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	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hertford Rehabilitation and Healthcare Center	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)
F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record reviews, and staff interviews, the facility failed to notify the resident and Resident Representative in writing of the reason for transfer/discharge to the hospital. The deficient practice affected 5 of 5 residents reviewed for hospitalization (Resident #28, Resident #24, Resident #2, Resident #47, and Resident #8). The following included: a.Resident #28 was admitted to the facility on [DATE]. A review of Resident #28's Minimum Data Set (MDS) assessment dated [DATE] revealed the resident had severe cognitive impairment. A review of Resident #28's nursing progress note dated 5/26/25 revealed she was discharged to the hospital on 5/26/25 due to a critical low hemoglobin and altered mental status. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 5/26/25. b. Resident #24 was admitted to the facility on [DATE]. A review of Resident #24's Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. A review of Resident #24's nursing progress notes revealed she was discharged to the hospital on 4/10/25 gastrointestinal bleeding and returned on 4/16/25. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 4/10/25. c. Resident #2 was admitted to the facility on [DATE]. A review of Resident #2's Minimum Data Set (MDS) assessment dated [DATE] revealed he was cognitively intact. (continued on next page)

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

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	A review of Resident #2's nursing progress notes revealed he was discharged to the hospital on 8/8/24 to have a tunneled catheter inserted for antibiotic administration and returned on 8/9/24. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 8/8/24. d. Resident #47 was admitted to the facility on [DATE]. A review of Resident #47's Minimum Data Set (MDS) assessment dated [DATE] revealed he had moderate cognitive impairment. A review of Resident #47's nursing progress notes revealed he was discharged to the hospital on 7/13/24 due to increases shortness of breath with difficulty breathing and returned on 7/17/24. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 7/13/24. e. Resident #8 was admitted to the facility on [DATE]. A review of Resident # 8's Minimum Data Set (MDS) assessment dated [DATE] revealed she was cognitively intact. A review of Resident #8's nursing progress notes revealed she was discharged to the hospital on 8/16/24 due to vomiting up blood and returned on 8/19/24. Review of the medical record revealed no written notification of transfer for the Responsible Party or the resident for 8/16/24. An interview conducted with the Social Worker on 6/4/25 at 3:35 PM revealed she had not been sending a written notification of transfer/discharge to the resident or Resident Representative. The Social Worker stated she had been placing a follow-up phone call about the transfer to hospital and notifying the Resident Representative verbally. The Social Worker further stated she sometimes documented the conversation in her personal notebook or in the resident chart. An interview conducted with the Administrator on 6/5/25 at 06:08 PM revealed she was aware a follow-up phone call was to be made to the resident or Resident Representative to inform them of the transfer to the hospital. The Administrator stated she expected that written notification of transfer/ discharge would be sent to the resident and Resident Representative when residents discharge to the hospital. The Administrator further stated that going forward all hospital discharges would be reviewed each day during the morning meeting to make sure the written notifications were sent out.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident and staff interviews, the facility failed to accurately code the Minimum Data Set (MDS) assessment in the areas of use of anticonvulsant medication (Resident #55) and use of anticoagulant medication (Resident #55 and Resident #26) for 2 of 22 residents whose MDS assessments were reviewed. The findings included: 1. Resident #55 was admitted to the facility on [DATE] with diagnoses which included convulsions, stroke, and nontraumatic intracranial hemorrhage. Resident #55 had a physician order dated 12/17/24 for levetiracetam (anticonvulsant medication) oral tablet 1000 milligram (mg) give one tablet twice a day for seizure disorder. The Medication Administration Record for March 2025 and April 2025 revealed Resident #55 was administered the levetiracetam as ordered. Review of Resident #55's current and discontinued physician order for March 2025 through April 2025 revealed no orders for an anticoagulant medication. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #55 had severe cognitive impairment and was not coded for the use of anticonvulsant medication. The assessment further noted that Resident #55 was coded for the use of an anticoagulant medication. An interview was conducted on 6/04/25 at 12:02 pm with the MDS Nurse who confirmed Resident #55 did not have a physician order for an anticoagulant medication. The MDS Nurse revealed she must have mistakenly clicked anticoagulant medication instead of anticonvulsant medication for Resident #55 when she completed the assessment. During an interview on 6/05/25 at 4:20 pm with the Administrator she stated the MDS Nurse was responsible to ensure that Resident #55's MDS assessment was accurately coded. 2. Resident #26 was admitted to the facility on [DATE] with diagnoses which included stroke. Review of Resident #26's current and completed physician orders for February 2025 through March 2025 revealed no orders for anticoagulant medication. The Minimum Data Set (MDS) end of Medicare Part A assessment dated [DATE] revealed Resident #26 had moderate cognitive impairment and was coded for use of an anticoagulation medication. During an interview on 6/04/25 at 12:02 pm with the MDS Nurse she confirmed Resident #26 was not prescribed an anticoagulant medication. The MDS Nurse stated she must have incorrectly coded Resident #26's MDS assessment in the area of anticoagulant medication. An interview was conducted on 6/05/25 at 4:20 pm with the Administrator. She stated the MDS Nurse was responsible to ensure that Resident #26's MDS assessment was accurately coded.

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide activities to meet all resident's needs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, staff interviews, and Responsible Party (RP) interview, the facility failed to provide an ongoing resident centered activities program that included one on one (1:1) activities to meet the interests of a resident who did not participate in group activities for 1 of 1 resident reviewed for activities (Resident #55). The findings included: Resident #55 was admitted to the facility on [DATE] with diagnoses which included cognitive communication deficit and nontraumatic intracranial hemorrhage (bleed in the brain tissue that occurs without any trauma). The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #55 had severe cognitive impairment and no speech. Resident #55's assessment of daily and activity preferences revealed it was important for family or significant other to be involved in the care discussion and he enjoyed listening to music. There were no other activity preferences noted. Resident #55's care plan last reviewed on 4/09/25 revealed Resident #55 was dependent on staff for meeting emotional and social needs with a goal to maintain involvement in cognitive stimulation and social activities. The care plan had interventions which included providing the resident with materials for individual activities as desired, invite the resident to scheduled activities, and ensuring that the activities the resident is attending were compatible with physical and mental capabilities. Review of the Kardex (resident care guide) revealed Resident #55's activities were to include one to one (1:1) program, group events, group programs, and self-directed activity. Review of the activity participation record for the month of May 2025 revealed no documentation that Resident #55 participated in any facility activity. Review of the 1:1 program record for the month of May 2025 revealed no documentation that Resident #55 had participated in any 1:1 activity. Review of the group events, group programs, and self-directed activity record for the month of May 2025 revealed no documentation that Resident #55 had participated in any group events, group programs, or self-directed activity. Observations were conducted on 6/02/25 at 10:32 am and 11:28 am revealed Resident #55 was in bed with his head turned toward the window and the wall mounted television was turned on. Resident #55 turned and made eye contact with the surveyor upon entering the room but he was unable to participate in an interview. There was no radio observed in Resident #55's room. (continued on next page)

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F 0679 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A telephone interview was conducted on 6/02/25 at 11:26 am with Resident #55's RP who revealed she was concerned that the facility did not include the resident in activity programs. The RP stated that Resident #55 was only in the room in bed when she or other family visited the facility and was not observed to be engaged in any activities. The RP stated Resident #55 enjoyed watching football and basketball and listening to music before he was admitted to the facility. The RP stated she did not recall being asked by anyone at the facility what Resident #55's interests were. Observations were conducted on 6/03/25 at 9:39 am, 12:37 pm, and 2:53 pm revealed Resident #55 was in bed with the wall mounted television turned on. There was no radio observed in Resident #55's room. An interview was conducted with Nurse Aide (NA) #1 on 6/03/25 at 12:37 pm who revealed she did not observe Resident #55 in any facility group activities or any activity staff in the room with him when she worked. NA #1 stated she was not aware of any particular activity that Resident #55 enjoyed but she stated the television in the room was on all the time. During an interview on 6/03/25 at 2:47 pm NA #2 revealed she did not see Resident #55 participate in any facility activities. NA #2 stated she believed he liked to listen to the television so she left the television on for him. The Activity Director was interviewed on 6/03/25 at 2:53 pm who reported that resident 1:1 activities were documented in the electronic health record when the activity was completed and she attempted to complete resident 1:1 activities at least once weekly for 10 minutes. The Activity Director stated Resident #55 had been to one facility activity that she was aware of in the past, but he had not been taken to any activities during the last few months. She was unable to recall when Resident #55 participated in a 1:1 visit, group activity, or group event. The Activity Director stated Resident #55 had a television in his room and she believed he had a radio in the room as well that could be turned on by her or floor staff when he wanted. An interview was conducted with the Director of Nursing (DON) on 6/05/25 at 1:06 pm who revealed the Activity Director was responsible for determining what 1:1 activities would be appropriate for Resident #55. During an interview with the Administrator on 6/05/25 at 4:24 pm she revealed the Activity Director was responsible to provide Resident #55 with activities that addressed the needs of the resident.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	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. Based on record reviews and staff interviews, the facility failed to schedule a Registered Nurse (RN) for at least eight consecutive hours per day seven days a week for 1 of 34 days reviewed for sufficient staffing. The findings included: A review of the daily posted nursing staff forms, daily nursing staff assignment sheets, and staff clock-in sheets from 5/01/25 through 6/03/25 was conducted. A review of the daily census posting sheets for 5/25/25 revealed no RN coverage for eight consecutive hours on 5/25/25. In an interview on 6/05/25 at 2:52 PM the Director of Nursing (DON) stated for staff call out, they would call the staffing agency for a nurse to fill an open position. She indicated as it was the Memorial holiday weekend, no facility or agency staff were available to fill the position on 5/25/25. In an interview on 6/05/25 at 11:54 AM the Clinical [NAME] President revealed they did not have a RN on 5/25/25 due to call out.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on record reviews and staff interviews, the facility failed to document accurate information on the daily nurse staffing sheets for 34 of 34 days (5/01/25 through 6/03/25) reviewed. The findings included: A review of the Staff Schedule/Assignment Sheets and daily Posted Nurse Staffing Information sheets for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25 revealed discrepancies in the areas of number of unlicensed staff (including Medication Aides (MAs) actual hours worked and actual nursing staff who worked. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed staff (including Medication Aides (MAs) on 1st shift (7:00 AM - 3:00 PM) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed staff on 2nd shift (3:00 PM - 11:00 PM) (including MAs) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. The number of unlicensed staff and actual hours worked of unlicensed on 3rd shift (11:00 PM - 7:00 AM) were incorrect for the following days: for 5/01/25, 5/02/25, 5/03/25, 5/04/25, 50/5/25, 5/06/25, 5/07/25, 5/08/25, 5/09/25, 5/10/25, 5/11/25, 5/12/25, 5/13/25, 5/14/25, 5/15/25, 5/16/25, 5/17/25, 5/18/25, 5/19/25, 5/20/25, 5/21/25, 5/22/25, 5/23/25, 5/24/25, 5/25/25, 5/26/25, 5/27/25, 5/28/25, 5/29/25, 5/30/25, 5/31/24, 6/01/25, 6/02/25 and 6/03/25. The Daily Posted Staffing for licensed staff and unlicensed staff documented staff were scheduled to work 2 twelve-hour shifts, when the actual hours worked by unlicensed staff were 3 eight-hour shifts. An interview was conducted with the Staffing Scheduler on 6/05/25 at 2:53 PM who revealed she was responsible for completing the Daily Staffing Hours data sheets and confirmed the assignment data sheets were the actual staff that worked on a specific date. She reported she was trained to document the staffing hours for licensed and unlicensed staff for 2 twelve-hour shifts for all licensed and unlicensed staff. In an interview on 6/05/25 at 2:27 PM the Clinical [NAME] President stated the daily staffing information was documented as 2 twelve-hour shifts versus 3 eight-hour shifts for unlicensed staff. (continued on next page)

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	345262	A. Building B. Wing	06/05/2025

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	In an interview on 6/05/25 at 2:24 PM the Administrator reported with the way the daily staffing was listed, it looked like the actual unlicensed staff hours were off.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, and staff and Consultant Pharmacist interviews, the facility failed to have effective systems in place for the return of discontinued controlled medications to the pharmacy which resulted in the controlled medication being diverted from the medication storage cart for 1 of 2 residents reviewed for misappropriation of residents' property (Resident #44). The findings included: Review of the Disposal of Medications Policy dated 1/24 read in part: Discontinued medications and/or medications left in the nursing care center, are identified and removed from current medication supply in a timely manner according to state and federal regulations for disposition. Resident #44 was admitted to the facility on [DATE]. Review of a physician's order for Resident # 44 dated 11/15/24 read, Oxycodone (a narcotic pain medication) 5 milligrams (mg) by mouth every six hours as needed for pain. The order was discontinued on 11/29/24. Review of the quarterly Minimum Data Set assessment dated [DATE] revealed the resident was cognitively intact and was on a scheduled pain medications regimen. He received opioid medication during the lookback period. A review of the December 2024 narcotic/control substance count sheet revealed on 12/9/24 Medication Aide #1 received the medication cart with 22 narcotic cards, and the count was validated by Nurse #3. Review of the pharmacy packing slip dated 11/26/24 revealed the facility received 8 doses of Oxycodone/Acetaminophen 5/325 mg for Resident #44. Review of the November 2024 MAR revealed no doses of Oxycodone/Acetaminophen 5/325 mg were administered to Resident #44 before it was discontinued on 11/29/24. A review of the initial allegation report dated 12/9/24 revealed the facility became aware of the misappropriation of facility property on 12/9/24 at 2:45 PM when the Director of Nursing (DON) reconciled the narcotic medications and found that the counts were not correct as documented. An allegation of misappropriation of resident property was submitted for Resident #44 and Medication Aide #1 was suspended pending the outcome of the investigation. The initial report was submitted by the previous Administrator. A review of the 5-day investigation report dated 12/13/24 revealed the allegation of misappropriation of facility property was substantiated. Medication Aide #1 was terminated on 12/10/24. The DON noted the number of narcotic sheets, and the number of narcotic cards was off by two. Resident #44 was found to be missing a medication card containing 8 Oxycodone/Acetaminophen 5/325 (milligram) mg tablets. This medication had been discontinued and the medication card had not been removed by the Nursing Administration from the medication cart. (continued on next page)

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An attempt to interview Medication Aide #1on 6/5/25 at 3:45 PM was unsuccessful. An attempt to contact Nurse #3 on 6/5/25 at 3:48 PM was unsuccessful. An interview was conducted with the facility Pharmacist on 6/5/25 at 4:04 PM. The Pharmacist verified Resident #44's Oxycodone had not been returned to the pharmacy. The Pharmacist stated the facility was supposed to remove the medication from the medication cart and return the medication back to the pharmacy. The Pharmacist stated a medication disposition was sent back with all medications returned for pharmacy disposal. She added that narcotic medications were placed in a bag and sealed in addition to their being locked in the plastic bin they were sent back in. The Pharmacist stated the facility had a contract with the pharmaceutical company and they did monthly checks of the medication carts to include checking for discontinued medications. An interview was conducted with the previous Director of Nursing (DON) on 6/5/25 at 4:47 PM. She confirmed she was the DON at the time of the medication diversion incident. The DON stated she had come out of the clinical meeting and checked her mailbox outside her door. The previous DON indicated she noticed there was one individual controlled drug record placed in her mailbox on her office door. The previous DON stated she became suspicious because the controlled drug record appeared randomly. The previous DON stated she immediately went to the medication cart to reconcile the narcotics. The previous DON stated the count was off by two narcotic count cards on the 200 Hall Medication Cart on 12/9/24. The previous DON stated one of the two missing narcotic count cards was located during the audit of the 200 Hall medication cart. The previous DON indicated there were 21 narcotic control sheets documented instead of 22 which were verified at the beginning of the shift by Nurse #3. The previous DON further stated she determined the narcotic medication card that belonged to Resident #44 which contained 8 Oxycodone/Acetaminophen 5/325 mg tablets was missing. The previous DON stated at the time of the incident that Nursing Administration was to remove the narcotic medication from the medication cart when the medication were discontinued but there was no specific time frame as to when the discontinued medications were removed from the medication cart. Two nurses were to verify and sign off the amount of medication that was left on the medication card that was being returned to the pharmacy. The amount being returned was documented on to the return medication disposition document (a document that tracks the final location of a medication). The previous DON stated the medication was placed in a sealed pharmacy bag and the sealed bag was then placed in a locked tote with the pharmacy return medication disposition. The previous DON stated the transporter picked up the medication and documentation of the receipt of medication was handed to the nurse for the return. The previous DON stated Medication Aide #1 was terminated on 12/13/24 and charges were filed related to the allegation. An interview was conducted with the Administrator on 6/5/25 at 6:08 PM. The Administrator stated the previous Administrator submitted the investigation report. She stated she had no concerns about misappropriation of resident property since becoming Administrator of the facility.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on staff interview and review of the Facility Assessment, the facility failed to ensure the staffing plan considered specific staffing needs for each unit and shift as required and failed to evaluate contracted services utilized by the facility to provide necessary care for its residents during normal operations and emergencies which had the potential to affect 64 of 64 residents. The findings included: Review of the Facility Assessment revealed that the staffing plan listed the number of Nurses (Registered Nurse or Licensed Practical Nurse) and Certified Nursing Assistants (CNAs) noted as the desired number FTE (full-time equivalent, the total number of full-time employees working in an organization) of staff and the professional requirement for those staff members. However, the staffing plan did not address staffing needs for each shift and weekends, or address staffing needs in these areas based on changes to the resident population as required. In addition, the Facility Assessment did not note if a contract or other agreement was in place related to the provider who was responsible for the provision of goods, facility management services, emergency services, transportation, and dialysis services for the facility. An interview was conducted with the Administrator on 6/05/25 at 2:24 PM who indicated she was not aware of the requirement to specifically address the nurse staff shift information according to each unit. She reported she was not aware they needed to list the contract services used at the facility in the Facility Assessment. She indicated she would expect all the contract services to be listed and reviewed annually.

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	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hertford Rehabilitation and Healthcare Center	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)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to maintain an effective pest control program as evidenced by the presence of flies that affected resident rooms 5 of 12 rooms observed on the 300 Hall (room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], room [ROOM NUMBER], and room [ROOM NUMBER]). The findings included: Review of the pest control service inspection report dated 5/14/25 revealed the interior and exterior of the facility for general pests as well as spreading granular around the exterior of the foundation of the building. The service inspection report further noted that rodent stations were inspected and baited, the attic was baited for roaches, and a wasp nest was removed on the exterior of the building. There was no mention of a fly program service. a. An observation of room [ROOM NUMBER] on 6/02/25 at 10:41 am was conducted. Multiple flies were visible in the room and were observed landing on the residents beds, over bed tables, heads and arms. The three residents present at the time of the observation were able to swat the flies away. An observation of room [ROOM NUMBER] on 6/03/25 at 12:30 pm was conducted and flies were visible in the room on resident beds and overbed tables. Resident #4, who had moderate cognitive impairment, stated the flies were horrible. b. An observation of room [ROOM NUMBER] on 6/02/25 at 10:52 am was conducted. Many flies were visible in the room on resident beds, residents head, upper body, and bedside table. The two residents present at the time of the observation were able to swat the flies away. c. An observation of room [ROOM NUMBER] on 6/02/25 at 11:11 am was conducted. Many flies were visible in the room and were observed to land on the residents head and arms. The two residents present at the time of the observation were able to swat the flies away. d. An observation of room [ROOM NUMBER] was conducted on 6/02/25 at 11:28 am and flies were observed landing on the blanket, hands, face, and head. Two of the three resident present during the observation were able to swat the flies away. Resident #1 was observed waving his hands by his head to remove flies. Resident #1, who was cognitively intact, reported the flies were always in the room and bothered him. An observation of room [ROOM NUMBER] on 6/03/25 at 2:45 pm was conducted and flies were observed around the resident's head and face. One of the two residents present during the observation was able to swat the flies away. e. An observation of room [ROOM NUMBER] on 6/05/25 at 11:24 am was conducted. The resident was observed in bed sleeping with multiple flies on his legs, back, head, and arms. The resident was able to swat away the flies. (continued on next page)

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	06/05/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	An observation of the smoking area was conducted on 6/05/25 at 3:45 pm with the Maintenance Director. The Residents were observed to be sitting outside the smoking exit door under a gazebo with a raised garden bed to the right of the exit door. The smoking area was clean and without debris or garbage. The Maintenance Director lifted the insect trap located at the smoking entrance and it was observed to have some flies attached to the glue strips but the glue strips were not completely covered. The smoking exit door was opened by the Maintenance Director and the blower fan, located on the wall at the smoking exit door, turned on automatically when the door was opened. No flies were observed to enter the facility at the time of the observation when the door was opened and the blower fan was on. During an interview with Nurse Aide (NA) #2 on 6/03/25 at 2:45 she revealed flies have been pretty bad and she stated they are in most rooms on the 300 Hall. NA #2 stated she believed the flies got in by the smoking door area because the residents go out so often to smoke. An interview was conducted on 6/05/25 at 11:26 am with Housekeeper #1 who revealed he did not spray any chemicals for flies at the facility. He stated the Maintenance Director was responsible for the treatment of flies. An interview was conducted with the Director of Nursing (DON) on 6/05/25 at 1:04 pm who revealed the flies had never been as bad as they were right now. The DON stated she believed the flies were entering the facility from the smoking area door because the door was opened for extended periods of time to allow for all the residents to exit and enter. The DON stated the smoking exit door had a blower that would turn on when the door opened to reduce the amount of flies and an insect trap (a wall-mounted fixture with a blue light and glue strips that attracted and trapped flies) was right at the smoking area entrance. She stated the flies were still getting in the facility because of the amount of time it took to get the residents in the door. An interview was conducted with the Maintenance Director on 6/05/25 at 3:24 pm. The Maintenance Director revealed that he was responsible to maintain the insect traps in the facility by changing out the light bulbs and replacing the glue traps. He stated the facility had 6 large wall mounted insect traps in the resident halls and he had started to place smaller insect traps in resident rooms but had not yet gotten to the 300 Hall. The Maintenance Director stated he changed the insect traps by the smoking entrance about every 2 weeks and the other insect traps lasted longer, like once a month. The Maintenance Director stated he did not maintain documentation for how often he changed the glue traps and lights for the insect traps. During an interview on 6/05/25 at 4:31 pm with the Administrator she revealed the facility had identified the need for insect traps in resident rooms and the facility had been working on getting insect traps ordered and installed. The Administrator stated with the weather warming up the number of flies in the facility had increased.