STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	05/05/2011

RECEIVED MAY 23 2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BARBOUR COURT NURSING AND REHABILITATION CENTER	515 BARBOUR RD 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 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to follow the individualized care plan on a dialysis resident on 1 of 1 sampled residents (Resident #80) on dialysis. Findings include: Resident # 80 was admitted on 02/25/11 with coronary artery disease, hypertension and end stage renal disease requiring hemodialysis three times a week The Hospital Transfer Summary, dated 02/24/11, indicated the resident had received a platelet transfusion on 02/23/11. The reason given was the resident was having bleeding through the catheter site. The Nursing Admission Assessment, dated 02/25/11, indicated Resident # 80 had occasional incontinence. A dialysis shunt was located on the front of the resident's right shoulder with a dressing intact.. The assessment indicated the resident received dialysis three times weekly. An appointment notice for 03/01/11 indicated the resident was having a new dialysis permacath placed.	F 282	Barbour Court Nursing and Rehabilitation Center acknowledges receipt of the statement of deficiencies and proposed this plan of correction to the extent that the summary of findings is factually correct a in order to maintain compliance with applicable rules a provisions of quality of care of resident's the plan of correction is submitted as a written allegation of compliance. Barbour Court Nursing and Rehabilitation Center's response to this statement of deficiencies and plan of correction does not denote agreement with the statement of deficiencies nor does it constitute as admission that any deficiency is accurate. Further, Barbour Court Nursing and Rehabilitation Center reserves the right to submit documentation to refute any of the deficiencies through informal dispute resolution, formal appeal procedure and/or any other administrative or legal proceeding.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Amy Swank	ADMINISTRATOR	5-20-11

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 282	Continued From page 1 Nurse's note, dated 03/01/11 at 5:47 PM indicated there was no new orders for the right arm dressing to the dialysis catheter site. The nurse stated she would continue to monitor. The Admission Minimum Data Set (MDS), dated 03/04/11, indicated Resident # 80 was able to understand and was understood. Resident # 80 was assessed as cognitively intact and able to make daily decisions. The resident was coded as receiving dialysis. On 03/16/11 at 9:33 AM, the treatment nurse documented he was able to feel the thrill on the left arm dialysis access site. He added there was no redness or swelling. The resident's care plan with a date of 03/17/11, indicated Resident # 80 was at risk for complications due to hemodialysis. Interventions to minimize complications included receiving dialysis on Monday, Wednesday and Friday, communicate with dialysis center as indicated, assess resident on return from dialysis, monitor access site for bleeding and signs of infection, diet as ordered, monitor for peripheral edema and report as needed, monitor for change in level of consciousness, weights, labs, dry skin and report as needed. Review of March 2011 Treatment Sheets indicated Resident # 80's dialysis access site was monitored on a weekly basis. Review of March 2011 nurse's notes indicated the access site had been assessed twice and not on return from dialysis as directed in the care plan.	F 282	**F282** Facility Residents to include Resident #80 are receiving care as directed according to each resident's individual care plan after dialysis treatments including assessment of the shunt site as evidenced by clinical documentation. The dialysis shunt site for Resident #80 was assessed on 5-4-11 by the Director of Nursing according to the resident's plan of care. . Nursing Staff were in serviced by the Staff Development Coordinator beginning on 5-4-11 and 5-20-11 related to the requirement to assess the shunt site after dialysis as indicated in the Resident's plan of care. In servicing included the components of the assessment and the requirement of Nurses to document this assessment in the Clinical record of each resident after return to the facility following each dialysis visit. A review of Facility Residents Dialysis Schedules was completed on 5-13-11 by the Director of Nursing and was provided to Nursing Staff. Audits will be conducted by the Quality Improvement Nurse or Administrative Nurse each dialysis day Monday through Saturday for All Residents to ensure assessments post dialysis are occurring and are documented. A QI tool will be utilized for recording the audit for a minimum of 3 months.	

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F 282	Continued From page 2 On 04/04/11 at 10:54 PM, the nurse documented Resident # 80 had returned from dialysis. There was no assessment that included the access site. On 04/06/11 at 2:26 PM, the nurse documented the resident had returned from dialysis. There was no assessment of the dialysis access site. The nurse's note for 04/13/11 at 10:25 PM indicated the resident had returned from dialysis. There was no indication the access site was assessed. There were no notes between 04/13/11 and 04/25/11 indicating the resident went or returned from dialysis or that the access site was assessed as the care plan directed. The nurse's note for 04/25/11 at 10:01 PM indicated the resident had returned from dialysis. There was no indication the dialysis access site was assessed. On 04/27/11 at 2:28 PM, the nurse documented the resident had returned from dialysis without incident. The nurse documented the access site to Resident # 80's left upper arm was dry and intact. Bruit and thrill were present. Capillary refill was brisk. On 04/29/11 at 1:21 PM the nurse documented the resident had returned from dialysis and was up in her wheelchair. There was no indication Resident # 80 had been assessed as directed in the care plan. A nurse's note, dated 05/02/11 at 2:28 PM, indicated the resident left for dialysis around 10:00 AM and had not yet returned to the facility. There were no further notes in the resident's	F 282	Audits will be reviewed weekly then monthly by the Quality Improvement Nurse or the Director of Nursing with follow-up as deemed necessary for any identified concerns. Results of audits will be forwarded to the Quality Improvement Committee for monthly reviews and for the identification of trends, development of action plans as indicated, and to determine the need and/ or frequency of continuing QI monitoring.	5/27/11

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F 282	Continued From page 3 chart to indicate if she had returned from dialysis or been assessed. Review of the nurse's notes for April 2011 indicated only one nurse on one day had assessed Resident # 80's dialysis access site after her return from dialysis. An interview was held with Resident # 80 on 05/03/11 at 3:45 PM. The resident stated she had been on dialysis for about 2 years. She stated she recently had a dialysis access site placed in her left arm. The resident stated dialysis staff were "on top of things" when it came to her access site and checked it each time she went for dialysis. She stated so far, staff at the facility had not checked her shunt. An interview was held with Nurse # 1 on 05/04/11 at 2:42 PM. The nurse stated the care plan was used to determine the care the resident received. When a resident was on dialysis vital signs, weights, intake and out-put should be monitored more closely. The dialysis access site should be monitored for drainage and the presence of a bruit and thrill. Information gathered during the assessment should be documented under the Health Status note in the resident's chart. Nurse # 1 stated documenting an assessment was the only way to show the assessment was actually completed. An interview was held with the Minimum Data Set (MDS) Coordinator on 05/04/11 at 3:13 PM. She stated the purpose of the care plan was to direct the care of the resident. The care plan tells the staff how to take care of the resident. If the staff was directed to assess they are expected to	F 282		

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F 282	Continued From page 4 assess. If the assessment was done, there should be documentation to verify the assessment had been completed. An interview was held with Nurse # 2 on 05/04/11 at 3:31 PM. Nurse # 2 was responsible for the care of Resident # 80 on 05/04/11 on the 3 to 11 shift. She stated the purpose of a care plan was to direct the care of a resident. She stated Resident # 80 had only been on her hall for a few days, but she had been to dialysis since moving to her hall. On return from dialysis, the nurse stated she would just make sure the resident was ok. She stated she had not assessed the dialysis access site for thrill and bruit. The nurse stated she should be assessing for bleeding as well. An interview was held with the Director of Nursing (DON) on 05/04/11 at 3:41 PM. The DON stated the purpose of a care plan was to provide a means for the staff to provide care to the resident. The care plan communicated what specifically should be done for the resident. The DON stated if the care plan directed the nurse to assess then an assessment should be done. She stated some nurses charted by exception so only abnormal results may be documented. An assessment of a dialysis resident should include appearance of the access site for bleeding, bruit and thrill, and making sure the resident tolerated dialysis. The DON reviewed the nurse's notes and acknowledged the nurses had not documented an assessment of the access site.	F 282	F309 Facility Residents receiving dialysis services to include Resident # 80 are having their Shunt sites assessed post dialysis by a facility Nurse as evident by clinical documentation. The dialysis shunt site for Resident #80 was assessed on 5-4-11 by the Director of Nursing. Nursing Staff were in serviced by the Staff Development Coordinator beginning on 5-4-11 related to the requirement to assess the shunt site after dialysis. In servicing included the components of the assessment and the requirement of Nurses to document this assessment in the Clinical record of each resident after return to the facility following each dialysis visit. A review of Facility Residents Dialysis Schedules was completed on 5-13-11 by the Director of Nursing and was provided to Nursing Staff. Audits will be conducted by the Quality Improvement Nurse or Administrative Nurse each dialysis day Monday through Saturday for All Residents to ensure assessments post dialysis are occurring and are documented by a facility nurse. A QI tool will be utilized for recording the audit for a minimum of 3 months.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain	F 309		

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F 309	Continued From page 5 or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on resident and staff interviews and record review, the facility failed to assess a dialysis resident after dialysis treatment on 1 of 1 sampled residents (Resident #80) on dialysis. Findings include: Resident # 80 was admitted on 02/25/11 with cumulative diagnoses of hypertension and end stage renal disease requiring hemodialysis three times a week. The Hospital Transfer Summary, dated 02/24/11, indicated Resident # 80 had received a platelet transfusion on 02/23/11. The reason given was the resident had bleeding through the dialysis access catheter site (shunt). The Nursing Admission Assessment, dated 02/25/11, indicated a dialysis shunt was located on the front of the resident's right shoulder with a dressing intact.. The assessment indicated Resident # 80 received dialysis three times weekly. An appointment notice for 03/01/11 indicated the resident was having a new dialysis permacath placed. Nurse's note, dated 03/01/11 at 5:47 PM	F 309	Audits will be reviewed weekly then monthly by the Quality Improvement Nurse or the Director of Nursing with follow-up as deemed necessary for any identified concerns. Results of audits will be forwarded to the Quality Improvement Committee for monthly reviews and for the identification of trends, development of action plans as indicated, and to determine the need and/or frequency of continuing QI monitoring.	5/27/11

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F 309	Continued From page 6 indicated there was no new orders for the right arm dressing to the dialysis catheter site. The nurse stated she would continue to monitor. The Admission Minimum Data Set (MDS), dated 03/04/11, indicated Resident # 80 was able to understand and was understood. Resident # 80 was assessed as cognitively intact and able to make daily decisions. Active diagnoses included diabetes and end stage renal disease. The resident was coded as receiving dialysis. On 03/16/11 at 9:33 AM, the treatment nurse documented he was able to feel the thrill on the left arm shunt. He added there was no redness or swelling. The resident's care plan with a date of 03/17/11, indicated Resident # 80 was at risk for complications due to hemodialysis. Interventions to minimize complications included receiving dialysis on Monday, Wednesday and Friday, communicate with dialysis center as indication, assess resident on return from dialysis, monitor access site for bleeding and signs of infection, diet as ordered, monitor for peripheral edema and report as needed, monitor for change in level of consciousness, weights, labs, dry skin and report as needed. A Physician's order sheet,dated 03/25/11, indicated Resident # 80's permcath (a type of dialysis access site) was removed. Review of March 2011 Treatment Sheets indicated Resident # 80's dialysis shunt was monitored on a weekly basis although the care plan directed three times a week on return from	F 309		

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F 309	Continued From page 7 dialysis. Review of March 2011 nurse's notes indicated the dialysis shunt had been assessed twice. On 04/04/11 at 10:54 PM, the nurse documented Resident # 80 had returned from dialysis. There was no assessment that included the dialysis shunt. On 04/06/11 at 2:26 PM, the nurse documented the resident had returned from dialysis. There was no assessment of the dialysis shunt. The nurse's note for 04/13/11 at 10:25 PM indicated the resident had returned from dialysis. There was no indication the dialysis shunt was assessed. There were no notes between 04/13/11 and 04/25/11 indicating the resident went or returned from dialysis or that the dialysis shunt was assessed. The nurse's note for 04/25/11 at 10:01 PM indicated the resident had returned from dialysis. There was no indication the dialysis shunt was assessed. On 04/27/11 at 2:28 PM, the nurse documented the resident had returned from dialysis without incident. The nurse documented the shunt to the resident's left upper arm was dry and intact. Bruit and thrill were present. Capillary refill was brisk. On 04/29/11 at 1:21 PM the nurse documented the resident had returned from dialysis and was up in her wheelchair. There was no indication the dialysis shunt had been assessed.	F 309		

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F 309	Continued From page 8 A nurse's note, dated 05/02/11 at 2:28 PM, indicated the resident left for dialysis around 10:00 AM and had not yet returned to the facility. There were no further nurse's notes as of 05/04/11 at 10:58. No note was found that indicated the resident had returned to the facility, or that she had been assessed on her return as directed by the care plan. Review of the nurse's notes for April 2011 indicated only one nurse on one day had assessed the resident's dialysis shunt after her return from dialysis.. An interview was held with Resident # 80 on 05/03/11 at 3:45 PM. The resident stated she had been on dialysis for about 2 years. She stated she recently had a shunt placed in her left arm. The resident stated dialysis staff were "on top of things" when it came to her shunt and checked it each time she was there. She stated so far, staff at the facility had not checked her shunt. An interview was held with Nurse # 1 on 05/04/11 at 2:42 PM. When a resident was on dialysis vital signs, weights, and intake and out-put should be monitored more closely. The dialysis shunt should be monitored for drainage and the bruit and thrill should be present. Information gathered during the assessment should be documented under the Health Status note in the resident's chart. Nurse # 1 stated that documenting a completed assessment was the only way to prove the assessment was done. An interview was held with the MDS Coordinator on 05/04/11 at 3:13 PM. She stated the purpose of the care plan was to direct the care of the	F 309		

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F 309	Continued From page 9 resident. The care plan told the staff how to take care of the resident. If the staff was directed to assess they are expected to assess. If the assessment was done, there should be documentation to verify the assessment had been completed. The Resident Care Guide was reviewed on 05/04/11 at 3:24 PM. The care guide, found in the inside of the resident's closet directed care provided by Nursing Assistants (NA). The Resident Care Guide indicated Resident # 80's dialysis shunt was located in her right arm. Instructions were listed on the Resident Care Guide not to take the resident's blood pressure in her right arm. An interview was held with Nurse # 2 on 05/04/11 at 3:31 PM. Nurse # 2 was assigned to care for Resident # 80 on the 3 to 11 shift on 05/04/11. She stated Resident # 80 had only been on her hall for a few days, but she had been to dialysis since moving. On return from dialysis, the nurse stated she would just make sure the resident was ok. She stated she had not assessed the dialysis shunt for thrill and bruit. The nurse stated she should also be assessing the dialysis site for bleeding. The nurse added she could not recall which arm the resident's shunt was located. The nurse reviewed the Resident Care Guide and stated if the shunt was in the left arm, then the guide was wrong and could cause serious issues with the resident if the left arm was used for blood pressures. An interview was held with NA # 4 on 05/04/11 at 3:36 PM. NA # 4 was assigned to care for Resident # 80 on the 3 to 11 shift on 05/04/11.	F 309		

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F 309	Continued From page 10 She stated the Resident Care Guide directed her not to take Resident # 80's blood pressure in her right arm, therefore, she would use the left. The NA was unaware the resident had a dialysis shunt in her left arm. An interview was held with the Director of Nursing (DON) on 05/04/11 at 3:41 PM. The purpose of a care plan was to provide a means for the staff to provide care to the resident and communicated what specifically should be done for the resident. The Resident Care Guide, the DON added, was an extension of the care plan with the purpose of giving information to the direct care staff. The DON stated if the care plan directed the nurse to assess Resident # 80, then an assessment should be done. She added some nurses charted by exception so only abnormal results of the assessment may be documented. If a resident had a dialysis shunt, all the staff would be expected to know. An assessment of a dialysis resident should include appearance of shunt site for bleeding, bruit and thrill, and making sure the resident tolerated dialysis. The DON reviewed the nurse's notes and acknowledged the nurses had not assessed the dialysis shunt site. She reviewed the Resident Care Guide and acknowledged the wrong arm was listed. The DON stated the danger in taking the blood pressure in the left arm, where the shunt was located and as directed by the Resident care Guide was occlusion of the dialysis graft.	F 309		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an	F 315	**F315** Facility Residents to include Resident #225 is being provided foley catheter care during incontinence care per facility policy and procedure as evident by observations of staff during provision of care initiated on 5-16-11. Staff reported observed on 5-4-11 during the Survey were addressed individually by the Director of Nursing on 5-4-11 and 5-6-11 and received Instruction on proper foley care with Incontinence care. In servicing was conducted by the Staff Development Coordinator for all Nursing Staff beginning on 5-4-11 related to the correct incontinence care procedure to include foley catheter care.	

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F 315	Continued From page 11 indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to provide indwelling urinary catheter care to 1 of 1 sampled dependent residents (Resident #225) when observed during incontinence care. Findings include: Upon review of the facility's procedure for perineal care, dated 02/07, it was noted that the procedure for providing care to a catheterized resident included cleansing around the meatus and cleansing the indwelling urinary catheter tubing. It also included cleansing the resident's penis. The objective of the procedure was to cleanse the perineum and prevent infection. Resident #225 was admitted to the facility on 04/16/11. Cumulative diagnoses included acute respiratory failure with tracheostomy, depression, congestive heart failure, pressure ulcer and hypertension. The Admission Minimum Data Set (MDS) of 03/14/11 indicated Resident #225 had severely impaired decision making skills and needed total assistance from staff for all activities of daily living. He had an indwelling urinary catheter and	F 315	The Director of Nursing or Administrative Nurse will randomly monitor incontinence care of residents to include Resident #225 to ensure foley care is being provided with incontinence care after each incontinent episode 3 times per shift per week for 4 weeks then weekly per shift x 4 weeks then monthly for minimum of 3 months utilizing a QI tool. Follow up action by the Director of Nursing or Administrative Nurses with the nursing staff will be made at the time of observation for any identified area of concern. Audits will be reviewed weekly then monthly by the Quality Improvement Nurse or the Director of Nursing with follow-up as deemed necessary for any identified concerns. Results of audits will be forwarded to the Quality Improvement Committee for monthly reviews and for the identification of trends, development of action plans as indicated, and to determine the need and/ or frequency of continuing QI monitoring.	5/27/11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	05/05/2011

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

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F 315	Continued From page 12 was incontinent of bowel. An unstageable pressure ulcer was indicated on admission. Resident #225's care plan, dated 05/02/11, identified several problem areas including altered pattern of urinary elimination with an indwelling catheter and he was at risk for developing further pressure ulcers related to incontinence. Included in the altered pattern of urinary elimination was to provide catheter care per facility protocol. Interventions included in the incontinence problem was to provide incontinence/perineal care after each incontinent episode. Resident #225 was observed in bed on 05/03/11 at 11:00 AM. An indwelling urinary catheter privacy bag was noted hanging on the frame of the bed. During wound care observation of Resident #225's sacral pressure ulcer on 05/04/11 at 3:30 PM, the treatment nurse performed wound care and then cleaned a large amount of soft blackish stool from the rectum and buttocks. He did not cleanse the front part of his body. He also did not provide any indwelling urinary catheter care. At 3:45 PM on 05/04/11, the second shift aide (NA#1) assisted by NA#2 came into Resident #225's room to provide care. NA#2 assisted by NA#1 rolled Resident #225 onto his left side. There was a moderate amount of soft blackish stool present. NA#2 used disposable wipes to remove stool from the rectal area. She did not cleanse the entire scrotal sac. Resident #225 was rolled onto his back and a clean brief applied. She did not open his legs to cleanse away stool nor did she check to see if she had	F 315		

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F 315	Continued From page 13 removed all of the stool from the perineal area. She did not cleanse the penis. The indwelling urinary catheter tubing was taped to the inner upper left thigh. Neither aide provided any catheter care to ensure the catheter tubing was clean and free from stool. No barrier cream was applied and a clean brief placed. NA#1 was interviewed immediately following the observation on 05/04/11 at 3:55PM. He stated he had visually observed the indwelling urinary catheter tubing and it did not appear to be soiled with stool so he did not provide care. When questioned when catheter care was provided, he responded during the bath. NA#2 was interviewed on 05/04/11 at 4:00 PM. She stated that she provided incontinence care to make sure the residents were clean and dry. She stated she had been taught to wash front to back. She stated if a resident had stool, she would use disposable wipes to remove it. She also stated she would use soap and water. When questioned about indwelling urinary catheter care, she stated that she did not routinely cleanse the tubing when she provided incontinence care. NA#2 added that NA#1 had looked at the tubing and didn't see any stool. She stated she had not cleansed Resident #225's entire perineal area and did not wash the catheter tubing. NA#2 stated she had not been checked off on any of her skills before being allowed to provide care on the floor. She also stated she did not know what the facility's procedure or expectation was for providing indwelling urinary catheter care. During an interview with the Director of Nurses (DON) on 05/04/11 at 9:44AM, she stated the	F 315		

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F 315	Continued From page 14 expectation for providing indwelling urinary catheter care was to cleanse around the meatus and then wash the catheter tubing from the meatus outward away from the body. She stated this should be done each time pericare was provided. She also stated when a resident had a bowel movement, staff should be cleaning all the creases and crevices to make sure all of the stool was removed.	F 315		