

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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Form Approved OMB
No. 0938-0391

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 07/30/2026
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)		
F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, resident, and staff interviews, the facility failed to document and provide written information to residents/representatives regarding their right to refuse medical/surgical treatment or to formulate an advance directive for 7 of 13 residents reviewed for advance directives (Residents #5, #8, #15, #40, #58, #72, and #80). Findings included: a. Resident #72 was admitted to the facility on [DATE]. Resident #72 had a Full Code physician order dated 10/6/23. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #72 was cognitively intact. An interview was conducted with Resident #72 on 7/29/26 at 9:30 AM. Resident #72 stated that he did not recall receiving written education regarding advance directives. There was no documentation in Resident #72's medical record for education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. b. Resident #80 was admitted to the facility on [DATE]. Resident #80 had a Full Code Physician order dated 7/27/26. An in-progress Medicare 5-day MDS assessment dated [DATE] revealed Resident #80 was cognitively intact. During an interview with Resident #80 on 7/29/26 at 9:24 AM she stated that she did not recall receiving written education regarding advance directives. There was no documentation in Resident #80's medical record for education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. (continued on next page)		

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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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	c. Resident #58 was originally admitted to the facility on [DATE]; he was readmitted on [DATE]. Resident #58 had a Do Not Resuscitate (DNR) physician order dated 3/12/25. A quarterly MDS assessment dated [DATE] revealed Resident #58 was moderately cognitively impaired. There was no documentation in Resident #58's medical record for education regarding formulation of an advance directive and/or an opportunity to formulate an advance directive was offered. Attempts to contact the Resident Representative (RR) were unsuccessful. d. Resident #40 was admitted to the facility on [DATE]. Resident #40 had a Full Code physician order dated 12/26/16. A quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #40 was assessed as having severe cognitive impairment. There was no documentation in Resident #40's medical record that education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. Attempts to contact the Resident Representative (RR) were unsuccessful. e. Resident #5 was admitted to the facility on [DATE]. Resident #5 had a Full Code physician order dated 5/19/26. An admission MDS assessment dated [DATE] revealed Resident #58 was cognitively intact. During an interview with Resident #5 on 7/27/26 at 3:00 PM he stated that he did not recall receiving written education regarding advance directives. There was no documentation in Resident #5's medical record that education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. f. Resident #8 was admitted to the facility on [DATE]. Resident #8 had a Full Code physician order dated 2/27/26. A quarterly MDS assessment dated [DATE] revealed Resident #8 was cognitively intact. During an interview with Resident #8 on 7/30/26 at 11:10 AM she stated that she did not recall receiving written education regarding advance directives. (continued on next page)		

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F 0578 Level of Harm - Potential for minimal harm Residents Affected - Some	There was no documentation in Resident #8's medical record that education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. g. Resident #15 was admitted to the facility on [DATE]. A quarterly MDS assessment dated [DATE] revealed Resident #15 had a moderate cognitive impairment. There was no documentation in Resident #15's medical record that education regarding formulation of advance directives and/or an opportunity to formulate advance directives was offered. Attempts to interview Resident #15 were not successful. An interview was conducted with the Social Worker (SW) on 7/30/26 at 10:17 AM. She stated she addressed advance directives during her initial conversation with the resident and/or the resident representative. She stated she read to them the facility's code status information and confirmed their initial code status. The SW stated she provided verbal explanation but no written material concerning advance directives was given. She stated she also informed the resident/ RR that they can change their code status at any time by contacting a staff member in the facility, and that staff member would contact her. The SW stated that advanced directives were also reviewed with the resident and/or RR during care plan meetings at which time their current code status was reviewed and either confirmed or changed as requested. The SW further stated she had not been documenting what education she was reviewing with residents and/or their RR regarding advance directives, however, moving forward she would be. An interview was conducted on 7/30/26 at 10:30 AM with the Director of Nursing (DON). The DON stated her expectation was that advance directives were discussed at the time of admission, code status was reviewed and confirmed, and the resident's wishes were followed. She stated the SW was responsible for providing written documentation of advance directives to the resident/RR and the DON was not aware that written documentation was not being provided. The DON further stated advance directives were also discussed and documented with any changes from baseline in a resident's health, as well as during quarterly care meetings. During an interview on 7/30/26 at 11:10 AM with the Administrator, she stated advance directives were discussed with a resident and/or their RR on admission and an acknowledgement form was signed confirming their code status. The Administrator further stated code status was also addressed with any change in condition of a resident, and at quarterly care plan meetings. She further stated the SW should document all advance directives/code status discussions within the social service progress note or the care plan meeting note. An interview was completed on 7/30/26 at 11:20 AM with the Regional Clinical Director. She stated upon admission and during quarterly care meetings a resident should be educated about the full advance directives, not just code status, and the SW should document any written materials and verbal education provided to residents and/or their RR in a progress note or interdisciplinary team care plan note.		