STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 5/13/24 through 5/16/24. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #1RUB11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 5/13/24 through 5/16/24. Event ID# 1RUB11. The following intakes were investigated NC00207668, NC00208162, NC00216808, and NC00216829. 2 of the 14 complaint allegations resulted in deficiency.	F 000		
F 600 SS=D	Free from Abuse and Neglect CFR(s): 483.12(a)(1) §483.12 Freedom from Abuse, Neglect, and Exploitation The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(1) Not use verbal, mental, sexual, or physical abuse, corporal punishment, or involuntary seclusion; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, Resident interview, and Responsible Party (RP) interview, the facility failed to protect a	F 600	F600: Free from Abuse and Neglect CFR(s): 483.12(a)(1) 1.Resident #10 and resident #217, both	6/9/24

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

Electronically Signed | 06/05/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 600	Continued From page 1 resident's right to be free from neglect for 2 of 2 resident reviewed for neglect (Resident #10 and Resident #217). The findings included: This tag is cross-referenced to: F677: Based on observation, record review, staff interviews, Resident interview, and Responsible Party (RP) interview, the facility failed to provide incontinence care to residents that were incontinent and dependent on staff for activities of daily living (ADLs) for 2 of 5 residents reviewed (Resident #10 and Resident #217).	F 600	had incontinent care provided on 5/13/24. 2.All residents have the potential to be affected by the deficiency, however, with staff reeducation and new staff education upon hire, the facility will ensure the problem will not recur. 3.All licensed staff will be reeducated by the Director of Nursing or designee by 06/09/2024 on the facilities Policy on Abuse and Neglect and to ensure that all residents will receive proper incontinence care in a timely manner. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure timely and complete incontinence care is provided. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement committee monthly for three months for review, and if warranted, further review. Date of compliance = 06/09/2024	
F 623 SS=B	Notice Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) §483.15(c)(3) Notice before transfer. Before a facility transfers or discharges a resident, the facility must- (i) Notify the resident and the resident's representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.	F 623		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 2	F 623		

(ii) Record the reasons for the transfer or discharge in the resident's medical record in accordance with paragraph (c)(2) of this section; and
(iii) Include in the notice the items described in paragraph (c)(5) of this section.

§483.15(c)(4) Timing of the notice.
(i) Except as specified in paragraphs (c)(4)(ii) and (c)(8) of this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.
(ii) Notice must be made as soon as practicable before transfer or discharge when-
(A) The safety of individuals in the facility would be endangered under paragraph (c)(1)(i)(C) of this section;
(B) The health of individuals in the facility would be endangered, under paragraph (c)(1)(i)(D) of this section;
(C) The resident's health improves sufficiently to allow a more immediate transfer or discharge, under paragraph (c)(1)(i)(B) of this section;
(D) An immediate transfer or discharge is required by the resident's urgent medical needs, under paragraph (c)(1)(i)(A) of this section; or
(E) A resident has not resided in the facility for 30 days.

§483.15(c)(5) Contents of the notice. The written notice specified in paragraph (c)(3) of this section must include the following:
(i) The reason for transfer or discharge;
(ii) The effective date of transfer or discharge;
(iii) The location to which the resident is transferred or discharged;
(iv) A statement of the resident's appeal rights,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 3	F 623		

including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request;
(v) The name, address (mailing and email) and telephone number of the Office of the State Long-Term Care Ombudsman;
(vi) For nursing facility residents with intellectual and developmental disabilities or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with developmental disabilities established under Part C of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (Pub. L. 106-402, codified at 42 U.S.C. 15001 et seq.); and
(vii) For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

§483.15(c)(6) Changes to the notice.
If the information in the notice changes prior to effecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

§483.15(c)(8) Notice in advance of facility closure
In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the State Survey Agency, the Office of the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 4 State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents, as required at § 483.70(l). This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide written notice of discharge or transfer to the Responsible Party (RP) for 1 of 3 residents reviewed for hospitalization (Resident #1). The findings included: Resident #1 was admitted to the facility on 11/24/2023. The Quarterly Minimum Data Set (MDS) dated 4/5/2024 revealed Resident #1 was cognitively intact. The change in condition assessment dated 4/13/2024 revealed Resident #1 was sent to the hospital due to chest pain. Record review of the nursing progress notes revealed there was no documentation that the Responsible Party (RP) received written notice of discharge or transfer when the resident was sent to the hospital. Review of the progress notes revealed Resident #1 returned to the facility on 4/15/2024. In an interview with the RP on 5/16/2024 at 1:06 p.m. he revealed he did not receive a written notice of discharge or transfer for Resident #1 for the hospitalization that occurred on 4/13/2024.	F 623	F623 Notice of Requirements Before Transfer/Discharge CFR(s): 483.15(c)(3)-(6)(8) 1.No written notification of transfer to the hospital for resident #1 was made to the RP (responsible party) on 4/13/24. 2.All residents have the potential to be affected by the deficiency, however, the facility has changed its practice to include providing written notification when a resident is transferred / discharged which will ensure the deficient practice does not recur. An audit was completed by the Social Worker on 06/04/2024 to ensure all previous transfers / discharges to the hospital within the past 3 months had been completed. 3.The Administrator will educate the Director of Nursing, Social Worker and Business Office Manager as of 06/07/2024 on the requirements for providing written notification to the responsible party (RP) on all resident transfers / discharges. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4.The Administrator or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure written notification to the responsible party (RP) on all resident transfers / discharges had been	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 623	Continued From page 5 During an interview with the Social Worker (SW) on 5/16/2024 at 9:44 a.m. she revealed she could not remember if the written notice of discharge or transfer was sent to the RP. She revealed she would usually provide the notice of discharge or transfer to the resident during a discharge or transfer. During an interview with the Administrator on 5/15/2024 at 9:32 a.m. he revealed it was the responsibility of the SW to send a written notice of discharge or transfer to the RP when there is a discharge or transfer.	F 623	completed. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of compliance = 06/09/2024	
F 657 SS=B	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs	F 657		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 6 or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to update the care plan in the area of contracture management for 1 of 1 resident reviewed for limited range of motion (Resident #39). The findings included: Resident # 39 was admitted to the facility on 5/21/21 with diagnoses which included stroke with hemiplegia (paralysis) of the right side. Review of the care plan last revised on 3/05/24 revealed Resident #39 had an activities of daily living (ADLs) self-care deficit related to hemiplegia with interventions which included physical and occupational therapy evaluation and treatment. The Minimum Data Set (MDS) annual assessment dated 3/20/24 revealed Resident #39 had severe cognitive impairment and had functional limitations of range of motion of the upper and lower extremities. A physician order dated 4/01/24 revealed occupational therapy splinting hand roll to right hand. A physician order dated 4/01/24 indicated to remove splint (hand roll) right hand at 2:00 pm. Skin checks around area of splint after removal	F 657	F657: Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) 1.Care plan for resident #39 was updated for area of contracture management as of 05/16/2024. 2.All residents have the potential to be affected by the deficiency, however, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. 3.The Administrator will reeducate the Minimum Data Set Nurse regarding completeness of the Minimum Data Set care plans by 06/05/2024. 4.Weekly, the Director of Therapy will provide Minimum Data Set nurse and Director of Nursing with list of current orthotics/contracture management devices in use throughout facility. List will be reviewed by Minimum Data Set nurse, Director of Nursing and or Unit manager during clinical meeting to ensure care plan is updated with devices weekly for 4 weeks, then monthly for 2 months. 5.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure care plans are updated correctly. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement committee	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 7 one time a day for contracture management. A physician order dated 4/02/24 stated to apply splint (hand roll) to right hand at 10:00 am. Skin checks around area of splint prior to application one time a day for contracture management. Resident #39's care plan did not reflect the use of hand splint for contracture management. Observations on 5/14/24 at 1:44 pm and 5/15/24 at 2:14 pm revealed Resident #39 was observed with a hand roll in the right hand. An interview was conducted on 5/15/24 at 12:16 pm with Nurse Aide (NA) #2 who revealed Resident #39 used the hand roll in the right hand and it was placed in her hand after morning care was completed. A telephone interview was conducted with the MDS Nurse on 5/16/24 at 11:47 am who reported she received an email (unsure of the date) from the Therapy Manager with a list of residents that used splints to develop a care plan, but she stated she may not have gotten to Resident #39's yet. The MDS Nurse confirmed Resident #39 was listed on the email from the Therapy Manager regarding the right-hand splint for contracture management, but she just had not gotten the care plan done yet. An interview was conducted with the Therapy Manager on 5/16/24 at 12:35 pm who revealed he sent the MDS Nurse information regarding Resident #39's right-hand splint when the order was placed so a care plan could be developed. An interview was conducted on 5/16/24 at 9:46	F 657	monthly for three months for review, and if warranted, further review. Date of compliance = 06/09/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 657	Continued From page 8 am with the Director of Nursing (DON) who reported the MDS Nurse was responsible to develop Resident #39's care plan for the right-hand splint. During an interview on 5/16/24 at 1:49 pm the Administrator revealed the MDS Nurse was responsible for development of the care plan for Resident #39's contracture management.	F 657		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observation, record review, staff interviews, Resident interview, and Responsible Party (RP) interview, the facility failed to provide incontinence care to residents that were incontinent and dependent on staff for activities of daily living (ADLs) for 2 of 5 residents reviewed (Resident #10 and Resident #217). The findings included: 1. Resident #10 was admitted to the facility on 8/11/11 with diagnoses which included multiple sclerosis (MS-a chronic disease of the nervous system), and stroke with right sided hemiplegia (paralysis). The Minimum Data Set (MDS) quarterly assessment dated 4/26/24 revealed Resident #10 was cognitively intact, was coded with limited range of motion function of the upper and lower	F 677	F677 ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) 1.Resident #10 and resident #217, both had incontinent care provided on 5/13/24. 2.All residents have the potential to be affected by the deficiency, however, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. 3.All license staff will be reeducated by the Director of Nursing or designee by 06/09/2024 to ensure that all residents will receive proper incontinence care in a timely manner. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure timely and complete incontinence	6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 9	F 677		

extremities, and the skin was intact. Resident #10 was coded as always incontinent of bowel and bladder and was dependent on staff for activities of daily living (ADLs).

Review of the care plan last revised on 4/29/24 revealed Resident #10 had an ADL self -care performance deficit related to MS and stroke with interventions that included the resident was dependent upon staff for bathing, bed mobility, dressing, and personal hygiene. A care plan was in place for bowel and bladder incontinence related to MS and stroke with interventions which included checking frequently and as required for incontinence, and to change frequently.

An interview was conducted on 5/13/24 at 12:17 pm with Resident #10 who reported she had asked Nure Aide (NA) #3 to change her brief and clothing at 8:30 am and the care had not yet been provided.

Observations and interviews conducted with Resident #10 on 5/13/24 at 1:15 pm, 1:45 pm, and 2:00 pm revealed Resident #10 was still in the same shirt, and she reported she had not been provided personal care or incontinence care as requested in the morning.

An interview was conducted with NA #3 on 5/13/24 at 2:07 pm who revealed she was prepared to provide incontinence care for Resident #10 at this time. NA #3 stated she left Resident #10 until this time because she was not a "heavy wetter", and she knew Resident #10 could wait until the end of the shift. She stated she did introduce herself in the morning, but she did not provide any care at that time, and she was unable to remember if Resident #10 reported she

care is provided. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review.
Date of compliance = 06/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 10	F 677		

needed care. NA #3 reported she assisted Resident #10 with the lunch meal but had not provided any other care during her shift. She stated she was assigned to provide care to ten residents on her shift and she was able to get her work done by the end of the shift. NA #3 stated she worked slow and had not had time to provide care to Resident #10 until the end of the shift but stated Resident #10 would be okay to wait until the end of the shift.

An observation of Resident #10's incontinence and personal care was conducted on 5/13/24 at 2:10 pm with NA #3. Resident #10's yellow incontinence brief was noted to be saturated and dark in color from the groin to midway up the brief toward the waistline in the front. Resident #10 was turned on her right side by NA #3 and the bottom of the yellow incontinence brief was noted to be dark in color and saturated from groin area up to mid buttock area.

An interview was conducted on 5/16/24 at 11:23 am with the Director of Nursing (DON) who revealed Resident #10 should have had the incontinence care and personal care provided when she asked NA #3 in the morning. The DON stated incontinence care should be provided every two hours and as needed throughout a shift. The DON reported NA #3 had not reported she did not have time to complete Resident #10's care or that she was unable to manage her assignment.

During an interview on 5/16/24 at 1:49 pm the Administrator revealed the DON was responsible to ensure that Resident #10's care was provided.
2. Resident #217 was admitted to the facility on 5/6/2024 with diagnoses which included

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 11	F 677		

encephalopathy, and pneumonitis.

Review of the baseline care plan initiated on 5/8/2024 revealed Resident #217 had an ADL self -care performance deficit related to limited range of motion of lower extremities. The care plan revealed Resident #217 required extensive assistance to total care by staff.

The Minimum Data Set (MDS) admission assessment dated 5/12/2024 revealed Resident #217 was cognitively impaired. He was coded with limited range of motion function of the lower extremities. Resident #217 was coded as always incontinent of bowel and bladder and was dependent on staff for ADLs.

During an interview with Resident #217's Representative on 5/13/2024 at 11:56 a.m. she stated she found Resident #217 in bed in a urine soaked brief and blanket when she visited on 5/8/2024 at about 1:27 p.m.

In an interview with Nurse #4 on 5/14/2024 3:39 p.m. she revealed she was approached by Resident #217's Representative to provide incontinence care for Resident #217 about 1:30 p.m. on 5/8/2024. She further revealed Resident #217 had last been changed during the morning nursing rounds but was not sure of the time. Nurse #4 stated incontinence care should be provided every two hours and as needed throughout a shift.

An interview with Nurse Aide (NA) #4 on 5/14/2024 at 3:16 p.m. revealed on 5/8/2024 she worked on both 100 and 400 halls when she was called by Nurse #4 at 1:30 p.m. to change Resident #217. NA #4 revealed she had 20

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 677	Continued From page 12 residents assigned to her which delayed incontinent care for Resident #217. NA #4 revealed she found Resident #217's brief and linen saturated in urine when she provided incontinence care to him. She further revealed the facility was short-staffed at that time. A review of the daily nurse staff assignment sheet dated 5/8/2024 revealed NA #4 was assigned a total of 14 residents on halls 100 and 400. During an interview with NA #5 on 5/15/24 8:34 a.m. she revealed she was pulled from her assignment on hall 300 on 5/8/2024 at 1:33 p.m. by Nurse #4 to help provide incontinence care for Resident #217. She further revealed Resident #217's brief, bed pad and the bed linen were soaked in urine. During an interview on 5/15/2024 at 11:01 a.m. the Administrator revealed he observed Resident #217 receiving incontinence care before 8:30 a.m. on 5/8/2024. He further revealed Nurse #4 was responsible for ensuring that Resident #217's care was provided.	F 677		
F 685 SS=D	Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) §483.25(a) Vision and hearing To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident- §483.25(a)(1) In making appointments, and §483.25(a)(2) By arranging for transportation to and from the office of a practitioner specializing in	F 685		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 13 the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Resident interview, and staff interviews, the facility failed to ensure that a resident with reported hearing difficulties was evaluated for 1 of 1 resident reviewed for vision and hearing (Resident #24). The findings included: Resident #24 was admitted to the facility on 2/16/16 with diagnoses which included stroke. Review of Resident #24's care plan last reviewed on 4/24/24 revealed no care plan related to hearing difficulty. Review of the Minimum Data Set (MDS) quarterly assessment dated 4/24/24 revealed Resident #24 was cognitively intact and was coded for adequate hearing without the use of a hearing aid. Review of the nursing progress notes revealed no documentation regarding Resident #24's reported hearing difficulties. Review of the active physician orders revealed no orders for an evaluation of Resident #24's reported hearing difficulty. An interview and observation were conducted on 5/13/24 at 2:05 pm with Resident #24. This surveyor had to move close and speak loudly within one to two inches of the right ear for Resident #24 to hear questions. Resident #24 reported to staff that she had a hearing problem	F 685	F685 Treatment/Devices to Maintain Hearing/Vision CFR(s): 483.25(a)(1)(2) 1.Resident #24 currently resides in the facility. The Nurse Practitioner evaluated the need for services on 05/16/2024, a specialist was consulted, and appointment scheduled. 2.All residents have the potential to be affected by the deficiency, however, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. An audit was performed by DON or designee on 06/03/2024 to ensure no other residents were in need of special services to maintain hearing/vision. No other residents were affected. 3.All licensed nurses will be reeducated by the Director of Nursing or designee by 06/09/2024 to ensure that all residents with special needs receive services. Additionally, all newly hired staff will be educated on these policies and practices during orientation. Also, any staff who were not working and did not receive initial education will be reeducated prior to the start of their shift. 4.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure residents with hearing difficulties have follow-up with a provider. Results of these audits will be presented to the facility and Quality Assurance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 14	F 685		

and she needed people to get close and talk loudly so she could hear, but she stated no one had checked to see if she needed a hearing aid.

An interview was conducted on 5/15/24 at 12:16 pm with Nurse Aide (NA) #2 who revealed she often provided care to Resident #24, and she stated in order to communicate with Resident #24 she needed to get close to her ear or she could read her lips. She stated Resident #24 would put her hand up to her ear and tell you she could not hear and that you needed to be closer, but she did not think that meant she was hard of hearing. NA#2 stated she just thought that was normal that she needed to speak a little louder and get close to communicate with Resident #24.

An interview was conducted on 5/16/24 at 9:20 am with the Unit Manager who revealed Resident #24 did not report she had hearing difficulty, but the Unit Manager stated she did need to get close to Resident #24 when she spoke.

A telephone interview was conducted with the Nurse Practitioner (NP) on 5/16/24 at 12:49 pm who revealed she was not aware of Resident #24's reported hearing difficulties until she was notified by the Director of Nursing (DON) today while at the facility. The NP stated she saw Resident #24 today and an otolaryngologist (ear, nose, and throat) consultation was ordered.

During an interview on 5/15/24 at 12:03 pm with the DON she revealed that she was unable to locate any further documentation regarding audiology consultations for Resident #24. She stated Resident #24 would always say to come closer because she could not hear but she stated she never put it together to have her seen by the

Performance Improvement Committee monthly for three months for review, and if warranted, further review.

Date of compliance = 06/09/2024

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 685	Continued From page 15 audiologist. The DON stated Resident #24 would tell you to come closer when talking so she could hear us, but she did not ask for a hearing aid. An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed he was able to communicate with Resident #24 without difficulty and he was not aware of the reported hearing difficulties, but it will be addressed.	F 685		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observation, record review, Resident interview, and staff interviews, the facility failed to obtain a physician order for a continuous positive airway pressure (CPAP) machine for 1 of 1 resident reviewed for respiratory care (Resident #7). The findings include: Review of Resident #7's hospital discharge oxygen therapy order requisition dated 11/15/21 revealed an order for non-invasive ventilation CPAP. Resident #7 was admitted to the facility on	F 695	F695 Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) 1. Resident #7 currently resides at the facility. A new physician order for the CPAP was completed 5/20/24. 2. All residents have the potential to be affected by the deficiency that utilize a CPAP machine, however, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. An audit was completed by the Minimum Data Set Nurse on 06/03/2024 to ensure all residents that utilize a CPAP have a physician order.	6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 16 11/16/21 with diagnoses which included obstructive sleep apnea (when the throat muscles relax and block the airway during sleep causing your breathing to be interrupted). Review of Resident #7's care plan last reviewed on 3/7/24 revealed no care plan for the CPAP machine. The Minimum Data Set (MDS) quarterly assessment dated 4/18/24 revealed Resident #7 was cognitively intact and was not coded for CPAP use. A record review conducted on 5/13/25 of Resident #7's active physician orders revealed there was no order for his CPAP. An interview and observation were conducted on 5/13/24 at 11:15 am with Resident #7 who had a CPAP machine on his bedside table. Resident #7 stated his CPAP machine was used every night, but he stated he thinks he needs a new one because it was blowing a lot of air. A telephone interview was conducted on 5/16/24 at 8:16 am with Nurse #3 who revealed she often provided care for Resident #7 during the 7:00 pm-7:00 am shift. Nurse #3 stated Resident #7 used the CPAP machine every night and that he was able to put on the mask independently and he would ask her to turn it on. Nurse #3 stated she could not recall if there was a physician order for the CPAP, but she stated she thought the order was there. During an interview on 5/16/24 at 9:17 am with the Unit Manager she revealed she was aware Resident #7 had a CPAP machine and that he	F 695	3. All license staff will be reeducated by the Director of Nursing or designee by 06/09/2024 to ensure that all residents with a CPAP have a physician order. Additionally, all newly hired staff will be educated on these policies and practices during orientation. Also, any staff who were not working and did not receive initial education will be reeducated prior to the start of their shift. 4. The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure residents utilizing a CPAP have a physician order. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of compliance = 06/09/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 695	Continued From page 17 used it at night. She stated the CPAP machine required a physician order which would at least include when to put it on and when to take it off. The Unit Manager stated physician orders were reviewed during the morning clinical meeting, but she was unable to state why Resident #7 did not have a physician order for his CPAP machine. A telephone interview was conducted with the Nurse Practitioner (NP) on 5/16/24 at 12:45 pm who revealed she was aware Resident #7 used a CPAP machine at night. She stated he did report to her today that he needed to have his CPAP checked so she wrote an order for a new CPAP machine and equipment for Resident #7. The NP stated Resident #7's CPAP machine should have had a physician order. An interview was conducted on 5/16/24 at 9:46 am with the Director of Nursing (DON) who revealed Resident #7 had used his CPAP for a long time and she thought the order was there. The DON stated the physician order for Resident #7's CPAP may have fallen off during a monthly physician order recapitulation (summary) and was missed during the review by nursing. The DON stated a physician order was required for Resident #7's CPAP but she was unable to state how it was missed. An interview was conducted with the Administrator on 5/16/24 at 1:49 pm who revealed the DON was responsible to ensure Resident #7 had a physician order for his CPAP machine.	F 695		
F 727 SS=E	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3)	F 727		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 18 §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to have a Registered Nurse (RN) on duty at least 8 hours a day with a facility census of greater than 60 residents for 6 of 91 days reviewed (6/11/2023, 6/18/2023, 6/22/2023, 6/25/2023, 6/28/2023, and 6/29/2023). The findings included: A record review of the schedules for June 2023, revealed there was no RN who worked at least 8 hours on 6/11/2023, 6/18/2023, 6/22/2023, 6/25/2023, 6/28/2023, and 6/29/2023. The daily nurse staff postings revealed the census was 67 on 6/11/2023, 70 on 6/18/2023, 70 on 6/22/2023, 68 on 6/25/2023, 68 on 6/28/2023, and 69 on 6/29/2023. During an interview with the Director of Nursing (DON) on 5/16/2024 at 9:25 a.m. she revealed she was the scheduler at the facility. She revealed she had scheduled an RN for 6/11/2023,	F 727	F727 RN 8 Hrs/7 days/wk, Full Time DON CFR(s): 483.35(b)(1)-(3) 1.No RN on duty at least 8 hours a day on 6/11/23, 6/18/23, 6/22/23, 6/25/23, 6/28/23 & 6/29/23. 2.Audit was completed by the Director of Nursing by 06/05/2024 to ensure RN coverage at least 8 consecutive hours per day, also, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. 3.Director of Nursing educated staff/staffing coordinator by 06/05/2024 to provide 8 hours of consecutive RN coverage each day. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure residents with hearing difficulties have follow-up with a provider. Results of	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 727	Continued From page 19 6/18/2023, 6/22/2023, 6/25/2023, 6/28/2023, and 6/29/2023 but the RN called out and she was not able to find coverage. An interview was conducted with the Administrator on 5/16/2024 at 10:22 a.m. He revealed there should be an RN scheduled with a census of more than 60 residents.	F 727	these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of compliance = 06/09/2024	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or	F 732		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 20 written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to post nurse staffing information in a location that was readily accessible to residents and visitors on 4 of 4 days during the survey (5/13/2024, 5/14/2024, 5/15/2024, and 5/16/2024). The findings included: During an initial observation on 5/13/2024 at 10:16 a.m., the Daily Nursing Staff posting could not be located at the lobby and all nursing halls. A further observation on 5/13/2024 at 1:17 p.m., and on 5/13/2024 at 3:17 p.m. revealed the daily nursing staff posting could not be located either in the nursing halls or the lobby. During an observation on 5/14/2024 at 11:42 a.m., the daily nursing staff posting could not be located either in the nursing halls or the lobby. An observation on 5/15/2024 at 9:40 a.m. revealed the daily nurse staff posting was hung on the wall past the nursing station on hall 200 by the Rehab Service entrance which was accessible for staff and residents on hall 200 only. The daily nurse staffing sheet was a white, landscaped 8x10-inch piece of paper inside a	F 732	F732 Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) 1. The facility permanently relocated the placement of the nurse staffing information signage to the front lobby on 06/03/2024. 2. All residents have the potential to be affected by the deficiency, however, the facility permanently relocated the placement of the nurse staffing information signage to the front lobby on 06/03/2024. Also, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. 3. All staff will be reeducated by the Administrator to ensure they understand that the facility permanently relocated the placement of the nurse staffing information signage to the front lobby on 06/03/2024. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Administrator will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure the placement of the nurse staffing information signage to the front lobby	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 732	Continued From page 21 folder strapped to the wall. The daily nurse staff posting was not visible or accessible for all residents or visitors to view. Additional observations on 5/16/2024 at 10:15 a.m. and on 5/16/2024 at 12:35 p.m. of the facility's daily nurse staff posting revealed it was hung on the wall past the nursing station on hall 200 by the Rehab Service entrance which was accessible for staff and residents on hall 200 only. The daily nurse staffing sheet was a white, landscaped 8x10-inch piece of paper inside a folder strapped to the wall. The daily nurse staff posting was not visible or accessible for all residents or visitors to view. In an interview with the Director of Nursing (DON) on 5/15/2024 at 9:40 a.m. she revealed she is the scheduler and thought the daily nursing staff posting was in the right location. She stated it should have been posted in a more visible place. She revealed she will move the daily nursing staff posting to an area where all residents and visitors can access it. An interview with the Administrator on 5/16/2024 at 1:20 p.m. revealed the facility's daily staff posting was to be placed in an area that was visible for all residents and visitors to view. He revealed he was aware it was placed in Hall 200 past the nursing station.	F 732	remains permanent. Results of these audits will be presented to the Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of Compliance: 06/09/2024	
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the	F 761		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 22 appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to remove expired medication, date open medications, and failed to refrigerate medication according to the manufacturer's recommendations for 1 of 2 medications cart reviewed (Hall 300). The findings included: During an observation of the Hall 300 medication cart with the Director of Nursing (DON) and Nurse #1 on 5/15/24 at 1:44 pm the following was observed. The DON and Nurse #1 confirmed all findings before the removal of the items. One glargine insulin injector pen with an	F 761	F761 Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) 1.Expired medication, missing dates on medication and failed to refrigerate medication according to manufacturer's recommendations. 2.Audit completed of all medication carts and expired medication removed from carts on 5/15/24. All residents have the potential to be affected by the deficiency, however, with staff reeducation and new staff education upon hire, including change in procedures, the facility will ensure the problem will not recur. 3.Director of Nursing or designee to educate staff by 06/09/2024 regarding	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 23 expiration date of 5/13/24 written on the label. One glargine insulin injector pen open, with no open date noted and approximately 60 units of the 100 units of insulin remaining. The manufacturer's recommendations for insulin glargine (a long-acting insulin) recommended should be discarded 28 days after first use. One glargine insulin injector pen unopened with 100 units of the 100 units of insulin remaining. The sticker on the bag which held the unopened glargine insulin injector pen noted, "keep in refrigerator". The manufacturer's recommendations for insulin glargine recommended that unopened insulin be stored in the refrigerator at approximately 36 to 46 degrees Fahrenheit. One vial of haloperidol (an antipsychotic medication) 5 milligram/milliliter per injection open, with no open date noted on the vial. One tube of nystatin antifungal cream open, with no open date noted on the on the tube. One tube of ketoconazole antifungal cream open, with no open date noted on the tube. An interview was conducted with Nurse #1 on 5/15/24 at 1:46 pm who revealed she was agency staff, that was her first day back at the facility and she would clean the cart after her medication pass was completed. A telephone interview was conducted on 5/16/24 at 8:35 am with Nurse #4, who was assigned to Hall 300 medication cart during the overnight shift prior to the observation, revealed she did not go	F 761	cleanliness and medication storage. 4.The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure cleanliness of medication carts and all expired medications are removed from the medication carts. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of Compliance: 06/09/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 761	Continued From page 24 through the medication cart to look for expired or undated items. Nurse #4 stated she would remove items from the medication cart if she saw they were expired when she passed medications, but she was not aware she was supposed to go through the entire cart. An interview was conducted with the Unit Manager who reported she tried to go through the medication carts weekly to look for expired and undated medications and she stated she would remove any identified items from the medication carts. The Unit Manager stated she believed the Hall 300 medication cart was last checked about a week ago. During an interview on 5/15/24 at 1:47 pm the DON stated the medication carts were to be checked for expired and undated medications every night by the nurse assigned to the medication cart during the overnight shift. She stated the Unit Manager and the pharmacy consultant completed monthly audits of the medication carts and she had not received information about issues with the medication carts.	F 761		
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:	F 867		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 25 §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators. §483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation. §483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events. §483.75(d) Program systematic analysis and systemic action. §483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 26	F 867		

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e).

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 27 Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section. §483.75(g) Quality assessment and assurance. §483.75(g)(2) The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews, resident interviews, Responsible Party (RP) interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions the committee put into place following the 2/24/22 focused infection control and complaint survey, and the 10/26/21 and 1/31/23 recertification and complaint survey. This was for 7 recited deficiencies on the current complaint and recertification survey of 5/16/24 in the areas of Care Plan Timing and Revision (F657), Activities of Daily Living Care Provided for Dependent Residents (F677), Respiratory/Tracheostomy Care and Suctioning	F 867	F867 QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) 1. The facility has established written policies and procedures for feedback, data collection and monitoring adverse events. However, the facilities Quality Assurance and Performance Improvement Committee failed to correct adverse events related to 7 recited deficiencies. The facility completed an Ad hoc Quality Assurance and Performance Improvement Committee meeting on 06/05/2024 to correct the deficiencies and ensure repeat deficiencies do not occur by 06/09/2024.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 28 (F695), Registered Nurse (RN) 8 hours/7 Days a Week, Full Time DON (F727), Posted Nurse Staffing Information (F732), Label and Store Drugs and Biologicals (F761), and Infection Prevention and Control (F880). The continued failure during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross-referenced to: F657: Based on observations, record review, and staff interviews, the facility failed to update the care plan in the area of contracture management for 1 of 1resident reviewed for limited range of motion (Resident #39). During the recertification and complaint investigation survey of 1/31/23, the facility failed to update a resident's individualized care plan related to discharge and failed to hold a quarterly care plan meeting for residents reviewed for care plans. An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of correction for the deficient practice. The Administrator stated the nursing department was responsible for the initial care plan, but the MDS Nurse was responsible for updating the care plan when the splint was ordered. F677: Based on observation, record review, staff interviews, Resident interview, and Responsible Party (RP) interview, the facility failed to provide	F 867	2. All residents have the potential to be affected by the deficiency, however, the facility will correct all deficiencies as outlined in the Plan of Correction and have an Ad hoc Quality Assurance and Performance Improvement Committee meeting to correct the deficiencies and ensure repeat deficiencies do not recur. 3. All Quality Assurance and Performance Improvement Committee members will be reeducated by the Administrator on 06/05/2024 to ensure they understand the purpose of the Quality Assurance and Performance Improvement Committee at the facility. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Administrator will complete an Ad hoc Quality Assurance and Performance Improvement Committee meeting on 06/05/2024 to ensure compliance. Then, the facility will have at least quarterly Quality Assurance and Performance Improvement Committee meeting to remain in compliance. Results of the Quality Assurance and Performance Improvement Committee will be reviewed, and if warranted, further review. The Administrator or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure the Quality Assurance and Performance Improvement Committee has met timely as outlined. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 29	F 867	Date of Compliance: 06/09/2024	

incontinence care to residents that were incontinent and dependent on staff for activities of daily living (ADLs) for 2 of 5 residents reviewed (Resident #10 and Resident #217).

During the focused infection control and complaint survey of 2/24/22, the facility failed to provide incontinence care for residents reviewed for Activities of Daily Living (ADL).

During the recertification and complaint investigation survey of 1/31/23, the facility failed to provide nail care to residents who needed extensive assistance and/or were dependent for Activities of Daily Living (ADL) care.

An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of corrections for the deficient practices. The Administrator stated the Director of Nursing was ultimately responsible for ensuring care was provided, but he stated the facility needed a more robust plan of education and thorough monitoring to ensure the deficient practice did not occur again.

F695: Based on observation, record review, Resident interview, and staff interviews, the facility failed to obtain a physician order for a continuous positive airway pressure (CPAP) machine for 1 of 1 resident reviewed for respiratory care (Resident #7).

During the recertification and complaint investigation survey of 1/31/23, the facility failed to ensure emergency equipment was present at the bedside for residents with tracheostomies.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 30 An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of correction for the deficient practice. The Administrator stated he expected that the deficient practice remained resolved, however it was clear the facility needed a more solid plan to ensure compliance. F727: Based on record review and staff interviews, the facility failed to have a Registered Nurse (RN) on duty at least 8 hours a day with a facility census of greater than 60 residents for 6 of 91 days reviewed (6/11/2023, 6/18/2023, 6/22/2023, 6/25/2023, 6/28/2023, and 6/29/2023). During the recertification and complaint investigation survey of 1/31/23, the facility failed to schedule a Registered Nurse (RN) for at least 8 consecutive hours a day for 53 days of 135 days reviewed for staffing. An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of correction for the deficient practice. The Administrator stated the Director of Nursing (DON) was currently the acting staffing coordinator, but he stated the previous staffing coordinator should have informed her of the need for RN coverage. F732: Based on observations and staff interviews the facility failed to post nurse staffing information in a location that was readily accessible to residents and visitors on 4 of 4 days	F 867		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 31	F 867		

during the survey (5/13/2024, 5/14/2024, 5/15/2024, and 5/16/2024).

During the recertification and complaint investigation survey of 1/31/23, the facility failed to post accurate nurse staffing information for Registered Nurses (RN) for 23 of 43 days reviewed and observed for posted staffing.

An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the prior deficient practice was resolved by the previous administrative team and the posted nursing staffing location was an area he identified but he did not follow up with the location of the nurse staff posting.

F761: Based on observations and staff interviews the facility failed to remove expired medications, date open medications, and failed to refrigerate medications according to the manufacturer's recommendations for 1 of 2 medications cart reviewed (Hall 300).

During the recertification and complaint investigation survey of 1/31/23, the facility failed to discard expired medication, date opened insulin and store medication per manufacturers recommendation.

An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of correction for the deficient practice. The Administrator stated the DON was responsible for ensuring the carts were checked, but he stated he was not aware of any concerns prior to the current survey.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 867	Continued From page 32 F880: Based on observations, record review, and staff interviews, the facility failed to implement infection prevention program policies and procedures when Nurse Aide (NA) #3 failed to perform hand hygiene after performing incontinence care for 1 of 1 resident observed for incontinence care (Resident #10), and NA #1 failed to perform hand hygiene between resident rooms when passing meal trays (Room #308 and Room #311) for 1 of 1 NA observed during meal tray delivery. During the recertification and complaint investigation survey of 10/26/21, the facility failed to use an approved procedure to clean and disinfect a shared glucometer used for residents reviewed for fingerstick blood glucose tests. The facility also failed to ensure staff performed hand hygiene when passing trays to resident rooms. During the recertification and complaint investigation survey of 1/31/23, the facility failed to maintain a sterile field while performing tracheostomy care. An interview was conducted on 5/16/24 at 1:49 pm with the Administrator who revealed the previous administrative team completed the education and auditing and resolved the plan of correction for the deficient practice and the facility had not identified any concern prior to the current survey.	F 867		
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an	F 880		6/9/24

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 33	F 880		

infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 34 (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to implement infection prevention program policies and procedures when Nurse Aide (NA) #3 failed to perform hand hygiene after performing incontinence care for 1 of 1 resident observed for incontinence care (Resident #10), and NA #1 failed to perform hand hygiene between resident rooms when passing meal trays (Room #308 and Room #311) for 1 of 1 NA observed during meal tray delivery. The findings included:	F 880	F880 Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) 1.Staff members had failed to perform hand hygiene after performing incontinent care and while passing trays during mealtime. 2.All residents have the potential to be affected by the deficiency, however, with the reeducation of staff and change in facility practice, the facility will ensure the deficient practice does not recur. 3.All license staff will be reeducated by the Director of Nursing or designee by 06/09/2024 to ensure that all Infection	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 35 The facility policy titled "Infection Prevention Program" last revised in 2009 revealed the Infection Prevention Program was a comprehensive program that addresses detection, prevention, and control of infections among residents and personnel. The facility policy titled "Handwashing/Hand Hygiene" last revised in August 2019 revealed that hand hygiene was the primary means to prevent the spread of infections and that all staff shall follow the handwashing/hand hygiene procedures to help prevent the spread of infections to other personnel, residents, and visitors. The policy further stated that hand hygiene was to be performed before and after assisting a resident with meals, and before moving from a contaminated body site to a clean body site during resident care. 1. An observation on 5/13/24 at 2:10 pm revealed NA #3 prepared to provide incontinence care to Resident #10. NA #3 donned her gloves and prepared a water basin and wash cloths and proceeded to clean Resident #10 on the front side and then turned the resident on her left side and cleaned her back side and in between her buttocks. NA #3 then placed a clean brief and a clean shirt on Resident #10 without removing her gloves and performing hand hygiene. NA #3 removed her gloves and performed hand hygiene before exiting the room with the trash and linen bags in her hand. An interview was conducted with NA #3 on 5/13/24 at 2:25 pm who reported she did not realize she did not change her gloves after cleaning Resident #10. She stated she normally would put on several pairs of gloves and after	F 880	control practices are maintained throughout the facility. Additionally, all newly hired staff will be educated on these policies and practices during orientation. 4. The Director of Nursing or designee will complete random audits weekly for 4 weeks and then monthly for 2 months to ensure that all Infection control practices are maintained throughout the facility. Results of these audits will be presented to the facility and Quality Assurance and Performance Improvement Committee monthly for three months for review, and if warranted, further review. Date of Compliance: 06/09/2024	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 36	F 880		

cleaning a resident she would remove the dirty gloves and then use the clean gloves that were under the ones she just took off to put on the clothes. NA #3 stated she should have washed up and changed her gloves before she put the new brief and clothes on Resident #10.

During an interview on 5/16/24 at 11:23 am with the Infection Preventionist (IP) she revealed NA #3 should have removed the soiled gloves and performed hand hygiene after Resident #10's incontinence care was completed. The IP stated NA #3 should have performed hand hygiene and put on clean gloves before she put the clean brief and clothing on Resident #10.

2. During a continuous observation on 5/15/24 from 8:13 am through 8:24 am on Hall 300, Nurse Aide (NA) #1 was observed to remove a meal tray from the meal cart and enter Room #308. She placed the breakfast tray on the overbed table next to the bed and exited the room without performing hand hygiene. A hand sanitizer dispenser was located on the wall to the left of the door frame of Room #308 upon exiting the room and a bathroom was located in the room. NA #1 was observed to walk to the linen cart, which was down the hall from Room #308, lift the linen cart cover and obtain a clothing protector and re-enter Room #308. NA #1 was not observed to perform hand hygiene by use of the hand sanitizer dispenser on the wall prior to entering Room #308 with the clothing protector. She was then observed to place the clothing protector on the Resident, reposition the Resident in bed, she touched, and operated the bed control device to raise the head of the bed, and moved the overbed table close to the Resident. NA #1, without performing hand hygiene with soap and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	1300 DON JUAN ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 880	Continued From page 37	F 880		

water in the bathroom or hand sanitizer located on the wall outside of the room, was then observed to pick up a slice of toast from the meal tray with her bare hands and proceeded to spread butter on the toast and then placed the toast on the meal tray for the Resident to eat. NA #1 then exited the room; she was not observed to have performed hand hygiene with soap and water in the bathroom or use the hand sanitizer dispenser on the wall outside of Room #308 and retrieved a meal tray from the meal cart and entered Room #311. She was observed to place the meal tray on the overbed table for the Resident in Room #311and exited the room without performing hand hygiene with soap and water in the bathroom or by the hand sanitizer dispenser which was located on the right side of the door frame on the wall outside of Room #311. NA #1 was observed to walk down the hall out of sight of this surveyor.

An interview was conducted with NA #1 on 5/15/24 at 11:19 am who revealed she was new to the facility, and she felt busy trying to get the meals out and just forgot to use hand sanitizer or wash her hands. She stated she should have used hand sanitizer between rooms when passing out trays, and she should not have picked up the toast with her hand. She stated she had received education on hand hygiene and when it needed to be done, but she just forgot.

During an interview with the Director of Nursing/Infection Preventionist (IP) on 5/16/24 at 11:30 am she revealed NA #1 was new to the facility but had been provided with education regarding hand hygiene. The IP stated NA #1 should have performed hand hygiene between each meal tray, and she should not have touched the resident's food with her hand.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	A. BUILDING _____ B. WING _____	C 05/16/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD REHABILITATION AND HEALTHCARE CENTER	**1300 DON JUAN ROAD HERTFORD, NC 27944**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE