

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 02/26/2026
NAME OF PROVIDER OR SUPPLIER Barbour Court Nursing and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 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.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>Ensure residents have reasonable access to and privacy in their use of communication methods.</p> <p>Based on record review and interviews with residents and staff, the facility failed to ensure the residents' right to receive mail delivered on Saturdays and on the date it was received. This had the potential to affect 136 of 136 residents in the facility. Findings included: During the Resident Council meeting on 2/25/26 at 2:08 PM Resident #26, Resident #39, Resident #54, Resident #73, Resident #94, Resident #95, and Resident #13 reported they did not get their regular mail delivered as the facility received the mail, including Saturdays. Resident #26, the Resident Council President, stated regular mail was delivered to Receptionist #1 Monday through Friday. Receptionist #1 sorted the mail and gave the residents' mail to the activities department to be delivered, but it was hit or miss how quickly the mail was delivered. The Resident Council President further stated Saturday's mail was held at the front desk and given to Receptionist #1 on Monday to sort and the residents' mail was then taken to activities to be delivered. The Resident Council President stated regular mail sometimes sat in the activities room for a week before it was delivered. The Resident Council President stated he was aware of this issue because his trade/professional magazines, outdoor sporting magazines, and product catalogues had been in the activities room for a week before he collected them himself after Resident #39 informed him the magazines were in the activities room. Resident #39 then confirmed this by stating he often read Resident #26's outdoor sporting magazines in the activities room before he told Resident #26 his magazines were in the activities room. Resident #26 stated the times he was concerned his mail sat in the activities room were not when he was out of the facility or hospitalized and he usually had to collect his magazines from the activities room. During an interview on 2/26/26 at 9:40 AM Resident #95 stated she went to the activities room after lunch daily just to check in with them and color her coloring pages. She further stated most of the time she went into the activities room, the rack that held the sorted, regular mail for residents was often full. She stated the same mail, such as the Resident Council President's magazines, remained in the activities room for a week before it disappeared and she assumed it was delivered or the residents picked it up themselves. She stated the magazines were the easiest to identify as the same mail sitting for a long time because the magazine cover image was different for each issue, but the same cover sat in the activities room for many days. She stated there was not a set pattern or day that the mail was taken out of the activities room, but it was very obvious to her that the same items of mail sat in the activities room for multiple days before being delivered or picked up by the residents. During an interview on 2/26/26 at 7:58 AM Receptionist #1 stated each weekday, Monday through Friday between 1:00 PM and 1:30 PM, she got the mail from the mailbox and went to the post office to pick up the mail at the post office. She then returned to the facility and sorted the mail and put the residents' mail in the box in the activities room. She stated on Saturdays when she was not at the facility, the mail was put in her box at the front, and she sorted Saturday's mail on Mondays. She stated that most Mondays she sorted residents' mail that was delivered on Saturday and put the mail in the box in the</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0576</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>activities room to be delivered to the residents on Monday. During an interview on 2/26/26 at 8:34 AM the Activities Director stated she worked some Saturdays and when she worked on Saturdays the mail was sorted and delivered to the residents. She stated someone from activities was in the facility every day and the mail should be sorted and delivered on Saturdays by activities staff. The Activities Director stated she knew sometimes if there was a question of whether a resident should receive an item like a bill, activities staff would put it in Receptionist #1's box to be sorted Monday. So, there were times when Saturday's mail was not delivered until Monday if there were questions about whether it should go to the resident or another party. She concluded she was not aware of any time any resident's mail sat in the activities room and was not delivered for a week unless the resident was in the hospital and mail was held for them secured in an office belonging to activity staff. During an interview on 2/26/26 at 8:07 AM the Administrator stated it was his expectation that mail was delivered daily to residents, including Saturdays. It was his understanding that regular mail was being distributed as it arrived by the activities department, including Saturdays. The Administrator stated he was not aware that the Receptionist sorted mail delivered on Saturday on most Mondays for residents or that residents had concerns with mail not being delivered daily throughout the week as no grievances had been completed about timely mail delivery.</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure each resident receives an accurate assessment.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of medications (Resident #8, Resident #4, and Resident #5) and Pneumococcal Vaccine (Resident #18). This was for 4 of 28 residents whose MDS assessments were reviewed. Findings included: a. Resident #8 was admitted to the facility on [DATE]. Resident #8's physician orders included Novolog (a rapid acting insulin) injection solution 100 units/milliliter inject 10 units subcutaneously (beneath the skin) with meals. Hold for blood sugar less than 150 with a start date of 3/18/25. Resident #8's December 2025 Medication Administration Record (MAR) noted Novolog was administered subcutaneously to him on 12/25/25 at 11:30 AM, on 12/26/25 at 6:30 AM, on 12/27/25 at 6:30 AM, 11:30 AM, and 5:30 PM, on 12/28/25 at 6:30 AM and 11:30 AM, on 12/29/25 at 6:30 AM and 5:30 PM, on 12/30/25 at 11:30 AM and 5:30 PM, and on 12/31/25 at 6:30 AM and 5:30 PM. Resident #8's quarterly MDS assessment dated [DATE] revealed he received both injections and insulin injections on 5 of the 7 look back days of the assessment. On 2/25/26 at 10:50 AM during an interview MDS Nurse #1 stated she coded the medication section of Resident #8's MDS assessment dated [DATE]. She reported she should have coded the section to indicate Resident #8 received both injections and insulin injections for 7 of the 7 look back days of the assessment period. She reported this was an error. b. Resident #4 was admitted to the facility on [DATE]. Resident #4's physician orders included Dulaglutide (non-insulin medication to improve blood sugar control) Solution Pen-injector 0.75 milligrams per 0.5 milliliter inject 0.75 mg subcutaneously one time a day every Saturday related to Type 2 Diabetes Mellitus with a start date of 12/6/25. There were no physician orders in December 2025 for Resident #4 to receive insulin. Resident #4's December 2025 Medication Administration Record (MAR) noted Dulaglutide was administered subcutaneously to him on 12/27/25. Resident #4's quarterly MDS assessment dated [DATE] revealed he received both an injection and an insulin injection on 1 of the 7 look back days of the assessment period. On 2/25/26 at 10:50 AM during an interview MDS Nurse #1 stated she coded the medication section of Resident #4's MDS assessment dated [DATE]. She reported that she coded the section to indicate Resident #4 received both an injection and an insulin injection on 1 of the 7 look back days of the assessment period. She stated she coded this medication as an insulin because it was prescribed for Resident #4's diabetes. c. Resident #5 was admitted to the facility on [DATE]. Resident #4's physician's orders for January and February 2026 did not reveal any orders for anticoagulant medication. Resident #4's January and February 2026 Medication Administration Records (MAR) did not reveal any documentation indicating anticoagulant medication had been administered. Resident #5's annual MDS assessment dated [DATE] noted she received anticoagulant medication during the 7 look back days of the assessment period. On 2/25/26 at 10:43 AM during an interview MDS Nurse #2 stated she coded the medications section of Resident #5's MDS assessment dated [DATE]. She reported her coding that Resident #5 received anticoagulant medication was an error. She stated Resident #4 had not received any anticoagulant medication during the look back period of the assessment. d. Resident #18 was admitted to the facility on [DATE]. Resident #18's quarterly MDS assessment dated [DATE] revealed she was up to date with her pneumococcal vaccine. The immunization section of Resident #18's medical record revealed documentation indicating Resident #18 had historically received a single dose of Pneumovax (Pneumovax, also known as Pneumococcal Polysaccharide Vaccine or PPSV23) on 6/1/2014. There was no documentation discovered in Resident #18's medical record to indicate she received any further pneumococcal vaccines. On 2/26/26 at 10:07 AM during an interview MDS Nurse #1 stated she coded Resident #18's MDS assessment dated [DATE] to indicate Resident #18's pneumococcal vaccine was up to date. She reported this was not correct. She went on to explain she had just</p> <p>(continued on next page)</p>		

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<p>F 0641</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>gone back to the Resident Assessment Instrument (RAI) manual and checked the most recent Centers for Disease Control and Prevention (CDC) guidelines and discovered a single historical dose of Pneumovax would not make Resident #18's pneumococcal vaccine up to date. MDS Nurse #1 reported she could not find a record indicating Resident #18 had received any other pneumococcal vaccines. She reported she must have looked at old CDC guidelines when she coded Resident #18's 11/15/25 MDS assessment. During an interview on 2/26/26 at 11:19 AM the Director of Nursing (DON) stated resident MDS assessments should be coded accurately. During an interview on 2/26/26 at 11:31 AM the Administrator stated resident MDS assessments should be coded accurately.</p>		

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<p>F 0760</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure that residents are free from significant medication errors.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and interviews with staff and the Nurse Practitioner (NP), the facility failed to ensure the resident's need for insulin (a hormone that regulates blood sugar levels) administration in accordance with the parameters provided by the physician before administering the insulin. This deficient practice affected 1 of 5 residents (Resident #8) reviewed for unnecessary medications. Findings included: Resident #8 was admitted to the facility on [DATE] with a diagnosis of diabetes mellitus type 2 (DM II). A current active physician's order for Resident #8 with a start date of 3/18/25 revealed Novolog injection solution (a type of fast acting insulin) 100 units per milliliter inject 10 units subcutaneously (SQ is beneath the skin) with meals and to hold (do not give) for blood sugar (BS) less than 150 (a normal adult BS before eating is between 70 to 99). A review of Resident #8's December 2025 Medication Administration Record (MAR) revealed documentation by Nurse #1 indicating that Resident #8's BS at 6:30 AM on 12/13/25 was 122 and she administered 10 units of Novolog insulin to Resident #8. Resident #8's BS at 11:30 AM on 12/13/25 was 236. On 12/15/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 122 and she administered 10 units SQ to Resident #8. Resident #8's BS at 11:30 AM on 12/15/25 was 205. On 12/27/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 122 and she administered 10 units SQ to Resident #8. Resident #8's BS at 11:30 AM on 12/27/25 was 134. On 12/29/25 at 6:30 AM Nurse #1 documented Resident #8's BS was 106 and she administered 10 units SQ to Resident #8. Resident #8's refused to have his BS checked at 11:30 AM on 12/29/25. On 2/25/26 at 9:25 AM in a telephone interview Nurse #1 stated she was familiar with Resident #8. She reported she did not recall Resident #8 having any parameters for the administration of his Novolog insulin. She stated normally, if a resident had BS parameters for the administration of insulin, it would show on the resident's electronic MAR on her computer screen. She went on to say her documentation on Resident #8's December 2025 MAR on 12/13/25, 12/15/25, 12/27/25 and 12/29/25 would indicate she administered 10 units of Novolog insulin SQ to Resident #8 at 6:30 AM each of those days. Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. He had no behaviors or rejection of care. He received injections, and insulin injections on 5 of the 7 look back period days of the assessment. On 2/26/26 at 10:58 AM an interview with the NP indicated she was familiar with Resident #8. She reported he frequently refused his BS checks and his insulin despite many conversations with him on the importance of these for managing his DM II. She stated because of this, his BS tended to run on the higher side. She went on to say as a result the instances of administration of 10 units of Novolog insulin to Resident #8 when his BS was less than 150 had not caused Resident #8 any harm. She reported there was always the possibility of harm to a resident, which included an unsafe drop in BS level, if insulin was administered to them outside of the parameters of the physician's order as this insulin would not be needed. She stated nurses should always follow the parameters for administering insulin. On 2/25/26 at 1:53 PM in an interview the Director of Nursing stated she would consider the administration of insulin to a resident outside the parameters of the physician's order to be a serious medication error. She reported that the potential harm to a resident receiving insulin that was not indicated by their blood sugar level would be an unsafe lowering of their blood sugar. On 2/25/26 at 3:14 PM an interview with the Administrator indicated nurses should be adhering to the parameters in the physician's order when administering insulin. He stated the facility did not have a corrective action plan in place for this.</p>		