

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Don Juan Road Hertford, NC 27944	

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0600</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>45045</p> <p>Based on observation, record review, staff interviews, Resident interview, and Responsible Party (RP) interview, the facility failed to protect a resident's right to be free from neglect for 2 of 2 resident reviewed for neglect (Resident #10 and Resident #217).</p> <p>The findings included:</p> <p>This tag is cross-referenced to:</p> <p>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).</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0623</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Provide timely notification to the resident, and if applicable to the resident representative and ombudsman, before transfer or discharge, including appeal rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45789</p> <p>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).</p> <p>The findings included:</p> <p>Resident #1 was admitted to the facility on [DATE].</p> <p>The Quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #1 was cognitively intact.</p> <p>The change in condition assessment dated [DATE] revealed Resident #1 was sent to the hospital due to chest pain.</p> <p>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.</p> <p>Review of the progress notes revealed Resident #1 returned to the facility on [DATE].</p> <p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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).</p> <p>The findings included:</p> <p>Resident # 39 was admitted to the facility on [DATE] with diagnoses which included stroke with hemiplegia (paralysis) of the right side.</p> <p>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.</p> <p>The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #39 had severe cognitive impairment and had functional limitations of range of motion of the upper and lower extremities.</p> <p>A physician order dated 4/01/24 revealed occupational therapy splinting hand roll to right hand.</p> <p>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 one time a day for contracture management.</p> <p>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.</p> <p>Resident #39's care plan did not reflect the use of hand splint for contracture management.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0657</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 5/16/24 at 9:46 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.</p> <p>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.</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. Resident #10 was admitted to the facility on [DATE] with diagnoses which included multiple sclerosis (MS-a chronic disease of the nervous system), and stroke with right sided hemiplegia (paralysis). <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #10 was cognitively intact, was coded with limited range of motion function of the upper and lower 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).</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p> <p>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.</p> <p>45789</p> <p>2. Resident #217 was admitted to the facility on [DATE] with diagnoses which included encephalopathy, and pneumonitis.</p> <p>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.</p> <p>The Minimum Data Set (MDS) admission assessment dated [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assist a resident in gaining access to vision and hearing services.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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).</p> <p>The findings included:</p> <p>Resident #24 was admitted to the facility on [DATE] with diagnoses which included stroke.</p> <p>Review of Resident #24's care plan last reviewed on 4/24/24 revealed no care plan related to hearing difficulty.</p> <p>Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #24 was cognitively intact and was coded for adequate hearing without the use of a hearing aid.</p> <p>Review of the nursing progress notes revealed no documentation regarding Resident #24's reported hearing difficulties.</p> <p>Review of the active physician orders revealed no orders for an evaluation of Resident #24's reported hearing difficulty.</p> <p>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 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0685</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 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.</p> <p>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.</p>

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide safe and appropriate respiratory care for a resident when needed.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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).</p> <p>The findings include:</p> <p>Review of Resident #7's hospital discharge oxygen therapy order requisition dated 11/15/21 revealed an order for non-invasive ventilation CPAP.</p> <p>Resident #7 was admitted to the facility on [DATE] with diagnoses which included obstructive sleep apnea (when the throat muscles relax and block the airway during sleep causing your breathing to be interrupted).</p> <p>Review of Resident #7's care plan last reviewed on 3/7/24 revealed no care plan for the CPAP machine.</p> <p>The Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #7 was cognitively intact and was not coded for CPAP use.</p> <p>A record review conducted on 5/13/25 of Resident #7's active physician orders revealed there was no order for his CPAP.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0695</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>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.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>45789</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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, 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.</p> <p>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.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/16/2024
NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Don Juan Road Hertford, NC 27944	
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Many</p>	<p>45789</p> <p>Post nurse staffing information every day.</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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 folder strapped to the wall. The daily nurse staff posting was not visible or accessible for all residents or visitors to view.</p> <p>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.</p> <p>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.</p> <p>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.</p>		

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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).</p> <p>The findings included:</p> <p>During an observation of the Hall 300 medication cart with the Director of Nursing (DON) and Nurse #1 on [DATE] at 1:44 pm the following was observed. The DON and Nurse #1 confirmed all findings before the removal of the items.</p> <p>One glargine insulin injector pen with an expiration date of [DATE] written on the label.</p> <p>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.</p> <p>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.</p> <p>One vial of haloperidol (an antipsychotic medication) 5 milligram/milliliter per injection open, with no open date noted on the vial.</p> <p>One tube of nystatin antifungal cream open, with no open date noted on the on the tube.</p> <p>One tube of ketoconazole antifungal cream open, with no open date noted on the tube.</p> <p>An interview was conducted with Nurse #1 on [DATE] 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.</p> <p>A telephone interview was conducted on [DATE] 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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Don Juan Road Hertford, NC 27944	

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<p>F 0761</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>During an interview on [DATE] 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.</p>

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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 (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.</p> <p>The findings included:</p> <p>This tag is cross-referenced to:</p> <p>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 1 resident reviewed for limited range of motion (Resident #39).</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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).</p> <p>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.</p> <p>(continued on next page)</p>		

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>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.</p> <p>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.</p> <p>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 during the survey (5/13/2024, 5/14/2024, 5/15/2024, and 5/16/2024).</p> <p>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.</p> <p>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.</p> <p>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).</p> <p>(continued on next page)</p>		

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NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZIP CODE 1300 Don Juan Road Hertford, NC 27944	

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<p>F 0867</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>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 [ROOM NUMBER] and room [ROOM NUMBER]) for 1 of 1 NA observed during meal tray delivery.</p> <p>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.</p> <p>During the recertification and complaint investigation survey of 1/31/23, the facility failed to maintain a sterile field while performing tracheostomy care.</p> <p>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.</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide and implement an infection prevention and control program.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045</p> <p>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 [ROOM NUMBER] and room [ROOM NUMBER]) for 1 of 1 NA observed during meal tray delivery.</p> <p>The findings included:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>

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<p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 [ROOM NUMBER]. 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 [ROOM NUMBER] 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 [ROOM NUMBER], lift the linen cart cover and obtain a clothing protector and re-enter room [ROOM NUMBER]. NA #1 was not observed to perform hand hygiene by use of the hand sanitizer dispenser on the wall prior to entering room [ROOM NUMBER] 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 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 [ROOM NUMBER] and retrieved a meal tray from the meal cart and entered room [ROOM NUMBER]. She was observed to place the meal tray on the overbed table for the Resident in room [ROOM NUMBER] and 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 [ROOM NUMBER]. NA #1 was observed to walk down the hall out of sight of this surveyor.</p> <p>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.</p> <p>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.</p>		