08 AM nursing notes reflected the resident had a change in condition as evidenced by vomiting and shivering.

According to the record diagnostic tests were ordered in addition to antiemetics.

Nurse # 1 had cared for Resident # 2 on the 7:00 AM to 3:00 PM shift of 11/8/21 and was interviewed on 12/7/21 at 2:20 PM. The nurse reported the following. The resident had thrown up yellow emesis which had clumps in it. It ran down his neck. She did talk to the on-call NP (NP # 1) and later that day another NP (NP #2) came in to see the resident. Around the time of NP #2's visit the nurse noted the resident was shivering again and had a little more of something coming from his mouth again; "but not like before." He did not take any liquids on her shift and he did not urinate.

NA # 1 had cared for Resident # 2 on the 7:00 AM to 3:00 PM shift of 11/8/21 and was interviewed on 12/7/21 at 2:50 PM. The NA reported the resident did not drink anything that day nor did he urinate on her shift.

Following Nurse # 1's nursing entry of 11/8/21 at 8:08 AM, the next entry into the record was made by NP #2 at 6:21 PM on 11/8/21. The note reflected the NP had seen the resident and evaluated some of his labs and diagnostic studies. The NP noted an ileus had been noted on one of his diagnostic studies. He had an elevated white count, hemoglobin and hematocrit

physician.

On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Minimum Data Set (MDS) Nurses assessed 100% of all current residents for changes in condition to include worsening of vital signs, diaphoresis, dry mouth, signs and symptoms of dehydration, and shaking/shivering. The DON, ADON, MDS nurse notified the physician during the audit for any changes observed to include worsening of vital signs or the inability to obtain vital signs. All noted changes and notification to the physician was documented in the resident's clinical records.
On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Facility Consultant audited 100% of all current residents' progress notes, 24-hour report communication sheets, and vital sign report logs from 11/1/21-12/11/21. This audit is to ensure that all documented changes in condition had been communicated to the physician to include worsening in vital signs and/or inability to obtain vital signs. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers reassessed the resident and notified the physician for all identified areas of concern noted during the audit. Audit was completed by 12/12/21.
On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Facility

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| F 580 | Continued From page 4<br>which were "likely due to dehydration." She was going to order intravenous fluids, and that a fleets enema and Dulcolax be given. The labs would be repeated on 11/10/21.<br><br>On 11/8/21 orders were written that the resident have normal saline at 60 cc/hour (cubic centimers/ hour) after administering a 500 cc of normal saline bolus. Record review revealed this order was never carried out and there had been no written orders to discontinue it or place it on hold.<br><br>Nurse # 2 had cared for Resident # 2 on the 3:00-11:00 PM shift of 11/8/21 and was interviewed on 12/8/21 at 10:50 AM. Nurse # 2 reported the following. The NP came a little after the beginning of her shift and left orders for intravenous fluids (IV). She attempted to get the IV in three times but was unsuccessful. She told the nursing supervisor about the unsuccessful IV attempts and passed it along to the next nurse.<br><br>Following the NP's entry on 11/8/21 at 6:21 PM, the next entry was made on 11/9/21 at 5:03 AM by the night shift nurse (Nurse # 3) who noted the following. Attempts were made to insert the IV again but were unsuccessful. There was no documentation the physician or Nurse Practitioner was notified by Nurse # 2 that IV attempts were unsuccessful.<br><br>Nurse # 3 was interviewed on 12/7/21 at 4:20 PM and reported the following. Three unsuccessful attempts were made to insert the IV, but the resident appeared stable. He passed along to the next shift regarding the IV.<br><br>Unit Manager # 1 was interviewed on 12/8/21 at | F 580 | Consultant audited 100% of physician orders for all residents identified acute 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 ensure orders were completed and followed per physician's order to include midline intravenous placement. Also, to ensure the physician was notified of any orders that were unable to be carried out. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers reassessed the resident and notified the physician for all orders that were not completed or carried out. Audit was completed by 12/12/21.<br>On 12/11/21, the Activity Director posted a bright colored sign at each nursing station regarding guidelines of things to communicate to the physician by phone to include but not limited to changes in condition, inability to carry out orders for any reason, inability to obtain vital signs, and/or inability to obtain labs. Signs were posted by 12/12/21.<br><br>On 12/11/21, an in-service was initiated by the Director of Nursing with 100% of all nurses regarding:<br><br>1. How to complete a Nursing assessment.<br>2. Examples of changes in condition to include but not limited to changes in vital signs, inability to obtain vital signs, changes in oral intake, changes in urine output, changes in normal body function, and changes in lab values. | |

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| F 580 | Continued From page 5<br>9:30 AM and reported the following. She had not been involved in the orders which had been given the previous day (11/8/21) but if IV access was not able to be obtained then the facility had a contract with an outsider company who could place a midline. The procedure was to notify the provider and get permission to use the company.<br><br>According to Resident # 2's record, no orders were obtained from the physician or the NP in regards to using the contract company to start an IV. Record review revealed the facility did have a contract with an outside company for midline placement.<br><br>Interview with NP # 2 on 12/13/21 3:15 PM revealed if the staff had called the on- call physician provider during the night shift which began on 11/8/21, then an order would have been given to contact the company for midline placement; but this had not been done. NP # 2 recalled at some point she recalled talking to a nurse about midline placement but did not recall if that was before or after his death.<br><br>Following Nurse # 4's nursing entry on 11/9/21 at 9:06 AM the next note was entered on 11/9/21 at 12:00 PM by Nurse # 4. The nurse noted around 10 AM the resident's temperature was 95; his pulse was 93, and his respirations were 30, and his blood pressure could not be obtained. The nurse noted she informed two supervisors and asked if they could check his blood pressure. There was no documentation the resident's physician or Nurse Practitioner were notified the resident's blood pressure was not registering or that his temperature had fallen to 95 degrees.<br><br>Nurse # 4 was interviewed on 12/8/21 at 11:10 | F 580 | 3. Notifying the physician by telephone when a change in condition is observed prior to starting another task.<br>4. Communicating a full assessment report to the provider of a resident's change in condition.<br>5. Following physician's orders and notifying the physician if orders are unable to be carried out.<br>6. What to do when a blood pressure monitor is not reading to include rechecking, checking to see if the cuff is too loose or too tight, taking the blood pressure manually, and notifying the physician.<br><br>In-service will be completed by 12/12/2021. After 12/12/2021, the Administrator will ensure the remaining in-services for staff who have not worked or have not received the in-services are mailed with instructions to review, sign the in-service, and return to the staff facilitator and/or director of nursing prior to next scheduled work shift.<br>The Unit Managers and Assistant Director of Nursing will audit all 24- hour communication reports and progress notes 5 x per week x 4 weeks then monthly x 1 month utilizing an Acute Change in Condition Audit Tool. This audit is to ensure that the nurse has identified and documented all changes in condition to include inability to obtain a blood pressure and communicated the change to the physician with follow up actions taken.<br>The Unit Managers and Assistant Director of Nursing will audit physician orders for | |

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| F 580 | Continued From page 6<br>AM and again on 12/8/21 at 3:10 PM and reported the following. She had talked to the NP and let her know the resident was drinking, they could not get the IV in, and the family wanted him sent to the hospital. Before 12:30 PM she had checked his vitals again and could not get his blood pressure to register on the machine. She got a cuff and tried to manually auscultate it and could not auscultate it. She had reported this to two unit managers and asked them to check the resident. She went to lunch around 12:30 PM. When she came back from lunch, she learned the NP had called and left orders with Unit Manager # 2 for Resident # 2 which included antibiotics. Nurse # 4 stated she never talked directly to the NP or gave the NP an update after the resident's blood pressure could not be auscultated.<br><br>Unit Manager # 1 was interviewed on 12/8/21 at 9:30 AM and reported the following. She recalled Nurse # 4 telling her that Resident # 2 was not doing well and the nurse was waiting on a phone call back from the NP. She went into check on him. She tried to get his blood pressure and could not with the machine. The nurse stated it was always hard to get a blood pressure reading due to the resident's movements but he did not look in distress. She had not reported to the physician she could not get a blood pressure.<br><br>NP # 2 was interviewed on 12/8/21 at 12:25 PM and again on 12/13/21 3:15 PM and reported the following. She had seen the resident on the morning of 11/8/21. He looked stable other than having hiccoughs. His vitals were stable. She saw him again on the evening of 11/8/21. His KUB had shown an ileus and she had left orders to address that and for IV fluids. On the morning of 11/9/21 | F 580 | all residents identified for acute changes through residents' progress notes, 24-hour report communication sheets, and vital sign report logs 5 times per week x 4 weeks then monthly x 1 month utilizing Orders Audit Tool. This audit is to ensure orders were completed and followed per physician's order.<br>The DON will present the findings of the Change in Condition Audit Tool and Orders Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Change in Condition Audit Tool and Orders Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. | |

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| F 580 | Continued From page 7 | F 580 | | |

Nurse # 4 had alerted her that the resident's family member wanted the resident sent to the hospital. At the time, Nurse # 4 had indicated the resident was starting to drink fluids and was no longer vomiting. She was aware his heart rate was high and therefore she had ordered some Rocephin for him because something "could be brewing." She had talked to the resident's family member, who was agreeable to treat the resident at the facility. She also talked to the physician and he wanted to add Flagyl also to the orders. She called the staff and let them know that also. She did not see the resident on 11/9/21 and from the conversations she was having with the staff, the resident seemed to be getting better. At no time did they tell her that they could not get a blood pressure on the resident, and she had been unaware the resident's temperature had dropped to 95 degrees. She would have wanted to know that. The resident seemed to have declined quickly.

The resident's physician was interviewed on 12/8/21 at 3:27 PM and reported the following. The physician felt the resident's 11/8/21 labs were not concerning for dehydration at the time they were drawn on 11/8/21. Given that he was starting to take oral fluids by the morning of 11/9/21 and the nurses had attempted several times to insert an IV, he felt it had been fine not to continue with trying to insert the IV as long as the resident was continuing to take fluids by mouth. According to the physician he would have wanted to know when two nurses could not have obtained a blood pressure on the resident. If he had been made aware of that, then he would have sent the resident out for further evaluation but he did not feel this would have changed the outcome for the resident. The resident's weight was very low and

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| F 580 | Continued From page 8<br>even if he had been transferred sooner to the hospital, the physician felt the resident would have been placed on palliative care. | F 580 | | |
| F 684 SS=D | Quality of Care<br>CFR(s): 483.25<br><br>§ 483.25 Quality of care<br>Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices.<br>This REQUIREMENT is not met as evidenced by:<br>Based on record review, family interviews, staff interviews, Nurse Practitioner interview, and Physician interview, for one (Resident # 2) of one sampled resident in the end stages of life, the facility failed to start intravenous fluids, obtain a lab study, and communicate effectively with the physician in order that he be hospitalized per the resident's plan of care and Responsible Party's wishes. The findings included.<br><br>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.<br><br>Review of Resident # 2's minimum data set | F 684 | F 684 Quality of Care<br>Resident #2 no longer resides at this facility thus no other corrective action can be completed for this resident.<br>Nurses #2 and #3, who failed to start the IV and Nurses #4 and Unit Manager #1 who were unable to obtain a blood pressure and failed to notify the practitioner, were in-serviced by Director of Nursing on 12/11/2021 regarding:<br><br>7. How to complete a Nursing assessment.<br>8. Examples of changes in condition to include but not limited to changes in vital signs, inability to obtain vital signs, changes in oral intake, changes in urine output, changes in normal body function, and changes in lab values.<br>9. Notifying the physician by telephone when a change in condition is observed | 1/11/22 |

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| F 684 | Continued From page 9<br>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.<br><br>Resident # 2's care plan, last reviewed on 10/27/21, revealed the resident reportedly had never weighing over 82 pounds and in 2018 the Responsible party had decided against a feeding tube, but would want intravenous fluids intervention if indicated. The care plan noted the resident's weight fluctuated but he continued to have a slow steady decline. On 10/23/21 the resident's goal that he maintain or increase his weight was discontinued and the goal was that he would adhere to his diet; which was noted to be a puree diet. Part of the care plan which remained current until the resident's death was that the resident was at risk for fluid volume deficient and that staff were to monitor for signs and symptoms which included dry skin/mucous membranes, increased pulse rate; decreased blood pressure, decreased pulse volume/pressure; change in mental status; and decreased urine output. The care plan also directed that the staff monitor labs as ordered with notification of physician regarding results.<br><br>Review of Resident # 2's weights revealed the following:<br>6/10/21-75<br>7/10/21-74<br>8/9/21-74<br>9/10/21-73<br>10/8/21-73<br><br>Record review revealed Resident # 2 had orders for Do Not Resuscitate in the event of his death. | F 684 | prior to starting another task.<br>10. Communicating a full assessment report to the provider of a resident's change in condition.<br>11. Following physician's orders and notifying the physician if orders are unable to be carried out.<br>12. What to do when a blood pressure monitor is not reading to include rechecking, checking to see if the cuff is too loose or too tight, taking the blood pressure manually, and notifying the physician.<br><br>On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Minimum Data Set (MDS) Nurses assessed 100% of all current residents for changes in condition to include worsening of vital signs, diaphoresis, dry mouth, signs and symptoms of dehydration, and shaking/shivering. The DON, ADON, MDS nurse notified the physician during the audit for any changes observed to include worsening of vital signs or the inability to obtain vital signs. All noted changes and notification to the physician was documented in the resident's clinical records.<br>On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Facility Consultant audited 100% of all current residents' progress notes, 24-hour report communication sheets, and vital sign report logs from 11/1/21-12/11/21. This audit is to ensure that all documented changes in condition had been | |

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| F 684 | Continued From page 10<br>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 would make the resident comfort care only.<br><br>NP # 2 was interviewed on 12/13/21 at 3:15 PM and reported the following. She had talked to Resident # 2's RP, who resided in the same room as Resident # 2, about care goals for the resident. The resident's weight was declining, and the RP did not want a feeding tube. The RP had acknowledged Resident # 2 had exceeded his life expectancy, but she still wanted him to have IV's, antibiotics, diagnostic tests, and hospitalization if ever warranted. This remained her choice up until the resident's death.<br><br>On 11/8/21 at 8:08 AM Nurse # 1 made a nursing entry noting the following. The resident had vomited a yellow substance and was shivering. The resident's vital signs were temperature: 97.0; pulse 94; respirations 18; and blood pressure 119/87. The nurse called the on call NP (NP # 1) and received orders for 1) antiemetics (nausea medication); 2) labs which included stat (right away) compete blood count, stat complete metabolic panel; and a urinalysis and culture and sensitivity 3) Stat chest x-ray; 4) stat KUB; 5) clear liquids for 24 hours; 6) vitals to be done every four hours for the next 24 hours.<br><br>Review of lab results revealed the urinalysis was never done and the order had never been | F 684 | communicated to the physician to include worsening in vital signs and/or inability to obtain vital signs. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers reassessed the resident and notified the physician for all identified areas of concern noted during the audit. Audit was completed by 12/12/21.<br>On 12/11/21, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Unit Managers and Facility Consultant audited 100% of physician orders for all residents identified acute 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 ensure orders were completed and followed per physician's order to include midline intravenous placement. Also, to ensure the physician was notified of any orders that were unable to be carried out. The Director of Nursing (DON), Assistant Director of Nursing (ADON), and Unit Managers reassessed the resident and notified the physician for all orders that were not completed or carried out. Audit was completed by 12/12/21.<br>On 12/11/21, the Activity Director posted a bright colored sign at each nursing station regarding guidelines of things to communicate to the physician by phone to include but not limited to changes in condition, inability to carry out orders for any reason, inability to obtain vital signs, and/or inability to obtain labs. Signs were posted by 12/12/21. | |

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discontinued in the record. The CMP, completed on 11/8/21 at 11:37AM, showed the resident's BUN and Creatinine (which can be an indication of hydration status) were within normal limits. The resident's white blood count was 11.8 (normal 3.8-10.8) and his hemoglobin was 17.2 (normal 13.2-17.1) and his hematocrit was 50 (normal 38.5-50). The resident's chest x-ray, completed on 11/8/21, showed no acute findings or infiltrate. The resident's KUB, completed on 11/8/21, showed he had a mild ileus (a disruption in the bowel's ability to move material) and marked gastric distention was suspected but the stomach was only partially visualized. The radiologist noted on the report "Follow up upper GI study is recommended."

NA # 3 had cared for Resident # 2 on the night shift before the day shift of 11/8/21. Interview with NA # 3 on 12/8/21 at 2:28 PM revealed Resident # 2 was shaking some and sweating that night to the point that the NA changed his clothing twice. He could not tell if it was emesis or phlegm but the resident had something coming from his mouth one time that got on his collar. He did report all this to the nurse. He did not give any fluids to the resident.

Interview on 12/7/21 at 4:20 PM with Nurse # 3, who had worked on the night shift before the dayshift of 11/8/21, revealed he did not recall problems on the night shift prior to 11/8/21.

Nurse # 1 had cared for Resident # 2 on the 7:00 AM to 3:00 PM shift of 11/8/21, was interviewed on 12/7/21 at 2:20 PM, and reported the following. The resident had thrown up yellow emesis which had clumps in it. It ran down his neck. She did talk to the on-call NP (NP # 1) and

On 12/11/21, an in-service was initiated by the Director of Nursing with 100% of all nurses regarding:

7. How to complete a Nursing assessment.
8. Examples of changes in condition to include but not limited to changes in vital signs, inability to obtain vital signs, changes in oral intake, changes in urine output, changes in normal body function, and changes in lab values.
9. Notifying the physician by telephone when a change in condition is observed prior to starting another task.
10. Communicating a full assessment report to the provider of a resident's change in condition.
11. Following physician's orders and notifying the physician if orders are unable to be carried out.
12. What to do when a blood pressure monitor is not reading to include rechecking, checking to see if the cuff is too loose or too tight, taking the blood pressure manually, and notifying the physician.

On 12/11/21, the Assistant Director of Nursing, Minimum Data Set Nurse (MDS) and/or RN Consultant will complete quizzes with all nurses regarding Recognizing Acute Changes and Physician Notification. This quiz is to validate staff knowledge of recognizing and communicating when to notify the physician to include but not limited to changes in condition. The Assistant Director of Nursing, Minimum Data Set

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| F 684 | Continued From page 12<br>later that day another NP (NP #2) came in to see the resident. Around the time of NP #2's visit the nurse noted the resident was shivering again and had a little more of something coming from his mouth again; "but not like before." He did not take any liquids on her shift and he did not urinate. She did not get the urine specimen and she reported this to the next nurse and the NP.<br><br>NA # 1 had cared for Resident # 2 on the 7:00 AM to 3:00 PM shift of 11/8/21 and was interviewed on 12/7/21 at 2:50 PM. The NA reported the resident did not drink anything that day nor did he urinate on her shift.<br><br>Following Nurse # 1's nursing entry of 11/8/21 at 8:08 AM, the next entry into the record was made by NP #2 at 6:21 PM on 11/8/21. The NP noted the following. She was seeing the resident because he had vomited twice. The UA had not been done due to no urine output. He appeared at his baseline. The ileus had been noted on the diagnostic study. His elevated white count and hemoglobin and hematocrit were "likely due to dehydration." She was going to order intravenous fluids, and that a fleets enema and Dulcolax be given. The labs would be repeated on 11/10/21.<br><br>Review of orders revealed NP # 2 wrote orders for intravenous fluids and for the administration of the fleets and Dulcolax. According the record, the Intravenous fluids were never administered and the order was never placed on hold or discontinued in the record.<br><br>There was no nursing note for the 3:00 PM to 11:00 PM shift of 11/8/21. Nurse # 2 had cared for Resident # 2 on this shift and was interviewed on 12/8/21 at 10:50 AM. Nurse # 2 reported the | F 684 | Nurse (MDS) and/or RN Consultant will reeducate and re-administer the quiz to any nurse who does not successfully demonstrate competency during the quiz. Nurses will not be allowed to work until successful demonstration is completed. The In-service and quiz will be completed by 12/12/2021. After 12/12/2021, the Administrator will ensure the remaining in-services and or quiz for staff who have not worked or have not received the in-services and/or quiz are mailed with instructions to review, complete, sign, and return to the Human Resource Coordinator and/or DON prior to next scheduled work shift.<br>The Unit Managers and Assistant Director of Nursing will audit all 24- hour communication reports and progress notes 5 x per week x 4 weeks then monthly x 1 month utilizing an Acute Change in Condition Audit Tool. This audit is to ensure that the nurse has identified and documented all changes in condition to include inability to obtain a blood pressure and communicated the change to the physician with follow up actions taken.<br>The Unit Managers and Assistant Director of Nursing will audit physician orders for all residents identified for acute changes through residents' progress notes, 24-hour report communication sheets, and vital sign report logs 5 times per week x 4 weeks then monthly x 1 month utilizing Orders Audit Tool. This audit is to ensure orders were completed and followed per physician's order.<br>The DON will present the findings of the | |

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| F 684 | Continued From page 13<br>following. The NP came a little after the beginning of her shift and left orders for intravenous fluids (IV). She attempted to get the IV in three times but was unsuccessful. The nurse stated she thought with each IV attempt she was in the resident's vein but got no flashback of blood. She thought this could have been because he was dehydrated. She tried to give him fluids and got the resident to drink part of a 240 cc (cubic centimeter) cup of fluid. She did not know about the urine specimen and did not get it. She told the nursing supervisor about the unsuccessful IV attempts and passed it along to the next nurse.<br><br>Following the NP's entry on 11/8/21 at 6:21 PM, the next entry was made on 11/9/21 at 5:03 AM by the night shift nurse (Nurse # 3) who noted the following. Attempts were made to insert the IV again but were unsuccessful. Fluids were encouraged with approximately 100 ml of water given. The resident had good results from the fleets and Dulcolax, was afebrile, and with pain/discomfort.<br><br>Nurse # 3 was interviewed on 12/7/21 at 4:20 PM and reported the following. The resident's vitals were stable although he had not documented them. Three unsuccessful attempts were made to insert the IV, but the resident appeared stable. He did not know anything about the urinalysis not being done.<br><br>Following Nurse # 3's nursing entry on 11/9/21 at 5:03 AM, the next entry was made by Nurse # 4 on 11/9/21 at 9:06 AM. Nurse # 4 noted the following. The resident's vital signs were temperature 96.3; pulse 114; respirations 34; and blood pressure 111/83. His oxygen saturation was 96%. Nurse # 3 noted she had given the resident | F 684 | Change in Condition Audit Tool and Orders Audit Tool to the Executive Quality Assurance (QA) committee monthly for 2 months. The Executive QA Committee will meet monthly for 2 months and review the Change in Condition Audit Tool and Orders Audit Tool to determine trends and/or issues that may need further interventions put into place and to determine the need for further frequency of monitoring. | |

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"one cotton of fluid" and the resident had taken it without difficulty. The nurse also noted the resident's family member, who was listed as emergency contact # 2, had called and requested for the resident to be sent to the hospital. Nurse # 4 noted NP # 2 instructed not to do anything at that time and she would talk to the family member.

Resident # 2's RP was interviewed on 12/8/21 at 9:58 AM. The RP stated she knew Resident # 2 had not been eating and had been concerned. The facility staff had said they would do an IV but they had trouble getting one started. Emergency contact # 2 was interviewed on 12/7/21 at 11:24 AM and reported that he had talked to the NP on 11/9/21 and it had been established that the resident would receive treatment at the facility but if he grew worse then he and the RP wanted the resident sent to the hospital. It was Emergency Contact # 2's understanding that an IV had not been established the previous day, but one would be done that day. According to Emergency Contact # 2 if it had been decided that an IV was not going to be established, then he and the RP would have wanted the resident sent to the hospital.

Following Nurse # 4's nursing entry on 11/9/21 at 9:06 AM the next note was entered on 11/9/21 at 12:00 PM by Nurse # 4. The nurse noted the following. "Around 10am, nurse checked on resident VS, 95, 93, 30, could not obtain BP, received call from NP. Rocephin 1 mg IM X 1 dose, which was given without difficulty, CBC in AM with diff (differential), encourage fluid, nurse told NP nurse will be leaving at 3 PM, NP requested nurse give her a call before left to make sure there is no vomiting on resident during

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the morning shift so we can change the diet, resident was on clear liquid diet currently, the whole time nurse gave resident only the juice, resident drank all together about 360 ml (milliters) at that time ..." The nurse further documented the resident's RP was concerned because he was not eating. The nurse ended the nursing note by documenting, "Nurse went to break room for lunch, saw nurse two supervisors and nurse asked if they can check resident out because his heart rate and respiration stay high, and nurse could not get the BP, when nurse came back to the hall from lunch, received the order from NP, nurse was busy to transcribe on the MAR (medication administration record) and get everything ready, did not hear any complain from (RP)."

Following Nurse # 4's entry on 11/9/21 at 12:00 PM, the next note was entered on 11/9/21 at 1:00 PM by the NP. She noted the resident's vitals had changed that morning with an increased heart rate and increased respirations and his blood pressure had been stable that am at 111/83. She had ordered the Rocephin (an antibiotic), consulted with the physician, and was adding Flagyl (another antibiotic). Repeat labs and a KUB would be done on 11/10/21. The resident's family had been consulted that morning and had agreed to attempt treatment in place.

Review of the record revealed no further vital signs after Nurse # 4's notation that the resident's blood pressure could not be obtained.
Review of the NP orders revealed they were received by Nurse # 4 as a telephone order by Nurse # 4.

Nurse # 4 was interviewed on 12/8/21 at 11:10

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AM and again on 12/8/21 at 3:10 PM and reported the following. On the morning of 11/9/21 Resident # 1's emergency contact # 2 had called and wanted the resident sent to the hospital. She knew the night shift had been unsuccessful in getting the IV in, but she had been able to get the resident to drink some fluids. The total for the day she was able to get the resident to drink was 360 cc. The resident had looked better after drinking and his vitals were okay in the morning except his heart rate was high. She had talked to the NP and let her know the resident was drinking, they could not get the IV in, and the family wanted him sent to the hospital. Before 12:30 PM she had checked his vitals again and could not get his blood pressure to register on the machine. She got a cuff and tried to manually auscultate it and could not auscultate it. She had reported this to two unit managers and asked them to check the resident. She went to lunch around 12:30 PM. When she came back from lunch, she learned the NP had called and left orders with Unit Manager # 2 for Resident # 2. Nurse # 4 stated she never talked directly to the NP or gave the NP an update after the resident's blood pressure could not be auscultated. She started gathering her supplies and transcribing orders for Resident # 2. The nurse confirmed the resident received one IM dose of Rocephin. As she was working on transcribing the resident's other orders she heard a call for help for the resident because he was not breathing.

Unit Manager # 1 was interviewed on 12/8/21 at 9:30 AM and reported the following. She recalled Nurse # 4 telling her that Resident # 2 was not doing well and the nurse was waiting on a phone call back from the NP. She went into check on him. His mouth looked dry and she was able to

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get him to drink 120 cc of fluid. She tried to get his blood pressure and could not with the machine. She did not try auscultating a blood pressure. The nurse stated it was always hard to get a blood pressure reading due to the resident's movements but he did not look in distress. In regards to the IV not being done, the Unit Manager stated she had not been involved in the orders which had been given the previous day (11/8/21) but if IV access was not able to be obtained then the facility had a contract with an outsider company who could place a midline. The procedure was to notify the provider and get permission to use the company.

According to Resident # 2's record, no outside provider was contacted to try to start an IV for Resident # 2 prior to his death. Review of the facility's contract with the company which places midlines revealed their response time was typically between 3 to 6 hours when notified during business hours; which began at 8:00 AM. The contract also stated priority might be adjusted based on need.

Unit Manager # 2 was interviewed on 12/8/21 at 12:20 PM and reported the following. The NP had called around 1:00 PM and given orders for antibiotics for the resident. She had not done any type of physical assessment for Resident # 2 that day and therefore she did not give the NP any type of physical assessment update. She took the orders and gave them to Nurse # 4.

NP # 2 was interviewed on 12/8/21 at 12:25 PM and again on 12/13/21 3:15 PM and reported the following. She had seen the resident on the morning of 11/8/21. He looked stable other than having hiccoughs. His vitals were stable. She saw

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him again on the evening of 11/8/21. His KUB had shown the ileus and she had left orders to address that and for IV fluids. On the morning of 11/9/21 Nurse # 4 had alerted her that the resident's family member wanted the resident sent to the hospital. At the time, Nurse # 4 had indicated the resident was starting to drink fluids and was no longer vomiting. She was aware his heart rate was high and therefore she had ordered some Rocephin for him because something "could be brewing." She had talked to the resident's family member, who was agreeable to treat the resident at the facility. She also talked to the physician and he wanted to add Flagyl also to the orders. She called the staff and let them know that also. She did not see the resident on 11/9/21 and from the conversations she was having with the staff, the resident seemed to be getting better. If the staff had called the on call provider at night when they could not get the IV in, then the provider would have given the order for the contract company to put the midline in. She did recall having a conversation with one of the nurses about a midline, but did not recall if that was before or after his death. At no time did they tell her that they could not get a blood pressure on the resident, and she had been unaware the resident's temperature had dropped to 95 degrees. She would have wanted to know that. The resident seemed to have declined quickly.

The resident's physician was interviewed on 12/8/21 at 3:27 PM and reported the following. The physician felt the resident's 11/8/21 labs were not concerning for dehydration at the time they were drawn on 11/8/21. Given that he was starting to take oral fluids by the morning of 11/9/21 and the nurses had attempted several

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| | 345237 | A. BUILDING _____ B. WING _____ | C 12/13/2021 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
|---|---|
| **BARBOUR COURT NURSING AND REHABILITATION CENTER** | **515 BARBOUR ROAD SMITHFIELD, NC 27577** |

| (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 684 | Continued From page 19<br>times to insert an IV, he felt it had been fine not to continue with trying to insert the IV as long as the resident was continuing to take fluids by mouth. According to the physician he would have wanted to know when two nurses could not have obtained a blood pressure on the resident. If he had been made aware of that, then he would have sent the resident out for further evaluation but he did not feel this would have changed the outcome for the resident. The resident's weight was very low and even if he had been transferred sooner to the hospital, the physician felt the resident would have been placed on palliative care. | F 684 | | |