STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER / SUPPLIER / CLIA IDENNTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345237	A. BUILDING _____ B. WING _____	03/10/2020

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
F 0550 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, staff, resident interviews, and record reviews, the facility staff failed to maintain dignity by yelling at a memory care resident that was hollering out (Resident #96) and failed to complete incontinence care and left the resident uncovered with the door opened (Resident #63) for 2 of 4 residents reviewed for staff interaction and incontinence care. Findings included: Resident #96 was admitted to the facility on [DATE] with the [DIAGNOSES REDACTED]. A quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #96's cognitive status was unable to be assessed and had behaviors that were not directed toward others. The care plan reviewed on [DATE] revealed a plan which focused on Resident #96 had repetitive actions related to cognitive impairment (making verbal noises). The interventions were to monitor episodes of repetitive behavior, report to MD as indicated, and redirect behavior (by watching TV, looking at magazine). A review of nurse's note on 2/10/2020 by Nurse #4 revealed Resident #96 displayed behaviors such yelling, screaming and using profanity. An observation on [DATE] at 10:10 am revealed Resident #96 was resting in bed and was hollering out, when Nurse #8 moved her medication cart in front of Resident #96's door. Nurse #8 stood outside of the door and yelled out loud to the resident Stop that hollering. What's wrong with you? There was dayroom and dining room full of residents that could hear the nurse. The corporate consultant walked over to Nurse #8 and they both went into the resident's room. During an interview with the corporate consultant on [DATE] at 2:29 pm, she stated she was standing in the nurse's station when she heard Resident #96 hollering out and, based on the way Nurse #8 responded, she went over to intervene by speaking with Nurse #8. The corporate consultant stated she informed Nurse #8 she should not speak to the resident in that manner. She also stated she went in Resident #96's room to see what she needed. During an interview with Nurse #8 on [DATE] 9:49 am, she stated Resident #96 was hollering as usual and she went to the resident's door, called the resident by name and told the resident to stop that, what's wrong? Nurse #8 then stated the nurse consultant came to her and told her that she could not speak to the resident that way and she could not tell Resident #96 to stop that. Nurse #8 said she continued the medication pass and then she received a call from the Director of Nursing (DON) to inquire about Resident #96. An interview on [DATE] at 4:21 pm with the DON, revealed Nurse #8 should not had yelled at Resident #96. During an interview on 3/7/2020 at 2:45 pm with the Administrator, she stated the incident should not have happened. 2. Resident #63 was admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. Resident #63's minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He had no moods and no behaviors. Resident #63 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene from 1 staff. He required supervision with locomotion on and off unit, transfers, walking on and off corridors, and eating. Resident #63's care plan dated [DATE] revealed he was care planned to require assistance with activities of daily living care. The interventions included to perform timely incontinent care. During an interview on [DATE] at 1:04 PM Resident #63 stated Nurse Aide #7 had a rough day and was telling him about her day when she was emptying his urinal. She stated she was stressed and tired of work. She began changing him as he had a bowel movement as well. She rolled up the soiled brief, the wipes and the draw sheet to his back as he was turned on his right side. She then rolled up the new draw sheet which was a full sheet she had folded multiple times and placed that at his back as well. She then wanted him to roll back over the hump which he was unable to do and was not normally how nurse aides would change him because it would hurt his back due to his spondylitis. He stated he informed her of this, and she told him it was the only way she knew how to do it. She then told him he could either roll over the hump or not get cleaned up. This was around 9 PM. They debated back in forth and he requested she remove some of the items from the old bunched up draw sheet. She then told him she would just pull everything out from under him with a quick yank like a band aide. He then asked her to please do not do that as it would hurt him even more to have it all pulled out from under him quickly. She then stated she had enough and walked out of the room and told him someone else would finish him. She left the door wide open and he was still in the bed unclothed and uncovered. 20 minutes went by with him lying there with the door open. He stated his phone was within his reach, so he finally called the facility approximately fifteen times and Medication Aide #1 answered about 20 minutes later. Medication Aide #1 told him he had not heard anything about it, hung up, and rushed down to his room. Medication Aide #1 asked why his door was left open and he relayed what had happened with Nurse Aide #7. Medication Aide #1 re-did everything and provided care to him very well. The medication aide deescalated the situation and made him feel like he mattered as a person again. At this point Nurse #1 came into the room and asked what had happened. He informed Resident #63 he had notified the Director of Nursing that something had happened, and the Director of Nursing told him to come down and speak with Resident #63. The resident stated he then informed the nurse of the situation. He did not see that nurse aide the rest of the night and did not miss any more care as Medication Aide #1 took care of him. He concluded the incident made him feel helpless and frustrated. During an interview on 3/5/20 at 3:25 PM Medication Aide #1 stated he was passing his medication around 9 PM. Nurse Aide #7 came to him and stated Resident #63 had been cursing at her and the medication aide told her to step away from the resident for ten minutes and then return as they had been trained. Medication Aide #1 stated Nurse Aide #7 did not inform him she had not completed care and did not tell him the state Resident #63 was left in. She implied care had been completed. He stated he planned to go in Resident #63's room after 10 or so minutes to let him calm down. About 10 minutes after the nurse aide reported this to him, he then received a call at the nurse's station, and he answered it. He stated Resident #63 had called the facility and asked if the medication aide knew he needed care. Medication Aide #1 hung up and went to see what Resident #63 needed. He stated he found the door to Resident #63's room open and Resident #63 was naked and laying on his right side in clear view of the hall. Medication Aide #1 entered, closed the door, and asked the resident what happened. Resident #63 informed him the draw sheet was too large to roll over because of his back and the nurse aide became upset and left him. Medication Aide #1 told Resident #63 he would go find a smaller draw sheet and get him cleaned and comfortable. He stated he then went and got a draw sheet as the sheet Nurse Aide #7 attempted to use was a regular flat bed sheet and larger than a normal draw sheet. He returned and placed the draw sheet behind Resident #63 and when he rolled to his left side, he noted the bed sheets were soiled as well so he completed a full sheet change and cleaned Resident #63 up and finish his care. Nurse Aide #7 was removed from Resident #63's assignment and Medication Aide #1 took over care of Resident #63. He concluded Nurse Aide #7 should not have left Resident #63 with no covering, incomplete incontinence care, and the door open. He stated from the time Nurse Aide #7 came to him to when he entered the resident's room was approximately 10 minutes and would have been how long the door was left open with him uncovered. During an interview on [DATE] at 4:52 PM Nurse #1 stated Nurse Aide #7 came to him and was concerned about the fact that Resident #63 was upset. He further stated she informed him the resident was upset at how she attempted to change his sheets. He stated he called

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

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 0550 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	(continued... from page 1) the Director of Nursing and the Director of Nursing told him to go interview Resident #63. He stated the resident told him that Nurse Aide #7 was attempting to have him roll over a large lump in the bed while she was changing linens, but he could not roll over it due to an issue with his back. He stated he then asked Resident #63 if he felt like it was abuse and he said he did not. He stated neither the resident nor Medication Aide #1 informed him he had been left uncovered with the door open, so he did not report that to the Director of Nursing. He concluded it was not appropriate for a resident to be left uncovered with the door open. During an interview on [DATE] at 9:07 AM Nurse Aide #7 stated she started providing care and Resident #63 became upset. She stated she told him she would get another staff member, placed a sheet over him, closed the door, and went to find Medication Aide #1. She stated no one else was on the hall who would have opened the door and uncover him, so she did not know why Medication Aide #1 and Resident #63 had said he was left like that. She concluded she would never leave a resident undressed with the door open when state was in the building because she had been a nurse aide for years. During an interview on [DATE] at 4:36 PM the Director of Nursing stated Nurse Aide #7 should not have left Resident #63 exposed with the door open due to dignity concerns and she had not been made aware that he had been left unclothed with the door open until just now.
F 0565 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to organize and participate in resident/family groups in the facility.** Based on interviews with Resident Council members, review of Resident Council minutes and staff interviews the facility failed to resolve concerns voiced by the Resident Council members during the previous 4 of 6 monthly Resident Council meetings. The findings included: The monthly Resident Council Meeting minutes from September 2019, October 2019, November 2019, December 2019, January 2020, and February 2020 were reviewed. A review of Resident Council minutes dated November 6, 2019 indicated residents voiced concerns regarding missing laundry and lack of hot water with the social worker to follow-up. The Resident Council minutes from December 11, 2019 revealed residents voiced concerns regarding missing clothing with the social worker to follow-up. There was no mention in the December minutes of any resolution from the missing laundry or hot water concerns from November. The Resident Council minutes from January 14, 2020 indicated residents expressed no concerns and no follow-up was mentioned from the previous month. The Resident Council minutes from February 12, 2020 indicated residents expressed no concerns and no follow-up was mentioned from the previous months. Review of resident council grievance reports revealed one grievance report dated 2/12/20 which expressed concerns about care delivery and a lack of response to call bells. A response from the Director of Nursing stated that audits were conducted to ensure call bells were answered, ice passed, and no doors were slammed. No additional grievance reports labeled Resident Council were located for review. An interview was conducted with Resident #19, the Resident Council President on 3/3/20 at 11:05 AM. She stated concerns are expressed in Resident Council and no follow-up is received. Resident #19 stated she has asked the social worker to complete grievances from the meeting and bring them back to the next meeting. She reported this has not been done. Resident #19 stated she was not given the resident council minutes to review. An interview was conducted on 3/4/20 at 2:30 PM with the facility's resident council. There were six residents present in the meeting. During the meeting residents expressed a concern with the resolution of grievances. The residents in the meeting reported not all grievances were acted on promptly by the facility and there was no explanation given as why the grievances were not resolved. The residents stated at each meeting they discussed the same concerns. The residents indicated none of their concerns have been addressed and the social worker never reported a resolution in the meetings for issues which included; not receiving ice, missing items, and hot water. Resident #87 stated he had voiced several times in meetings concerns about ice not being passed and the snack cart not being available to all residents. He indicated no follow-up was ever received during Resident Council meetings. Social Worker #3, who was present at the meeting, stated she did complete a grievance from the February 2020 meeting and reviewed it with the residents. Members of resident council asked about the other grievances that had been voiced. Social Worker #3 stated grievances are not completed for resident council and issues are just addressed during resident council. An interview was conducted with Resident #9 on 3/5/20 at 1:12 PM. She stated that the Resident Council members have repeatedly discussed call lights not being answered, ice not being passed, not receiving showers and aides not being polite. The Director of Nursing (DON) and Administrator #2 stated during an interview on 3/4/20 at 5:04 PM that there were issues with the process of concerns received from Resident Council. Administrator #2 stated resident council grievance forms should have been completed after Resident Council meetings and given to the appropriate department for investigation. She continued Social Worker #3 should have communicated the results of the department's investigation to members of the Resident Council.
F 0580 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Immediately tell the resident, the resident's doctor, and a family member of situations (injury/decline/room, etc.) that affect the resident.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, family and staff interviews the facility failed to notify the responsible party of a resident's swollen hand for 1 of 8 residents reviewed for accidents (Resident #14). The findings included: Resident #14 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Resident #14 ' s most recent Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment revealed she was assessed as severely cognitively impaired. A progress note written by Nurse #2 dated 1/25/20 revealed Resident #14 was assessed to have a swollen left hand and could not grasp the nurse's fingers. The note indicated she contacted the on-call provider and received an order for [REDACTED].#14's responsible party regarding her swollen hand. An interview was conducted with Nurse #1 on 3/4/20 at 10:21 AM who stated she could not recall if she spoke with Resident #14's responsible party regarding her swollen hand. An interview with the Director of Nursing (DON) on 3/4/20 at 1:49 PM indicated Resident #14's responsible party should have been notified of her swollen hand. She requested contact be made with Resident #14's guardian to ensure that contact had been made. During a phone interview on 3/4/20 at 2:00 PM Resident #14's guardian stated she did not recall receiving notification from the facility about the resident's swollen hand. She stated she would check her records and verify notification. An interview with DON on 3/5/20 at 3:39 PM stated she received notification from Resident #14's guardian that she did not receive notification from staff about the resident's swollen hand.
F 0582 **Level of harm** - Potential for minimal harm **Residents Affected** - Some	**Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to provide a Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice prior to discharge from Medicare Part A skilled services for 2 of 3 residents reviewed for beneficiary protection notification review (Resident #75 and Resident #148). The findings included: 1. Resident #75 was admitted to the facility on [DATE]. He was readmitted to Medicare Part A skilled services on 12/13/19. Resident #75's Medicare Part A skilled services ended on [DATE]. He remained in the facility. Record review revealed that Resident #75 was not given the CMS- Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with the Business Office Manager on 3/2/20 at 3:32 PM she stated there was an error in processing and Resident #75 did not receive the correct notification. An interview was conducted with the Administrator on 3/2/20 at 4:01 PM who indicated Resident #83 should have received the CMS- as required by Federal guidelines. 2. Resident #148 was admitted to the facility on [DATE]. She was readmitted to Medicare Part A skilled services on [DATE]. Resident #148's Medicare Part A skilled services ended on [DATE]. She remained in the facility. Record review revealed that Resident #148 was not given the CMS- Skilled Nursing Facility Advanced Beneficiary Notice (SNF-ABN). During an interview with the Business Office Manager on 3/2/20 at 3:32 PM she stated there was an error in processing and Resident #148 did not receive the correct notification. An interview was conducted with the Administrator on 3/2/20 at 4:01 PM who indicated Resident #148 should have received the CMS- as required by Federal guidelines.
F 0585 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.**

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F 0585 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	(continued... from page 2) **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on resident interviews, family interviews, staff interviews, and record review the facility failed to resolve grievances for 3 of 4 residents reviewed for grievances (Resident #19, Resident #57, and Resident #46). The findings included: 1. Resident #19 was admitted to the facility on [DATE]. The Minimum Data Set (MDS) assessment dated [DATE], a quarterly assessment revealed Resident #19 was cognitively intact. An interview was conducted with Resident #19 on 3/3/20 at 10:43 AM who stated she had filed grievances with the facility and received no response. A review of a grievance report dated 11/22/19 indicated Resident #19 had communicated to Social Worker #3 that she had some missing clothing items. An investigation on 11/22/19 revealed search in the laundry had not located the items. No resolution had been completed on the grievance report. Administrator #2 stated during an interview on 3/4/20 at 5:03 PM that once a grievance is completed by a resident or family member it is given to the social worker to log the grievance in the system for tracking. It is then given to the appropriate department for investigation and resolution. The grievance is given to the social worker who communicates the resolution to the resident or family member. She stated the social worker should have communicated the resolution of the grievance to Resident #19. 2. Resident #57 was admitted to the facility on [DATE]. Resident #57's most recent Minimum Data Set (MDS) assessment dated [DATE] coded him as moderately cognitively impaired. An interview was conducted with Resident #57's responsible party on 3/4/20 at 9:22 AM who stated she expressed concerns about Resident #57 being moved to a room closer to the smoking area which made the room smell of smoke. She reported she also expressed concern that a wheelchair was in his room which had led to falls in the past when Resident #57 attempted to ambulate. The responsible party stated that she expressed these concerns to Social Worker #2 and had not received a written response. An interview was conducted with Social Worker #2 on 3/4/20 at 10:26 AM who stated he did not complete a grievance form because he was able to resolve the responsible party's concerns. Resident #57 was moved to another room. Social Worker #2 stated the wheelchair was removed from Resident #57's room. He stated no written notice of resolution of the grievance was given. Administrator #2 stated during an interview on 3/4/20 at 5:03 PM that once a grievance is completed by a resident or family member it is given to the social worker to log the grievance in the system for tracking. It is then given to the appropriate department for investigation and resolution. She stated the social worker should have completed a grievance for Resident #57. 3. Resident #46 was admitted to the facility on [DATE]. Resident #46's most recent Minimum Data Set assessment dated [DATE], a quarterly assessment revealed he was assessed to be cognitively intact. An interview was conducted with Resident #46 on 3/3/20 at 9:16 AM who stated he had filed grievances with the facility and received no response. A review of a grievance report dated 12/[DATE]9 had been communicated to the social worker that Resident #46 had concerns regarding the water temperature, a therapy evaluation and a transfer to another facility. No resolution had been completed on the grievance report. Review of a letter dated 12/10/19 written by the former Administrator revealed a therapy evaluation was requested, water temperature meets facility guidelines and a referral to another facility was requested. Review of documentation revealed no evidence this letter was given to the resident. A review of a grievance report dated 1/27/20 indicated Resident #46 had communicated to Social Worker #3 that he had eleven pair of shorts that were missing. An investigation on 1/27/19 revealed search in the laundry room was conducted for missing linens. No resolution had been completed on the grievance report. Review of a letter dated 2/3/20 written by the former Administrator revealed a search for missing linen was completed. Review of documentation revealed no evidence this letter was given to the resident. Administrator #2 stated during an interview on 3/4/20 at 5:03 PM that once a grievance is completed by a resident or family member it is given to the social worker to log the grievance in the system for tracking. It is then given to the appropriate department for investigation and resolution. She reported an investigation should have been done for Resident #46's missing shorts and a resolution should have been communicated to him.
F 0641 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Ensure each resident receives an accurate assessment.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, staff, resident and family interviews and record review the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of exhibiting wandering behavior, hospice, discharge destination, and nutrition for 4 of 51 residents whose MDS assessments were reviewed (Resident #399, Resident #148, Resident #149 and Resident #119). The findings included: 1. Resident #399 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A wandering risk assessment completed 2/21/20 indicated Resident #399 was assessed to be high risk for wandering. Resident #399's admission Minimum Data Set (MDS) assessment with an Assessment Reference Date of 2/25/20 indicated that Resident #399 had not exhibited any wandering behavior. An interview was conducted with the Director of Nursing (DON) on 3/7/20 at 10:31 AM who stated she completed the wandering risk assessment dated [DATE]. She stated the assessment was completed after Resident #399 exited the building while unsupervised. The DON stated Resident #399 indicated she had contacted her family member to take her to the bank. She reported she was able to convince the resident to return to the building and she explained to the family member he was not allowed to remove her from the building as he was not her guardian. She further stated a wander alarm was placed on Resident #399 at that time. The DON stated the guardian was contacted and requested Resident #399 be placed in the secured unit as she was insistent that she was going to leave the facility. The DON stated that this incident should have been reflected on the 2/25/20 MDS assessment. She stated this incident was discussed in the morning meeting on 2/22/20. An interview with MDS Nurse #1 on 3/7/20 at 10:58 AM was conducted. She stated she was not aware of the incident on 2/21/20 so it was not reflected on the assessment. During an interview with Administrator #2 on 3/6/20 at 11:59 AM she indicated that MDS assessments should be completed accurately and completely. 2. Resident #148 was admitted to the facility on [DATE]. Her active [DIAGNOSES REDACTED]. Resident #148's progress note dated 12/3/19 revealed the resident was admitted to hospice services. Resident #148's notice of hospice admitted d 12/3/19 revealed the resident was admitted to hospice services for senile dementia with an admission date of [DATE]. Resident #148's minimum data set assessment dated [DATE] revealed she was coded in section O question O0100 K as not receiving hospice services. During an interview on 3/3/2020 at 1:48 PM MDS Nurse #1 stated Resident #148 was on hospice and the question was coded in error. She concluded she would modify the assessment. During an interview on 3/3/2020 at 2:08 PM the Director of Nursing stated minimum data set assessments should accurately reflect hospice status of residents and she would have the MDS nurses do a modification of change. 3. Resident #149 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. The care plan dated 1/17/2020 revealed a plan which focused on Resident #149's desire to return home or another facility upon completion of rehabilitation therapy with the interventions to evaluate and discuss with the resident prognosis for independent or assisted living and identify, discuss and address limitations, risks, benefits, and needs for maximum independence. Minimum Data Set ((MDS) dated [DATE] revealed Resident #149 was unable to be interviewed for a cognitive status due to the resident was rarely able to be understood and was discharge to an acute hospital. During an interview with Nurse #6 on 3/5/2020 at 1:10 pm, she stated she remembered Resident #149 and the resident was discharged home with home health for physical therapy, wound care, home safety, and assisted home care. An interview with MDS Nurse #2 on 3/5/2020 at 1:50 pm, she stated Resident #149 was discharged home and the MDS dated [DATE] was incorrect. MDS Nurse #2 then stated it was an error and the assessment would be modified. During an interview with the Administrator on 3/7/2020 at 2:50 pm, she stated the MDS was the responsibility of the MDS nurses and the assessment should have been accurate. 4. Resident #119 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. Minimum Data Set ((MDS) dated [DATE] revealed Resident #119 was unable to be assessed for a cognitive status and had severely impaired decision making. Resident #119 was able to feed herself with limited assistance. MDS indicated no weight loss of 5% or more in the last month or loss of 10% or more in last 6 months. Resident #119 weights were documented as follows: 8/20/2019 96 pounds (lbs.), 9/9/2019 101.0 lbs., 10/9/2019 99.0 lbs., 11/27/2019 82.0 lbs., 12/9/2019 88.0 lbs., 1/23/2020 86.0 lbs. Resident #119 lost more than 10 percent of weight during the six month time period prior to her 2/01/2020 MDS being completed. During an interview with MDS Nurse #2 on 3/4/2020 at 11:05 am, she stated dietary completed the nutritional part of the assessment and she just signed the MDS assessment which showed the assessment was completed. An interview with the dietary supervisor on 3/4/2020 at 11:26 am revealed she completed the nutritional part of the MDS assessment and missed the resident's weight loss. She stated the weight loss section on Resident #119's 2/1/2020 MDS was incorrect. During an interview with the Administrator on 3/7/2020 at 2:50 pm, she stated the 2/1/2020 MDS assessment for Resident #119 should have been code accurately.
F 0655 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Some	**Create and put into place a plan for meeting the resident's most immediate needs within**

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F 0655 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 3) **48 hours of being admitted** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident and staff interviews the facility failed to provide a written summary of the baseline care plan to residents or their representatives for 3 of 5 residents reviewed for baseline care plans. (Resident #87, Resident #399 and Resident #141) Findings included: 1. Resident #87 was admitted to the facility 07/09/19 with [DIAGNOSES REDACTED]. The comprehensive Minimum Data Set (MDS) assessment for Resident #87 dated 7/18/19 indicated he was independent for daily decision making. The medical record for Resident #87 indicated he was his own representative. Resident #87's baseline care plan was dated 07/09/19. Resident #87's medical record did not reveal any documentation he received a written summary of his baseline care plan. On 03/03/2020 at 9:40 AM an interview with Resident #87 indicated he did not recall receiving a written summary of his baseline care plan since his admission to the facility. He stated he did know he was supposed to receive a written summary of his care plan. Resident #87 indicated he felt he understood the care being provided to him and if he had questions, he could ask someone. On 03/03/2020 at 2:05 PM an interview with the MDS nurse indicated the facility Social Worker (SW) provided residents with the written summary of their baseline care plan. On 03/03/2020 at 4:13 PM a telephone interview with facility SW #1 indicated she did not recall giving Resident #87 a written summary of his baseline care plan. She stated this was the facility's practice and if she had, documentation would be reflected in her notes. On 03/04/2020 at 12:39 PM an interview with the Director of Nursing indicated she searched Resident #87's medical record and was not able to find any documentation he received a written summary of his baseline care plan since his admission to the facility. 2. Resident #399 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most current care plan for Resident #399 dated 2/17/20 indicated focus areas including medication risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized. A review of the most current Minimum Data Set (MDS) assessment dated [DATE] indicated she was moderately cognitively impaired. Attempts to contact Resident #399's guardian were unsuccessful. On 3/3/20 at 2:05 PM an interview was conducted with MDS Nurse #1 who stated that social work was responsible for providing copies of baseline care plans to residents or their representative. On 3/4/20 at 10:38 PM Social Worker #3 stated she did not provide a copy of the baseline care plan to Resident #399 and was unaware that it was her responsibility. During an interview with Administrator #2 on 3/6/20 at 11:59 AM she indicated Resident #399 or her guardian should have been provided a copy of her baseline care plan. 3. Resident #141 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the baseline care plan for Resident #141 dated 1/31/20 indicated focus areas including medications risks, activities of daily living needs such as dressing, bathing and grooming, and fall risk with goals that were measurable and interventions which were individualized. A review of the most Current Minimum Data Set (MDS) assessment dated [DATE] indicated she was cognitively intact. On 3/3/20 at 2:05 PM an interview was conducted with MDS Nurse #1 who stated that social work was responsible for providing copies of baseline care plans to residents or their representative. During an interview with Resident #141 on 3/4/20 at 9:26 AM she indicated she did not recall receiving a copy of her baseline care plan. On 3/4/20 at 10:38 PM Social Worker #3 stated she did not provide a copy of the baseline care plan to Resident #399 and was unaware that it was her responsibility. During an interview with Administrator #2 on 3/6/20 at 11:59 AM she indicated Resident #141 should have been provided a copy of her baseline care plan.
F 0657 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Few	**Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, representative/family member, staff interviews, and record review, the facility failed to revise a care plan for the use of a bedside floor mat for 1 of 1 resident (Resident #4) reviewed for care plans. Findings included: Resident #4 was originally admitted to the facility on [DATE] and readmitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A quarterly Minimum Data Set ((MDS) dated [DATE] revealed Resident #4 was rarely understood and was not assessed for a cognitive status. MDS also showed the resident required extensive assistance for bed mobility, had an impairment on both sides of her lower extremities, and received Hospice services. The care plan revised on 5/8/2019 revealed a plan which focused on Resident #4 was at risk for falls related to a history of falls, impaired mobility, dementia, poor safety awareness with the interventions for a fall mat on floor when in bed. The care plan meeting was attended by the representative/family member. The risk for falls and Hospice services care plan was reviewed. The most recent date of revision for the Hospice care plan was 9/1/2019 and the falls care plan was 5/08/2019. A fall risk assessment dated [DATE] revealed Resident #4 had no falls within the last 30 days, was chairfast with total assist with transport, required no follow up, and was low risk for falls. There were no comments added in the comment section of the assessment. An observation on [DATE] at 10:30 am revealed Resident #4 resting in bed with her eyes closed with a family member/representative in the room. There was no bedside mat on the floor or in the room. An observation on 3/3/2020 at 9:00 am Resident #4 was resting in bed with her eyes closed with no bedside mat on the floor. During an interview on 3/3/2020 at 11:00 am with the representative/family member, she stated Resident #4 would swing her legs off the side of the bed to go to the bathroom unassisted. The representative also stated she visited the resident daily and have never seen a bedside fall mat on the floor when Resident #4 was in the bed. On 3/3/2020 at 3:07 pm during an interview with Nurse Aide #10, she stated Resident #4 will try to get out of the bed unassisted and the resident did not have a bedside fall mat. An interview with Nurse #6 on 3/3/2020 at 3:11 pm revealed Resident #4 would try to get out of the bed on her own and she could not remember the resident ever having a fall mat in her room. During an interview with MDS Nurse #1 on 3/4/2020 at 11:04 am, she stated Resident #4 did not have a bedside fall mat in her room and had not been using a fall mat. MDS Nurse #1 also stated she had spoken with the DON (Director of Nursing) about the fall mat and it was determined the fall risk care plan would be revised to discontinue the bedside fall mat.
F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	**Provide appropriate care for a resident to maintain and/or improve range of motion (ROM), limited ROM and/or mobility, unless a decline is for a medical reason.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations and staff and resident interviews the facility failed to provide restorative services per therapy recommendations and care plan directives for 2 of 3 residents reviewed for range of motion. (Resident #63, Resident #46) Findings included: 1. Resident #63 was admitted to the facility on [DATE]. His active [DIAGNOSES REDACTED]. Resident #63's restorative summary dated 5/14/19 revealed he was to receive restorative services by being placed on the sci-fit (an exercise bike) for 15 minutes decreased from 6 times a week to 3 times a week per the resident's request. Resident #63's minimum data set assessment dated [DATE] revealed he was assessed as cognitively intact. He had no moods and no behaviors. Resident #63 required extensive assistance with bed mobility, dressing, toilet use, and personal hygiene. He required supervision with locomotion on and off unit, transfers, walking on and off corridors, and eating. He was documented to receive active range of motion 2 times in the 7 day look back period with restorative therapy. Resident #63's care plan dated [DATE] revealed he was care planned to require assistance and had potential to restore or maintain maximum function of self-sufficiency for mobility. The interventions included active range of motion exercises using sci-fit (an exercise bike) for 15 minutes at level 1 three times per week. If Resident #63 did not participate in restorative active range of motion program, staff were to document the reason. Resident #63's documentation of sci-fit exercises for the week of 2/23/2020 revealed he was documented to have been on the sci-fit bike for 5 minutes on 2/25/2020. He was not documented to have any refusals and was not documented to have been on the sci-fit bike any other day during the week of 2/23/2020. During an interview on 3/3/2020 at 8:28 AM Restorative Aide #1 stated Resident #63 was supposed to get on a sci-fit bike for restorative three times a week. She further stated to her knowledge he did not get on the sci-fit bike last week. She stated nurse aides were trained to give restorative therapy when the restorative nurse aide was not available but none of the nurse aides who worked with Resident #63 last week did it. During an interview on 3/3/2020 at 8:58 AM Resident #63

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	345237	A. BUILDING _____ B. WING _____	03/10/2020

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

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F 0688 **Level of harm** - Minimal harm or potential for actual harm **Residents Affected** - Some	(continued... from page 4) stated he had not been on the bike for six months. He stated Restorative Aide #1 and Restorative Aide #2 were the only aids who had gotten him on the bike. He further stated he had not refused to get on the bike last week and no nurse aides offered to provide him restorative with the sci-fit bike last week. He concluded he felt like his balance was worse now when transferring. During an interview on 3/4/2020 at 7:45 AM Nurse Aide #1 stated nurse aides did not get residents on an exercise bicycle to her knowledge. She stated she had not offered to put Resident #63 on an exercise bike. She cared for Resident #63 regularly including 2/26/ , 2/27/2020, and 2/28/2020. During an interview on 3/4/2020 at 7:59 AM Restorative Aide #2 stated she was the restorative nurse aide. She stated today she was working restorative but she also sometimes worked as a floor nurse aide. She stated when she was pulled to the hall the nurse aide was supposed to perform restorative, but the facility had a lot of new nurse aides and they did not understand what residents needed for restorative. She further stated she was pulled from restorative last week and only worked the floor and did not do restorative therapy with residents the week of 2/23/2020. She stated she did not perform any restorative therapy with Resident #63 last week. She further stated he did not get on the sci-fit bike last week per his restorative orders. The nurse aide stated she knew this because aides had to be trained on the sci-fit bike and none of the nurse aides who worked on his hall had been trained on the restorative bike and she was on the floor. She further stated Resident #63 had not been on the bike in a long time and it was not due to him refusing care. He had only ever asked to have the amount of time he was on the bike reduced to three times a week instead of six times a week. She further stated she did not understand why the nurse aide documented he had been on the bike for five minutes because it would be a waste of time since he would just be getting started at the end of five minutes. During an interview on 3/4/2020 at 9:05 AM Nurse Aide #2 stated she had not been trained to use the sci-fit bike and was not supposed to get residents up on the bike to her knowledge. She concluded she was his nurse aide at this time. During an interview on 3/4/2020 at 1:39 AM Nurse Aide #3 stated she did walk Resident #63 during the week of 2/23/2020 but did not place him on the sci-fit bike. She further stated she had not been educated to place residents on a bike and was not aware of having the bike in the facility. During an interview on 3/4/2020 at 3:25 PM Nurse Aide #4 stated on 2/23/2020 she took care of Resident #63 on first shift. She further stated she was not aware he was supposed to be on an exercise bike and had not been educated by the facility how to put the resident on the bike. She stated she did not put him on the bike during the week of 2/23/2020. During an interview on 3/4/2020 at 3:39 PM Medication Aide #1 stated he had never placed any residents including Resident #63 on the sci-fit bike. He concluded he had not been trained on how to use the bike. During an interview on 3/4/2020 at 3:40 PM Nurse Aide #5 stated she had not placed any residents on the sci-fit bike including Resident #63. She further stated she was not aware of any need for any residents to receive this restorative therapy and she did not place Resident #63 on the bike the week of 2/23/2020. During an interview on 3/4/2020 at 3:48 PM the Therapy Director stated when residents are discharged from therapy they are placed on restorative and the recommendations are given to restorative and she no longer oversaw the resident. She further stated Resident #63's last restorative recommendation from therapy on 5/14/19 was for Resident #63 to be on the sci-fit bike three times a week per Resident #63's request. She stated she was not aware Resident #63 had not been receiving restorative therapy on the sci-fit bike per the recommendation and he would need to be reevaluated. She stated she knew for a while after the recommendation he did get restorative, but she had not seen him in a long time. During an interview on 3/4/2020 at 4:15 PM Nurse Aide #6 stated he had not placed Resident #63 on the sci-fit bike the week of 2/23/2020. He further stated he had never been educated to place a resident on the sci-fit bike and did not know what it was. During an interview on 3/4/20 at 4:40 PM Nurse Aide #7 stated she had never placed Resident #63 on the sci-fit bike including the week of 2/23/2020 and had never been educated by restorative how to place a resident on the exercise bike. During an interview on 3/4/20 at 4:43 PM Nurse Aide #8 stated she had never placed Resident #63 on the sci-fit bike including the week of 2/23/2020 and had never been educated by restorative how to place a resident on the exercise bike. During an interview on 3/4/20 at 4:48 PM the Direct of Nursing stated the nurse aides had been educated in January 2020 that if there was not a designated restorative nurse aide it was their responsibility to perform restorative tasks or document the refusal on the electronic record. She further stated she educated staff about the different restorative services so they had been trained on the sci-fit bike. She stated she then educated the nurse aides how to document the restorative task if it was performed or how to go to the separate tab to document refusals. She stated all staff had received the education and signed the education so she did not know why they were saying they did not know about the bike or who would do restorative if there was not a restorative nurse aide available. She further stated she was monitoring ten residents three times a week per her plan of correction. Resident #63 was not a part of the monitoring due to the fact he usually came forward to the Director of Nursing with any complaints. She concluded Resident #63 should have received his restorative therapy as planned. She stated since Resident #63 had not been getting restorative services for an extended time she would submit a physical therapy referral in order to ensure the appropriateness of his therapy. 2. Resident #46 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED].#46's Care Plan dated 12/5/19 revealed an intervention that read in part, ambulate with rolling walker with minimal assist and wheelchair follow 100 feet 6 of days per week. The care plan specified this being done by the restorative nurse aide or the nurse aide. Resident #46's most recent Minimum Data Set assessment dated [DATE], a quarterly assessment revealed he was assessed to be cognitively intact with no behaviors. He was assessed to be dependent with ambulation. Review of documentation of restorative nursing from [DATE]-3/4/20 revealed Resident #46 did not receive restorative ambulation on [DATE], 2/25/20, 3/2/20 and 3/3/20. During an interview on 3/3/20 at 9:16 AM Resident #46 stated he was not receiving restorative ambulation because the restorative aides were often given a hall assignment. He reported that if anyone stated he refused ambulation that was incorrect. Resident #46 stated he could not recall the last time he received ambulation. Observations of Resident #46 during the survey revealed he was able to ambulate with a rolling walker with minimal assistance a distance of 100 feet. During an interview on 3/5/20 at 11:00 AM Nurse Aide #10, who cared for Resident #46 on the first shift, stated that she did not offer ambulation to Resident #46 and that did not know that was part of his care plan. An interview was conducted with Restorative Aide #2 on 3/5/20 at 11:06 AM who stated she was not able to offer restorative services to Resident #46 on 3/4/20 because she was doing monthly weights for residents. She reported that other days when she had Resident #46 on her hall assignment she would provide ambulation. Restorative Aide #2 stated she was pulled to the hall to work as a nurse aide most of the time. An interview was conducted with Nurse Aide #11 on 3/5/20 at 1:05 PM, who cared for Resident #46 on the first shift, stated she did not provide ambulation for residents under her care because she was an agency nurse aide. She stated she was unfamiliar with the residents and was uncomfortable with providing ambulation to them. An interview was conducted with Nurse Aide #12 on 3/5/20 at 5:10 PM who cared for Resident #46 on the second shift. He stated that at times he did not have time to do restorative services but it would be communicated to the next shift. During an interview with Nurse Aide #13 on 3/6/20 at 8:19 AM she reported that she worked on 3rd shift and did not offer ambulation to Resident #46. She reported it would not be appropriate to wake a resident to offer ambulation. Nurse Aide #13 stated that when she checked Resident #46 refused ambulation on 2/27/20 and 3/5/20 it was in error. An interview was conducted with Nurse Aide #1 on 3/6/20 at 9:51 AM, who cared for Resident #46 on the first shift. She stated she did not provide restorative services to Resident #46 because those services are provided by the restorative aides. She stated if the restorative aides were given an assignment to work as nurse aides she was unsure who would provide restorative services. An interview was conducted with the Director of Nursing (DON) on 3/6/20 at 3:15 PM. She confirmed that Resident #46 should be ambulated six days each week. The DON stated she was uncertain why nurse aides were not ambulating Resident #46. She stated that the restorative aides were given a nurse aide assignment most of the time and the nurse aide assigned to Resident #46 was responsible for providing ambulation.
F 0689 **Level of harm** - Immediate jeopardy **Residents Affected** - Few	**Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, interviews with staff, resident, van driver, wound clinic staff, Physician, legal guardian, security officer and a citizen, viewing of security videos and record reviews the facility failed to accompany a cognitively impaired resident, who resided in the facility's secured memory care unit, to a medical appointment and failed to implement planned interventions to prevent falls for 2 of 8 sampled residents (Resident #399 and Resident #39) reviewed for supervision to prevent accidents. Resident #399 was dropped off at a wound clinic by a facility van driver and was left

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 5) unsupervised at the clinic. The resident left the premises of the wound clinic and was located in the community with the involvement of security personnel and a local citizen. This resulted in Resident #399 being out in the community unsupervised by facility staff or her responsible party for one hour and twelve minutes which placed her at risk for serious injury and/or accidents. The resident was located without any apparent injuries and returned to the facility. The facility also failed to implement planned fall risk interventions for Resident #39. Immediate Jeopardy began on 3/4/2020 when Resident #399 was left by a facility van driver at a wound clinic appointment without supervision, the resident left the wound clinic in her wheel chair with an unknown man and for an hour and twelve minutes she was in the community in her wheel chair crossing road ways, going to a bank and a drug store, smoking a cigarette and interacting with people she did not know. Immediate jeopardy was removed on 3/7/2020 when the facility provided and implemented an acceptable allegation of Immediate Jeopardy removal. The facility remains out of compliance at a lower scope and severity of D (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure monitoring systems put in place are effective. Example #2 related to Resident #39 was cited at a scope and severity of a D where a plan of correction is required. Findings Included: 1. The facility's missing resident policy dated 1/2009 read in part (2) out of facility search (a) search the grounds as assigned by the license nurse (b) after the initial search of the grounds is completed and resident's location is not determined, notify the law enforcement agency (c) notify the attending physician (d) notify the responsible party or legal representative (e) continue search procedure as indicated and directed (f) The administrator or designee will notify and or update the regional vice president of the occurrence, as appropriate (g) notify and or update Risk Management as directed by the Regional Vice President. (3) (a) document event as appropriate (b) document any injuries (c) complete the resident QI reporting form according to procedure including witness statements for the internal QI process. Resident #399 was admitted to the facility on [DATE] from the hospital with an order on motion for appointment of an interim legal guardian that was signed on 2/10/2020. The motion stated Resident #399 had experienced a mental and physical decline which resulted in several hospitalization s and surgeries in 2020. The motion specified the resident had very poor decision-making capacity, was unable to understand anything complex, and unable to appreciate any serious weighing of risks and benefits of potential interventions. The motion also stated the resident lacked the capacity to understand, complete, or sign a Medicaid application or admission paperwork. Resident #399's was admitted to the facility [DIAGNOSES REDACTED]. The Physician order [REDACTED].#399 could leave the facility as permitted by stable health status and accompanied by responsible party. The Wandering Risk assessment dated [DATE] revealed Resident #399 had one or more attempts to leave home/facility and or wander in the past three months, had frequent periods of fidgeting, repetitive physical movements, or verbalizations of fear, anxiety 4-6 of last 7 days, chair-bound total assist with transport, had dementia or moderate cognitive loss, had frequent periods of confusion and mental impairment, and was moderately impaired. The assessment also showed the resident's decisions were poor, cues and supervision were required and sometimes understands and was understood, responds adequately to simple, direct communication only, ability was limited to making concrete requests. A review of the admission Minimum Data Set ((MDS) dated [DATE] revealed Resident #399 had moderately impaired cognition. The MDS showed the resident's speech was clear and she was able to understand others, had no behaviors and took an antipsychotic medication 7 days during the assessment look back period. The MDS further showed the resident required supervision with locomotion off the unit. Resident #399 was assessed to have a lower extremity impairment on one side and had a surgical wound. The Care plan dated 2/26/2020 for Resident #399 revealed a plan which specified the resident was at risk for unsupervised exits from facility related to cognitive impairment. The care plan interventions included; to allow resident to wander on unit, to approach wandering resident in non-threatening manner, and a wander guard alarm bracelet to left ankle. A review of a smoking evaluation form dated 2/26/2020 revealed the Resident did not have adequate cognitive function, did not have adequate hand dexterity and use of upper extremities. The smoking evaluation also revealed the resident was an unsafe smoker and required direct supervision while smoking. During an interview with Resident #399 on 3/6/2020 at 10:25 am the Resident stated on Wednesday (3/04/2020) she went to the wound doctor without a staff member with her. The Resident stated she left the wound clinic and a friend rolled her across the street to the bank to withdraw some money and then to the store to buy cigarettes and a drink. Resident #399 also stated she smoked a cigarette and then went to the mental health place (located across the street from the wound clinic) where a security person came and got her and called the facility to come pick her up. During an interview with the facility's van driver on 3/10/2020 at 3:20 pm, he stated on 03/04/2020 he took Resident #399 to the wound clinic for an appointment and checked her in with the wound clinic's receptionist. He stated he gave the receptionist the resident's paperwork and told the receptionist to call him when the resident was finished with the appointment. He stated the receptionist called him to tell him to pick up the resident because she had missed the appointment. The van driver stated the receptionist told him the resident said she wanted something to drink and left to get a drink. He stated the receptionist ended the call and went to look for the resident. The receptionist called the van driver again to let him know the resident was not found. The van driver said when he got to the wound clinic, he went to every medical office in the building looking for Resident #399 and when he did not find her, he requested assistance from the hospital security office. The driver stated the Director of the Wound Clinic asked the hospital security staff to review the security video footage and a security officer informed him the video showed the resident in her wheelchair being pushed by an unknown man to the north exit door of the building. The van driver stated he went to the nearby bank and drug store to look for the resident. He stated the security officer notified him the resident was found and where to locate the resident. The van driver stated when he reached the resident's location there were two security officers with Resident #399 in the hospital's parking lot. The van driver stated he loaded the resident into the van and transported her back to the facility. The van driver stated he was aware Resident #399 was a memory care resident but did not alert the wound clinic staff to this fact when he checked the resident in for her appointment. He also stated normally a memory care resident was accompanied by a staff member for an appointment, but he did not know why Resident #399 was not accompanied by a staff member. During an interview with the receptionist at the wound clinic on 3/6/2020 at 3:30 pm, she stated Resident #399 was not checked in for her appointment at the wound clinic on 03/04/2020 and this was the resident's first appointment at the wound clinic. The receptionist specified the resident came into the wound clinic's waiting area accompanied by the van driver at 9:20 am and the driver opened the receptionist's window and shoved the resident's paperwork through the window. She stated the van driver provided no information about the resident. The receptionist stated she called the resident's name at 9:25 am and when she did not answer, she went to look for her on the benches outside of the office but she was not there. The receptionist stated she waited until after Resident #399's appointment would need to be cancelled to see if she would show up. She further stated after 20 minutes she called the van driver to inform him the resident was not present for her appointment and informed the wound clinic's director the resident was not in the clinic. The receptionist stated during the call with the van driver, he informed her that Resident #399 resided in the facility's memory care unit. During an interview with the Director of the wound clinic on 3/6/2020 3:45 pm she stated she was informed by the clinic's receptionist that Resident #399 was dropped off for an appointment on 3/04/2020 and was no longer in the clinic. The director stated she called hospital security to report the resident was missing and provided the security officer with a photo from Resident #399's last hospital admission. The director stated the receptionist called the facility to report the resident was not at the facility while she viewed the security footage. She said the security video showed an unknown man pushing Resident #399 to the building's north exit door. The director stated there was no security footage recorded outside of the building to show what transpired after the resident and unknown man exited the building. The director further stated the wound clinic policy was a memory care resident was required to have someone accompany them to their appointment. She then stated if the clinic's staff had been informed by the facility that Resident #399 resided on the facility's memory care unit, she would have placed the resident in a room where she would have been observed more frequently. During an interview with Nurse #5 on 3/6/2020 at 5:20 pm, she revealed she received a call on 03/04/2020 from the wound clinic to inform the facility Resident #399 was not at her wound clinic appointment. Nurse #5 stated she notified the DON (Director of Nursing) and the resident's responsible party (RP) was called to see if she had picked the resident up from the would clinic appointment and the RP stated she had not picked up the resident. Nurse #5 specified the resident's RP called the facility and informed the DON that Resident #399 called her, and the RP provided the phone number the resident used to call her. Nurse #5 said she called the phone number provided by the resident's RP and her call was answered by an unknown woman (Citizen #2) who stated the resident was trying to go to the drug store to buy cigarettes. Nurse #5 stated the van driver was called and directed to the drug store where Citizen #2 stated the resident was at and the facility's Social Worker and Maintenance supervisor were sent to assist with finding the resident. On 03/07/2020 at 9:54 am the drug store's security video was viewed. This video showed on 03/04/2020 at 9:50 am Citizen #2 (an

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 6) unknown woman) pushing Resident #399 in her wheelchair to the drug store (which was on the same side of the road as the wound clinic). In the video the resident can be seen giving money to Citizen #2. Citizen #2 entered the drug store and left the resident unattended outside. Citizen #2 purchased a soda and cigarettes in the drug store. At 9:56 am Citizen #2 exited the drug store and gave her the resident her soda and cigarettes. At 9:59 am Citizen #2 lit Resident #399's cigarette and the resident began smoking as she talked to Citizen #2. At 10:02 am Citizen #2 pushed the resident toward the road and out of the view of the drug store's video camera. On 03/07/2020 at 11:22 am the hospital's security video was viewed. This video showed on 03/04/2020 at 10:09 am Resident #399 was in the health department's parking lot (which was located across the road from the wound clinic) being pushed in her wheelchair to the health department. It could not be determined if the person pushing the resident in her wheelchair in the video was Citizen #2 or someone else. At 10:30 am the resident was observed on the video to be alone and leaving the health department parking lot. Resident #399 can be seen on the video in her wheelchair crossing a road (with a 10 mile per hour speed limit) without assistance. A white truck was seen in the video to have to stop to let Resident #399 cross the road. Resident #399 entered the hospital parking lot in her wheelchair and went behind a row of bushes. At 10:38 am hospital security pulled up to the bushes where Resident #399 was located and stopped. At 10:46 the video showed the facility's transport van pull up to the bushes and picked up Resident #399. During an interview with the hospital security officer on 3/6/2020 at 4:00 pm, he stated he received a call on 03/04/20 at 9:50 am that Resident #399 was not in the wound clinic. The officer stated he obtained a description of the resident. He and another officer then checked the hospital's security camera video. The officer stated the video showed at 9:26 am an unknown man pushing the resident in her wheelchair to the wound clinic's north exit door. He stated he found the resident by herself in the hospital's parking lot. The officer stated a Social Worker and another individual arrived and stayed with the resident until the facility's transport van came to pick up the resident. During an interview with the Director of Nursing (DON) on 3/6/2020 at 10:45 am she stated Resident #399 went to her wound clinic appointment on 3/04/20 without a facility escort. The resident was assisted in her wheelchair by an unknown woman to go to a drug store to purchase cigarettes. The DON also stated when transport went to pick the resident up from the appointment, she was not at the wound clinic. The DON said Nurse #5 informed her that the wound clinic called and said Resident #399 was not at the clinic for her appointment. She stated she called Citizen #1 to help look for Resident #399 because he was in the vicinity of the wound clinic and could get there quickly. The DON stated she did not notify law enforcement because she did not consider the resident was missing. An interview with Citizen #1, who the DON called to search for Resident #399, was conducted on 3/6/2020 at 1:55 pm. The interview revealed on 03/04/2020 Citizen #1 was on the way to town when he received a call from the DON, and she asked him to go by the drug store to see if he could find Resident #399. Citizen #1 stated he passed an alley and saw Resident #399 in a wheelchair smoking a cigarette. Citizen #1 stated at 10:39 am he saw Resident #399 with two security officers in the hospital's parking lot and felt she was safe. An interview with the facility's Social Worker (SW) and the facility's Maintenance Supervisor was conducted on 3/6/2020 at 5:35 pm. The interview revealed after the facility received a call from the wound clinic on 3/04/20, the maintenance supervisor and SW were asked to go find Resident #399. The Maintenance Supervisor stated they found the resident in the hospital parking lot and the resident stated she had gone to the bank and the hospital. The SW stated the resident was her normal self and did not have any injuries. The SW stated the hospital security officer was with the resident. The SW said he and the maintenance supervisor stayed with the resident until the facility's transport van came to pick the resident up. The SW stated Resident #399 was dressed in a long sleeve shirt and pants which were appropriate for the weather. On 3/7/2020 at 9:50 am an interview was conducted with Nurse #4, who worked on the facility' s secured memory care unit on 3/04/2020, when Resident #399 returned to the facility. Nurse #4 stated a nursing assessment or skin assessment was not completed when Resident #399 returned to the facility on [DATE] because she was not informed the resident was missing and her whereabouts was unknown when she was to be at an appointment earlier in the day. On 03/06/2020 at 4:30 pm observations were made of the area Resident #399 traversed in her wheelchair while out in the community on 3/4/2020. The observation revealed the distance from the wound clinic to the bank, where the resident was seen withdrawing money, was approximately 540 feet. The approximate distance from the bank to the drug store, where the resident was observed with Citizen #2, was an approximate distance of 360 feet and the resident had to cross a 2-lane road with a posted speed limit of 10 miles per hour (mph) to get to the drug store. The distance from the drug store to the hospital parking lot, where the resident was found, was approximately 1,500 feet and the resident had to cross a four-lane road which had a posted speed limit of 35 mph to get to the hospital parking lot. The weather on 3/4/2020, in the city where the wound clinic was located, revealed the temperature was 60 degrees Fahrenheit and it was partly cloudy per the computer website weather.com. An interview with the facility's appointment scheduler on 3/6/2020 at 11:00 am revealed she normally would send an escort to an appointment with a resident who reside in the facility's secured memory care unit. She stated Resident #399's room number confused her because she forgot the secured memory care unit was expanded to include Resident #399's room. The scheduler further stated she did not think Resident #399 resided on the secured memory care unit because she seemed coherent and her mind together, so she did not send an escort to accompany Resident #399 to her wound clinic appointment on 03/04/2020. During an interview with Resident #399's legal guardian on 3/10/2020 at 12:20 pm, she stated the facility informed her the resident left the wound clinic on 3/4/2020 and went to the drug store to buy cigarettes. The legal guardian also stated she felt the facility did everything they could to find the resident when she left the clinic. She stated Resident #399 should have never been left alone to start with because she was a resident on the facility's memory care unit. The legal guardian said the resident was on the memory care unit because on two occasions she had gotten out of the facility while unsupervised. The primary care physician for Resident #399 was interviewed on 3/6/2020 at 1:55 pm. The physician revealed he only saw Resident #399 once and could not remember the resident's cognitive status or the specifics of the case. The physician stated because the resident was in the facility's secured memory care unit, was incompetent, and had a guardian, he would think the resident going to the wound clinic appointment unescorted would be a problem. He stated he was informed by the facility of the occurrence. During an interview 3/7/2020 at 9:57 am the DON stated a nursing assessment was not completed when Resident #399 returned to the facility and the facility's missing resident policy was not followed because Resident #399 was not considered a missing resident. During an interview with the DON on 3/7/2020 at 2:02 pm the DON stated Resident #399 had a [DIAGNOSES REDACTED]. She stated residents of the facility's memory care unit should never be off the unit without supervision. The DON further stated Resident #399 should have been accompanied by a staff member to her wound care appointment on 3/4/2020. She further indicated Resident #399 would go to all upcoming appointments accompanied by a staff member. The Administrator and DON were notified of Immediate Jeopardy on 3/6/2020 at 6:30 pm. On 3/07/2020 at 12:25 pm the facility provided the following credible allegation of Immediate Jeopardy removal: F 689- Free of Accidents/Hazards/Supervision/ Devices Resident #399 had an initial BIM's completed on 2/25/2020 by the Social Worker which was a 12. On 3/7/2020 Resident #399 had a new BIM's assessment completed by the Social Worker which is now a 15. On 3/5/2020 the Director of Nursing audited the transportation log to ensure that all residents with a BIM's of 12, having cognitive deficits and/or disabilities will be supervised during the appointment and until the resident is returned to facility. On 3/5/2020 and 3/6/2020 all other residents on the transport log were reviewed by the Director of Nursing to ensure they had a safe plan for transport. The Unit managers, transportation scheduler, and C.N.A.'s received in-service by the ADON to ensure residents that have an appointment and require supervision have a staff or family member to accompany them. This in-service was completed by 3/6/2020. The in-service covered appointment scheduling and transportation of residents with a BIM's of 12 or less or other cognitive deficits and/or disabilities will be supervised during the transport, appointment time, and return transport. On 3/6/2020 the ADON and LPN/Resource Nurse completed a new smoking assessment on all residents in the facility that smoke. Resident #399 had a smoking evaluation completed on 3/6/2020 by the ADON, the smoking assessment indicated resident #399 as a safe smoker. Resident #399 will be accompanied when smoking secondary to being in the SPARK unit. The smoking policy was reviewed with all unsupervised smokers and placed in their chart. Actions taken to alter the process or system failure to prevent a serious adverse outcome for occurring or recurring: Residents that are scheduled for an appointment outside of the facility that are not alert and oriented have the potential to be affected. On 3/6/2020 the Regional VP completed an in-service on the Missing Persons Policy to include the Administrator, Director of Nursing, Assistant Director of Nursing, and the Unit Managers. On 3/6/2020 the Assistant Director of Nursing initiated an in-service for licensed nurses on performing the smoking evaluation and review of the smoking policy. This in-service will be completed by 3/7/2020. After 3/7/2020 the receptionist will mail the in-service education via certified mail to all remaining staff who has not worked and not received the in-service with instruction to review, sign the in-service, and return to the staff facilitator or Director of Nursing prior to their next scheduled work shift. On 3/7/2020 Unit Managers audited rooms of residents who smoke to ensure they had no smoking paraphernalia in their

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	345237	A. BUILDING _____ B. WING _____	03/10/2020

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

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

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F 0689 **Level of harm -** Immediate jeopardy **Residents Affected -** Few	(continued... from page 7) possession. During this process, they educated residents on the importance of complying with the facility smoking policy. A letter will be sent to resident families of those who smoke to educate them on how to safely provide their loved one with smoking items. 0n 3/6/2020 the Assistant Director of Nursing initiated an in-service for all staff in all departments on the Missing Person Policy. This in-service will be completed by 3/7/2020. After 3/7/2020 the receptionist will mail the in-service education via certified mail to all remaining staff who has not worked and not received the in-service with instruction to review, sign the in-service, and return to the staff facilitator or Director of Nursing prior to their next scheduled work shift. On 3/6/2020 the Resource Nurse completed new wander/risk assessments on all residents that have a wander guard, care plan will be reviewed by the Director of Nursing and updated if needed, the elopement board in the break room which identifies all Residents at risk for wandering was audited by the Medical Records Coordinator to assure it is up to date. All needed changes will be completed immediately. On 3/6/2020, 3-11 shift, an elopement drill was conducted by the Assistant Director of Nursing. On 3/7/2020 the 11-7 shift the Director of Nursing will conduct an elopement drill and the maintenance director will conduct an elopement drill on the 7-3 shift. The transportation scheduler and unit managers will review appointments that require transportation Monday thru Friday to ensure that the resident being transported have been evaluated for the need to be supervised. The Transportation scheduler and/or the unit managers will contact family to see if they will be accompanying them to the appointment. If the family is not available a staff member will be assigned to go on the appointment with the resident. Director of Nursing or Assistant Director of Nursing will validate if a resident will require supervision during an appointment. This will occur Monday thru Friday during Cardinal IDT with each new appointment scheduled. The Administrator and Director of Nursing were responsible for the implementation of corrective actions to include 100% in-services and audits. Immediate Jeopardy Removal Date will be 3/7/2020 The credible allegation for Immediate Jeopardy removal was validated on 3/07/2020, which removed the Immediate Jeopardy on 3/07/2020 as evidenced by staff interviews, in-service record reviews, and observations. The in services included information on the missing resident policy, smoking, providing an escort with transportation for appointments. 2.Resident #39 was admitted to the facility on [DATE] with [DIAGNOSES REDACTED]. A review of the most recent quarterly MDS assessment for Resident #39 dated 1/1/2020 indicated he was comatose and required the total assistance of one person for all activities of daily living. The resident required the total assistance of two persons for bed mobility. He had one fall since admission without major injury. A review of Resident #39's most recent falls risk assessment indicated he was at risk for falls. A review of the current care plan for Resident #39 updated 1/16/2020 indicated a focus area of at risk for falls related to impaired cognition (thinking). This risk area indicated a goal of will not experience major injury through next review. The interventions included bed in lowest possible position (3/18/19), observe resident position in bed and make sure he is not close to the edge of the bed and use wedge pillows for positioning (12/20/19). A nursing progress note dated 12/11/19 indicated at 3:30 AM Resident #39 was found with his feet on the bed and his upper body on the floor. It further indicated his bed was in the low position, his face was reddened, his lips were swollen, and a small amount of blood was noted to his face. The note went on to say Resident #39 was sent to the emergency room (ER) for evaluation. A nursing progress note dated 12/11/19 at 6:30 AM indicated Resident #39 returned to facility and all imaging tests done in the ER were normal. A review of a fall investigation report dated 12/11/19 indicated Resident #39 had an unwitnessed fall from a low bed and was found with his head on the floor and his feet still on the bed. It further indicated Resident #39 was at times restless in bed and determined a root cause for the fall to be this restless movement. The fall investigation report indicated wedge pillows would be implemented to assist with positioning and to help Resident #39 remain centered in bed. On 3/5/2020 at 8:04 AM Resident #39 was observed centered in bed with his bed elevated approximately two and one-half (2.5) feet from the floor and not in the lowest possible position (one foot). Resident #39 was observed with his eyes open. He made brief eye contact but did not respond verbally. Resident #39 was observed to be making non-purposeful movements with his right arm. His wedge pillow was observed on a chair beside his bed. A continuous observation of Resident #39 made from 8:04 AM to 8:42 AM revealed the following: On 3/5/2020 at 8:16 AM the Administrator was observed to enter Resident #39's room and provide fresh ice water to Resident #39's roommate. She did not provide any care to Resident #39. Resident #39 was in bed and his bed continued to be approximately two and one half (2.5) feet from the floor and no wedge pillows were in the resident's bed. On 3/5/2020 at 8:19 AM Resident #39 was observed centered in bed with his bed elevated approximately two and one half (2.5) feet from the floor. His wedge pillow was not in his bed and remained on a chair in his room. On 3/5/2020 at 8:28 AM Social Worker #2 was observed to enter Resident #39's room to provide his roommate with a meal tray. He did not provide any care to Resident #39. Resident #39's wedge pillow remained on a chair in his room. On 3/5/2020 at 8:32 AM Resident #39 was observed centered in bed with his bed elevated approximately two and one half (2.5) feet from the floor. His wedge pillow remained on a chair in his room. On 3/5/2020 at 8:35 AM interview with Nurse Aide (NA) #9 indicated she was currently responsible for the care of Resident #39. She stated Resident #39 was at high risk for falls because he sometimes moved around in bed, wedge pillows were used to keep him centered in bed, and his bed was supposed to be in the lowest position possible as this minimized the risk of serious injury if Resident #39 fell from the bed. NA #9 further stated Resident #39's bed was currently not in the lowest position possible but was elevated. She stated she did not know why, and she had not been in his room yet that day. On 3/5/2020 at 8:38 AM an interview with Nurse #3 indicated she was currently responsible for the care of Resident #39. She stated she had been in his room to check on him at 7:07 AM after receiving report but had not noticed whether his bed was in the lowest position possible. Nurse #3 went on to say Resident #39's bed did not need to be in the lowest position possible as he was not at risk for falls because he was not able to walk. She further indicated she was an agency nurse and had last cared for Resident #39 about a month ago. On 3/5/2020 at 8:42 AM an observation of Resident #39 was made with the Director of Nursing (DON) present. An interview with the DON at that time indicated Resident #39's bed was not in the lowest position possible and should have been. She then lowered Resident #39's bed as far as it would go to approximately one (1) foot from the floor. The DON stated the care planned interventions for Resident #39 of keeping his bed in the lowest position and the use of wedge pillows were designed to protect Resident #39 and prevent major injuries in the event Resident #39 fell from bed. She stated this was still appropriate for Resident #39 as he was still at risk for falls as he sometimes had restless movements and had fallen from bed in the past. The DON went on to say Nurse #9 had access to Resident #39's care plan and should have reviewed it before providing care to him and should have known the resident was at risk for falls. On 3/5/2020 at 8:50 AM a follow up interview with Nurse #9 indicated she had access to Resident #39's care plan but had not reviewed it before providing care to him. She went on to say she reviewed it after the DON spoke with her and Resident #39 was at risk for falls and should have had his bed in the lowest position possible to prevent major injury in the event of a fall from bed. On 3/6/2020 at 1:23 PM an interview with Administrator #2 indicated going forward the facility would ensure all staff were aware of the safety measures in place for residents.
F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.** **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations and staff interviews the facility failed to keep medications secured in a locked treatment cart for 1 of 2 treatment carts observed. (Treatment Cart #1) Findings included: During observation on 3/4/2020 at 8:56 AM Treatment Cart #1 was observed to be unlocked and unattended on the 800 hall outside of a room. The door was closed to the room. At 8:56 AM a nurse aide walked past the unlocked treatment cart. At 8:58 AM Treatment Nurse #1 came out of the room to the treatment cart. During an interview on 3/4/2020 at 8:58 AM Treatment Nurse #1 stated she was to lock her treatment cart when it was out of view for safety. She further stated the cart should have been locked and it was unlocked. During observation on 3/4/2020 at 8:59 AM Treatment Cart #1 was observed to contain antifungal powder with [MEDICATION NAME] 2%, 10% zinc oxide adult barrier spray, moisture barrier antifungal cream, iodine antiseptic, 0.125% sodium hypochlorite solution, Kendal amorphous hydrogel wound dressing, [MEDICATION NAME] santyl ointment 250 units/gram, and mupirocin ointment 2%. During observation on 3/4/2020 at 10:23 AM Treatment Cart #1 was again observed to be unlocked and unattended on the 300 hall outside of a room with the door closed. At 10:23 AM a nurse aide walked past the treatment cart. At 10:23 AM another nurse aide walked past the unlocked treatment cart. At 10:24 AM a housekeeping staff member walked past the

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F 0761 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	(continued... from page 8) unlocked treatment cart. At 10:25 AM a housekeeping staff member walked past the unlocked treatment cart. During an interview on 3/4/2020 at 10:27 AM Treatment Nurse #1 stated she was to lock her treatment cart when it was out of view and she left it unlocked again. She further stated the cart should have been locked and it was unlocked. She concluded the treatment cart was her responsibility. During an interview on 3/4/2020 at 12:31 PM the Director of Nursing stated treatments carts were to be locked when unattended.
F 0867 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.** Based on staff interview, and record review the Facility's Quality Assessment and Assurance Committee (QAA) failed to maintain implemented procedures and monitor interventions that the committee put into place following the 1/14/2020 complaint investigation survey. This was for one recited deficiency in the area of providing treatment and services to increase range of motion and/or to prevent a further decrease in range of motion (F-688). This deficiency was cited again on the annual recertification survey on 03/10/2020. The continued failure of the facility during two federal surveys of record showed a pattern of the facility's inability to sustain an effective QAA program. Findings included: This tag is cross referenced to: F- 688 Based on record review and staff interviews the facility failed to provide restorative services per therapy recommendations for 2 of 3 residents reviewed for range of motion. (Resident #63, Resident #46) During the facility's 1/14/20 complaint survey the facility failed to provide ambulation as specified in the plan of care for 2 of 2 residents reviewed for range of motion (Resident #7 and Resident # 9). During an interview with the Administrator on 3/7/2020 at 3:07 PM, the Administrator indicated she felt the cause of the repeat deficiency was possibly the facility had only reviewed ten percent of affected residents during the Quality Assurance (QA) process and the facility should have reviewed one hundred percent of residents. She further indicated going forward the facility would be reviewing one hundred percent of the residents possibly affected by issues during their QA process.
F 0880 **Level of harm -** Minimal harm or potential for actual harm **Residents Affected -** Few	**Provide and implement an infection prevention and control program.** Based on observations and staff interviews, the facility failed to cover clean linen stored in a linen cart on the hallway to prevent contamination for 1 of 5 linen carts reviewed for infection control. Findings included: An observation on 3/4/2020 at 8:04 am revealed 5 linen carts were on the hallway opposite of the laundry room. One of the carts was labeled as the Sparks unit and had clean and folded flat and fitted sheets, wash cloths, and towels in it. The linen cart's front cover was not in place which left the front of the cart opened and the linen stored inside of the cart uncovered and exposed to the open environment. An observation on 3/4/2020 at 8:30 am revealed the Sparks unit linen cart was still on the hallway across from the laundry room with the cart's front cover still not in place, so the linen stored inside the cart remained exposed. A housekeeper was observed buffing the floor in front of the linen cart. The cart was repositioned from one side of the hallway to the other side of the hallway by staff, so the housekeeper could buff the floor, but the linen on the cart remained uncovered as the staff member cleaned the floor near the cart. During an interview on 3/4/2020 at 9:00 am with laundry employee #1 she stated after she washed and folded the linen, she would stock the linen carts. She then stated the carts would sit outside the laundry room door in the hallway and she would normally pull the covering back over the linen cart until she needed to put more linen on the cart. Laundry employee #1 also stated the cart was not covered because she had not finished putting clean linen on the cart. She then stated she should have pulled the covering down over the front of the linen cart after she finished putting the clean linen on the cart. An interview on 3/5/2020 at 4:06 pm with the housekeeping supervisor revealed the linen carts are supposed to be covered when not in use. She also stated when clean linen needed to be place on the cart, the cart should be brought to the laundry room door and loaded in the doorway. During an interview with the Director of Nursing on 3/5/2020 at 4:21 pm, she revealed the linen on the linen cart should have been taken back to the laundry room and rewashed. The DON also stated linen carts should be covered when on the hallways.