Printed: 08/29/2024 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 10/26/2021		
NAME OF PROVIDER OR SUPPLIE Hertford Rehabilitation and Healtho		STREET ADDRESS, CITY, STATE, ZII 1300 Don Juan Road Hertford, NC 27944	P CODE		
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 0550 Level of Harm - Minimal harm or potential for actual harm	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731				
Residents Affected - Some	Based on observation, record review, and staff and resident interviews the facility failed to maintain dignity of residents by failing to knock on doors or ask permission to enter resident rooms for 5 of 15 residents observed (Resident #2, Resident #31, Resident #7, Resident #20, and Resident #17).				
	Findings included:				
	Resident #2 was admitted to the facility on [DATE]. Resident #2's most recent quarterly minimum data set assessment dated [DATE] revealed he was significantly cognitively impaired.				
	During an observation on 10/17/21 at 11:55 AM NA#3 entered Resident #2's room without knocking to deliver his lunch tray.				
	During an interview on 10/17/21 at 12:42 PM NA #3 stated she did not knock or ask permission to enter. She stated she was aware she should do so and could not articulate why she did not.				
	During an interview with the Direct announce themselves when enterior	or of Nursing on 10/20/21 at 9:47 AM w ng a resident's room.	ho stated staff should knock or		
		ne Assistant Director of Nursing on 10/2 introduce themselves when entering a			
	An interview was conducted with Resident #2 on 10/20/21 at 2:22 PM who stated he wanted staff to knock prior to entering his room. He stated he did not like it when staff just walked into his room and felt disrespected.				
	During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.				
	2. Resident #31was admitted to the facility on [DATE].				
	(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

FORM CMS-2567 (02/99) Previous Versions Obsolete Event ID:

Facility ID: 345262

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STATEMENT OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY		
AND PLAN OF CORRECTION	IDENTIFICATION NUMBER:	A. Building	COMPLETED		
	345262	B. Wing	10/26/2021		
NAME OF PROVIDER OR SUPPLIE	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE		
Hertford Rehabilitation and Healtho	care Center	1300 Don Juan Road Hertford, NC 27944			
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by	CIENCIES full regulatory or LSC identifying informati	on)		
F 0550 Level of Harm - Minimal harm or	Resident #31's most recent quarter significantly cognitively impaired.	rly minimum data set assessment dated	d [DATE] revealed he was		
potential for actual harm Residents Affected - Some	During an observation on 10/17/21 deliver his lunch tray.	at 11:55 AM NA#3 entered Resident #	31's room without knocking to		
		12:42 PM NA #3 stated she did not kno ne was aware she should do so and co			
	During an interview with the Director announce themselves when entering	or of Nursing on 10/20/21 at 9:47 AM w ng a resident's room.	ho stated staff should knock or		
	An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she that staff should always knock and introduce themselves when entering a resident's room.				
	During an interview with Resident #31 on 10/20/21 at 1:52 PM he stated staff should knock or announce themselves prior to entering his room.				
	During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to enteri resident's room.				
	3. Resident #7 was admitted to the facility on [DATE].				
	Resident #7's most recent minimur he was cognitively intact.	n data set assessment, an admission a	ssessment dated [DATE] revealed		
	During an observation on 10/17/21 deliver his lunch tray.	at 11:57 AM NA#3 entered Resident #	7's room without knocking to		
	_	12:42 PM NA #3 stated she did not known to so and could not articulate why she of	•		
	During an interview with the Director of Nursing on 10/20/21 at 9:47 AM who stated staff should knock or announce themselves when entering a resident's room.				
	An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that staff should always knock and introduce themselves when entering a resident's room.				
	During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained on resident rights and dignity. He stated NA #3 should have knocked and announced herself prior to entering a resident's room.				
	Attempts to interview Resident #7 were unsuccessful				
4. Resident #20 was admitted to the facility on [DATE].					
	(continued on next page)				

			No. 0936-0391
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 10/26/2021
NAME OF PROVIDER OR SUPPLIE Hertford Rehabilitation and Healtho		STREET ADDRESS, CITY, STATE, ZI 1300 Don Juan Road Hertford, NC 27944	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informati	ion)
F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	significantly cognitively impaired. H During an observation on 10/17/21 deliver his lunch tray. During an interview on 10/17/21 at Resident #31's room. She stated sl During an interview with the Directe announce themselves when enterin An interview was conducted with the that staff should always knock and During an interview with the Admin resident rights and dignity. He state resident's room. 5. Resident #17 was admitted to th Resident #17's most recent quarter moderately cognitively impaired. During an observation on 10/17/21 deliver his lunch tray. During an interview on 10/17/21 at Resident #17's room. She stated sl During an interview with the Directe announce themselves when enterin An interview was conducted with the that staff should always knock and During an interview with the Admin	ne Assistant Director of Nursing on 10/2 introduce themselves when entering a sistrator on 10/20/21 at 3:38 PM he stated NA #3 should have knocked and and e facility on [DATE]. Thy minimum data set assessment dated at 11:55 AM NA#3 entered Resident #12:42 PM NA #3 stated she did not known was aware she should do so and corr of Nursing on 10/20/21 at 9:47 AM was a resident's room. The Assistant Director of Nursing on 10/2 introduce themselves when entering a istrator on 10/20/21 at 3:38 PM he stated NA #3 should have knocked and anity and the stated NA #3 should have knocked and anity introduce themselves who have stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce themselves who have the stated NA #3 should have knocked and anity introduce the stated NA #3 should have knocked and anity introduce the	rable. 231's room without knocking to ock or ask permission to enter ould not articulate why she did not. The stated staff should knock or 20/21 at 10:52 AM and she stated resident's room. 24 (DATE) revealed she was 31's room without knocking to ock or ask permission to enter ould not articulate why she did not. The stated staff should knock or 20/21 at 10:52 AM and she stated resident's room. 26 (27) at 10:52 AM and she stated resident's room.

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 10/26/2021	
NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		STREET ADDRESS, CITY, STATE, ZI 1300 Don Juan Road	P CODE	
		Hertford, NC 27944		
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0582	Give residents notice of Medicaid/N	Medicare coverage and potential liability	y for services not covered.	
Level of Harm - Potential for minimal harm	**NOTE- TERMS IN BRACKETS H	IAVE BEEN EDITED TO PROTECT CO	ONFIDENTIALITY** 39731	
Residents Affected - Some	Based on record review and staff interviews, the facility failed to provide an acknowledged Centers for Medicare and Medicaid Services (CMS) Skilled Nursing Facility Advanced Beneficiary Notice (SNF ABN) (form 10055) for 2 of 3 residents reviewed for beneficiary notification protection review (Resident #3 and Resident #16).			
	The findings included:			
	1. Resident #3 was admitted to the	facility on [DATE] with diagnoses inclu	ding hypertension.	
	He was admitted to Medicare Part A skilled services on 7/14/21.			
	Resident #3's significant change Minimum Data Set assessment dated [DATE] revealed she was cognitively intact.			
	Resident #3's Medicare Part A skilled services ended on 8/4/21. He remained in the facility.			
	The SNF ABN reviewed had Resident #43's name, the date services were to end, and a statement that resident was made aware of non-coverage on 8/2/21. There were no options checked for the decision made about continuing Medicare Part A services on the notice.			
	option checked for the decision ma she reviewed options with the resid	terview was conducted with Social Worker #1 on 10/19/21 at 1:13 PM. She stated there should be an n checked for the decision made about continuing Medicare Part A services. The Social Worker stated eviewed options with the resident but failed to ensure an option for continuing services was checked by dent #3. She stated that there should have been documentation on the form about the discussion.		
	An interview was conducted with R signing the SNF-ABN	esident #3 on 10/20/21 at 1:52 PM who	o stated he did not remember	
		was conducted 10/20/21 at 3:38 PM was been completed accurately by Resi		
	Resident #16 was admitted to th to Medicare Part A skilled services	e facility on [DATE] with diagnoses incl on 5/13/21.	luding dementia. She was admitted	
	Resident #16's quarterly Minimum	Data Set assessment dated [DATE] rev	vealed she was cognitively intact.	
	Resident #16's Medicare Part A sk	illed services ended on 5/31/21.		
	5/28/21. The SNF ABN reviewed h	t16's SNF-ABN was reviewed over the ad Resident #78's name and the date so made regarding continuing Medicare	services were to end. There were	
	(continued on next page)			

			10. 0930-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2021
NAME OF PROVIDER OR SUPPLIE Hertford Rehabilitation and Health		STREET ADDRESS, CITY, STATE, Z 1300 Don Juan Road Hertford, NC 27944	IP CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	CIENCIES full regulatory or LSC identifying informat	ion)
F 0582 Level of Harm - Potential for minimal harm Residents Affected - Some	been an option checked for the dec She stated she spoke with Resider ending and appeal rights. She state discussion.	ocial Worker #1 on 10/19/21 at 1:13 P cision made about continuing Medicare at #15's resident representative on 5/26 ad there should have been documenta was conducted 10/20/21 at 3:38 PM vesident #16.	Part A services for Resident #16. 3/21 about Medicare Part A services tion on the form about the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262 STREET ADDRESS, CITY, STATE, ZIP CODE 10/26/2021 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 efficiency must be preceived by full regulatory or LSC identifying information) Provide medically-related social services to help each resident achieve the highest possible quality of life. "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 39731 Based on record review and staff inhorieves the facility failed to ensure a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident #7). The findings included: Resident #7's hospital discharge summary dated 7/30/21 read in part, Patient will need referral/follow up will an outpatient nephrology provider to continue to help manage his CKC3 (Stronic kidney disease) and requiring supplemental social mibicathonate. This refers to the secretion of social man obtain and bicarbonate due urine having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MOS) assessment, dated 8/6/21, indicated the resident was regimental social record revealed no appointments achieved with heaphrology since his administration of an appointment of Resident #7's hould have made this appointment. A review of Resident #7's medical record revealed no appointment of Resident #7's hould have made this appointment and provided with the piecetor of Nursing (DON) on 10/20/21 at 9.03 AM. She stated Resident #7's hould have made this appointment as required with an exphrologist. The DON stated it was her expectation when a nurse admits a				No. 0938-0391
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. (X6) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0745 Level of Harm - Minimal harm or potential for a citual harm Residents Affected - Few "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY" 39731 Based on record review and staff interviews the facility failed on source a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident # 7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7 hospital discharge summary dated 7/30/21 read in part, Patient will need referral/follow up with an outpatient nephrology provider to continue to help manage his CKD3 (chronic kidney disease) and chronic metabolic acidosis from ileal conduit (a system of urinary drainage created after bladder removal) requiring supplemental sodium bicarbonate. This refers to the secretion of sodium and bicarbonate due urine having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MDS) assessment, dated 8/6/21, indicated the resident was cognitively intact. Resident #7 required extensive assistance with most activities of daily living including transfer, folieting, dressing and personal hygiene. A review of Resident #7's medical record revealed no appointments scheduled with nephrology since his admission. During an interview with the facility's Assistant Director of Nursing on 10/20/21 at 13:55 AM, she stated that she was unable to locate documentation of an appointment for Resident #7 should have had an appointment scheduled with a nephrologist. The DON stated		IDENTIFICATION NUMBER:	A. Building	COMPLETED
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few "NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY* 39731 space on record review and staff interviews the facility failed to ensure a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident # 7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7s hospital discharge summary dated 7/30/21 read in part, Patient will need referral/follow up with an outpatient nephrology provider to continue to help manage his CKD3 (chronic kidney disease) and chronic metabolic acidosis from lieal conduit (a system of urinary drainage created after bladder removal) requiring supplemental sodium bicarbonate. This refers to the secretion of sodium and bicarbonate due urind having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MDS) assessment, dated 8/6/21, indicated the resident was cognitively intact. Resident #7 required extensive assistance with most activities of daily living including transfer, tolieting, dressing and personal hygiene. A review of Resident #7's medical record revealed no appointments scheduled with nephrology since his admission. During an interview with the facility's Assistant Director of Nursing on 10/20/21 at 8:55 AM, she stated that she was unable to locate documentation of an appointment for Resident #7 during the period from July 2021 to present with nephrology. She indicated the nurse who admitted Resident #7 should have made this appointment. The nurse who admitted Resident #7 was unavailable for i			1300 Don Juan Road	P CODE
F 0745 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few Based on record review and staff interviews the facility failed to ensure a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident # 7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7 shospital discharge summary dated 7/30/21 read in part, Patient will need referral/follow up with an outpatient nephrology provider to continue to help manage his CKD3 (chronic kidney disease) and chronic metabolic acidosis from ileal conduit (a system of urinary drainage created after bladder removal) requiring supplemental sodium bicarbonate. This refers to the secretion of sodium and bicarbonate due urine having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MDS) assessment, dated 8/6/21, indicated the resident was cognitively intact. Resident #7 required extensive assistance with most activities of daily living including transfer, toileting, dressing and personal hygiene. A review of Resident #7's medical record revealed no appointments scheduled with nephrology since his admission. During an interview with the facility's Assistant Director of Nursing on 10/20/21 at 8:55 AM, she stated that she was unable to locate documentation of an appointment for Resident #7 should have made this appointment. The nurse who admitted Resident #7 was unavailable for interview. An interview was conducted with the Director of Nursing (DON) on 10/20/21 at 9:03 AM. She stated Resident #7 should have had an appointment scheduled with a nephrologist. The DON stated it was her expectation when a nurse admits a resident all referral appointments are made. An interview was conducted on 10/20/21 at 11:	For information on the nursing home's	plan to correct this deficiency, please con	,	agency.
Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 39731 Based on record review and staff interviews the facility failed to ensure a resident was referred to an outpatient nephrologist as indicated in the hospital discharge instructions for 1 of 1 sampled resident reviewed for medically related social services (Resident # 7). The findings included: Resident #7 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease. Resident #7's hospital discharge summary dated 7/30/21 read in part, Patient will need referral/follow up with an outpatient nephrology provider to continue to help manage his CKD3 (chronic kidney disease) and chronic metabolic acidosis from ileal conduit (a system of urinary drainage created after bladder removal) requiring supplemental socilum bicarbonate. This refers to the secretion of sodium and bicarbonate due urine having contact with the bowel wall. Resident #7's most recent Minimum Data Set (MDS) assessment, dated 8/6/21, indicated the resident was cognitively intact. Resident #7 required extensive assistance with most activities of daily living including transfer, toileting, dressing and personal hygiene. A review of Resident #7's medical record revealed no appointments scheduled with nephrology since his admission. During an interview with the facility's Assistant Director of Nursing on 10/20/21 at 8:55 AM, she stated that she was unable to locate documentation of an appointment for Resident #7 should have made this appointment. The nurse who admitted Resident #7 was unavailable for interview. An interview was conducted with the Director of Nursing (DON) on 10/20/21 at 9:03 AM. She stated Resident #7 should have had an appointments a resident all referral appointments are made. An interview was conducted on 10/20/21 at 11:15 AM with Resident #7's primary care physician. He indicated Resident #7 should have followed up with an outpatient nep	(X4) ID PREFIX TAG			on)
	Level of Harm - Minimal harm or potential for actual harm	Provide medically-related social se **NOTE- TERMS IN BRACKETS H Based on record review and staff ir outpatient nephrologist as indicated reviewed for medically related social The findings included: Resident #7 was admitted to the fat Resident #7's hospital discharge social an outpatient nephrology provider to chronic metabolic acidosis from ileat requiring supplemental sodium bicat having contact with the bowel wall. Resident #7's most recent Minimum cognitively intact. Resident #7 requit transfer, toileting, dressing and per A review of Resident #7's medical in admission. During an interview with the facility she was unable to locate document to present with nephrology. She incomposite to the proposition of the propo	rvices to help each resident achieve the IAVE BEEN EDITED TO PROTECT Conterviews the facility failed to ensure a resident the hospital discharge instructions and services (Resident # 7). cility on [DATE] with diagnoses that incommany dated 7/30/21 read in part, Pate to continue to help manage his CKD3 (real conduit (a system of urinary drainage arbonate. This refers to the secretion of an Data Set (MDS) assessment, dated 8 irred extensive assistance with most account hygiene. The cord revealed no appointments scheen as Assistant Director of Nursing on 10/2 tation of an appointment for Resident # dicated the nurse who admitted Resident # was unavailable for interview. The Director of Nursing (DON) on 10/20/2 at scheduled with a nephrologist. The Director appointments are made. 20/21 at 11:15 AM with Resident #7's profollowed up with an outpatient nephrologist at the Administrator on 10/20/21 at 3:38 PM are Administrator on	e highest possible quality of life. ONFIDENTIALITY** 39731 resident was referred to an for 1 of 1 sampled resident cluded chronic kidney disease. ient will need referral/follow up with chronic kidney disease) and e created after bladder removal) is sodium and bicarbonate due urine is sodium and bicarbonate dia so

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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 10/26/2021	
NAME OF PROVIDER OR SUPPLIE		STREET ADDRESS, CITY, STATE, ZI	D CODE	
Hertford Rehabilitation and Health		1300 Don Juan Road Hertford, NC 27944	PCODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0835	Administer the facility in a manner	that enables it to use its resources effe	ctively and efficiently.	
Level of Harm - Immediate	20711			
jeopardy to resident health or safety	Based on observation, staff interview	ew and record review the facility failed t	o implement effective systems for	
Residents Affected - Some	I .	Iff were educated and competent to cle des observed to perform fingerstick blo nd Med Aide #2).		
	Immediate Jeopardy began on 10/19/21 when administration did not ensure effective protocols or system were in place to ensure medication aides were educated and competent to clean and disinfect a shared glucometer. This was evident for 2 of 2 medication aides observed to perform fingerstick blood glucose te (Med Aide #1 and Med Aide #2). There was no protocol in place to ensure this training and competency a there was not a protocol in place to orient new medication aides. The facility was not able to show that a skills checklist was completed for the 2 medication aides. Immediate Jeopardy was removed on 10/22/21 when the facility provided and implemented an acceptable credible allegation of Immediate Jeopardy removal. The facility will remain out of compliance at a lower scope and severity level of E (No actual harr with a potential for minimal harm that is not Immediate Jeopardy) to ensure the monitoring of systems put into place and to complete facility employee and agency staff in-service orientation and training.			
	The findings included:			
	This tag is cross referenced to:			
	F880 - Based on observations, staff interviews and record review the facility failed to use an ap procedure to clean and disinfect a shared glucometer used for 5 of 5 residents (Resident #15, # and #1). Shared glucometers can be contaminated with blood and must be cleaned and disinfe each use with an approved product and procedure. Failure to use an Environmental Protection (EPA) approved disinfectant in accordance with the manufacturer of the glucometer increased of the spread of blood borne infections between residents. Failure to disinfect a shared glucome observed when 2 of 2 medication aides were observed to perform a fingerstick blood glucose to residents and did not disinfect the glucometer per manufacturer 's specifications (Med Aide #1 Aide #2). On 10/19/21 at 12:10 PM an interview was conducted with the Assistant Director of Nursing (Al was also the Infection Control Nurse in the facility. The ADON stated she was also was responsitationing in the facility. The ADON stated that Med Aide #1 had recently received her certification started working as a med aide. The ADON further stated that Med Aide #1 received orientation medication (med) cart for 2-3 days with a nurse until the Med Aide was comfortable. The ADON Med Aide #2 was from an agency and was expected to be able to go straight to the med cart at The ADON further stated that agency staff received some general orientation to the facility but receive training related to medications or the glucometer. (continued on next page)			

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NAME OF PROVIDER OR SUPPLIE	-n	CTREET ADDRESS CITY STATE 71	D CODE
		STREET ADDRESS, CITY, STATE, ZI 1300 Don Juan Road	PCODE
Hertford Rehabilitation and Healtho	care Center	Hertford, NC 27944	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	On 10/20/21 at 1:20 PM the ADON the facility on 9/23/21 and had work not a training protocol in place for the worked on the med cart most of the shift. The ADON stated that Med Aid worked on the med cart and would glucose for the residents on her ass to 7 PM shift and Med Aide #2 work. On 10/21/21 at 2:20 PM an interview ith Med Aide #1 for 1-2 days. The discussed things that came up during lucose to do they did that. The Nulet it air dry. The Nurse further state minutes while they were talking about 10/20/21 at 11:15 AM the Nurse Aide #2, but they did not address the On 10/20/21 at 11:42 AM the ADOI days when she first started as a med Aide #1 was trained on cleaning and On 10/20/21 at 10:45 AM the Adminimediate Jeopardy removal indicated and disinfect as required to have a blood sugar glucon to disinfecting the glucometer in be adequate evidence of education and Every resident that receives a finger The facility administration team, income and Unit Manager failed to implement checks and failed to educate the lice procedures. The administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to have a process in place to train in the facility administration failed to the facility administration failed to have a process in place to train in the facility administration failed to the facility administration failed to the facil	stated in an interview that Med Aide # ked under the guidance of Nurse #1. The he nurse that trained the Med Aide. The at time she worked and would frequently ide #2 had worked in the facility for at lifter frequently use a glucometer during her signed hall. The ADON further stated the ked mostly 7 AM to 7 PM but had worked was conducted with Nurse #1 who so Nurse further stated she did not have not make the facility of the working medication pass. The Nurse stated rese stated she would physically wipe the ed she observed Med Aide #1 to clean bout other things related to the med pass of the consultant stated they had education her cleaning or disinfecting procedures for the ADON further stated she had disinfecting the glucometer. Inistrator was notified of the Immediate gration of Immediate Jeopardy removal atted: The stated in an interview that Med Aide is a shared glucometer used for five resider to see. The facility Certified Medication and training provided prior to staff performance of the provided prior to staff performance in the pr	1 started working as a Med Aide in the ADON further stated there was a ADON stated Med Aide #1 had a use the glucometer during her east several months and always a shift to check a fingerstick blood that Med Aide #1 worked the 7 AM and some 7 PM to 7 AM shifts. Itated she worked on the med cart a protocol for this orientation and if they had a fingerstick blood the glucometer for 3-5 minutes, then and disinfect the glucometer for 3-5 so but did not time her. I records from the agency for Med for the glucometer. #1 trained with Nurse #1 for 2-3 that no documentation that Med Jeopardy. on 10/21/21. The allegation of aides failed to use the appropriate that (#15, #2, #50, #38 and #1), aides (#1 and #2) were observed ministration team did not have ming the task. arses, Assistant Director of Nurses the use of fingerstick blood glucose aides of these policies and ore tasks were assigned and failed licy and procedures for blood

			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 10/26/2021
NAME OF PROVIDER OR SUPPLIE	ER .	STREET ADDRESS, CITY, STATE, ZI	P CODE
Hertford Rehabilitation and Healtho	are Center	1300 Don Juan Road Hertford, NC 27944	
For information on the nursing home's	plan to correct this deficiency, please conf	tact the nursing home or the state survey	agency.
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFIC	IENCIES full regulatory or LSC identifying informati	on)
F 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Unit Manager, over the Infection Couse of fingerstick blood glucose che This was completed on 10/20/21. Trevised on 10/20/21 to reflect indivinglucometers. The use of shared glucometers. The use of shared glucometers. The use of glucometers procedure for the use of glucometers cleaning and disinfecting and devel certified medication aides over the residents 'individual glucometer. The salous a blood sugar glucose has bee bedside as of 10/19/21 by the Direct from the medication aides over the ensure new admissions or resident completed on 10/20/21. On 10/21/21, responsible parties (Finders have been notified by the Aid exposure of blood borne pathogens informed that we will be using indivithat the local Health Department has provide regarding the potential expinitive that the Health Department has provide regarding the potential expinitive to cleaning and disinfect glucose monitoring cleaning checklinclude observation and return demigermicidal bleach wipes and the confollowing cleaning check list process spread of blood borne pathogens a and certified medication aides regain will continue to clean and disinfect the residents' bedside. This education assistant Director of Nursing. Effective process and certified medication aides.	prices educated the administrative team control Manual-Glucometer Decontaministrative team control Manual-Glucometer he Infection Control Manual-Glucometer he Infection Control Manual-Glucometer dual use glucometers will be used for elector of Nursing and the Assistant Director and the county Health Department nurs with residents, reviewed the manufactoped a plan of action and an education facility 's corrective action plan and over administrative corrective plan of acting given an individually assigned glucortor of Nursing (DON). The previously sters are available for staff that do the first with new orders for FSBS have their services and those residents the sistant Director of Nursing or Director and the continuous didual glucometers for each resident. Resident to not properly disinfecting a shall do been notified and we will be following source to blood borne pathogens. The henendations would be completed and prestrator indicated to the Health Departmentations. The diducementation of the Health Departmentation of the Health Departmentation. This checklist indicates the intact time required is 3 minutes. The esting the glucometers due to the likelihood mong residents. The education has being the procedure for cleaning and did the individually issued glucometers befutive 10/20/21, no medication aide or lication of the blood glucose monitoring of the procedure for cleaning and did the individually issued glucometers befutive 10/20/21, no medication aide or lication of the blood glucose monitoring of the procedure for cleaning and did the individually issued glucometers befutive 10/20/21, no medication aide or lication of the blood glucose monitoring of the procedure for cleaning and did the individually issued glucometers befutive 10/20/21, no medication aide or lication of the blood glucose monitoring of the procedure for cleaning and did the individually issued glucometers befutive 10/20/21, no medication aide or lication of the blood glucose monitoring of the procedure for cleaning and did the individually	ation policy and procedures for the ers and cleaning requirements. Er Decontamination policy was each resident versus shared policy. Actor of Nursing worked with the rise to review the policy and currer's recommendations for a tool for training nurses and er the proper management of the ion ensured that each resident that meter that has been placed at their chared glucometers were removed agerstick blood sugar (FSBS) to own glucometer. This was attreceive fingerstick blood sugar of Nursing of the potential red glucometer. They were read and residents were informed ag any recommendations that they dealth Department Nurse, on site rovided to the facility in ent Nurse that the facility would the DON or ADON on the siguidelines using the blood wers the process of cleaning, it will facility will use the (name of) ducation includes the purpose for of cross contamination and the en provided to all licensed nurses sinfecting glucometers, that they ore and after use that are stored at Director of Nursing and the ensed nurse will do a fingerstick

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2021	
NAME OF PROVIDER OR SUPPLI	FD.	STREET ADDRESS, CITY, STATE, ZI	P CODE	
Hertford Rehabilitation and Health		1300 Don Juan Road Hertford, NC 27944	r CODE	
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0835 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	The Director of Nursing will be responented and trained before perform be performed by the DON, ADON of agency staff before the fingerstick is the process of cleaning and will incleated from the process of cleaning and will incleated from the facility will use the (name of) germined ducation includes the purpose for of cross contamination and the spread of crediting ducometers and infection glucometers for each resident that in the resident 's room with a suppilication of the cross and stored in each resident that in the resident 's staff followed the same procedure to case and stored in each resident's the glucometer prior to testing her to fin-service training for the nurses of cleaning and included observation (name of) germicidal bleach wipes purpose for following the cleaning contamination and the spread of bleaudits completed per their credible. Staff from the local Health Departm Nursing (DON) on 10/26/21 at 12:1 and they had no additional recommodation that the partment. Review of the facility documentation glucose monitoring without the required demonstration evidence for all licer	consible to ensure licensed nurses and ning the task of a fingerstick blood sugar or Unit Manager for any new facility nurblood glucose checks are done. The tractude observation and return demonstraticidal bleach wipes and the contact time following cleaning check list process for lead of blood borne pathogens among rediate Jeopardy 10/22/21. 45 PM, multiple staff members were intriviewed staff members validated they had not control. Interviewed staff members were quired blood glucose checks. Staff start strips. Three staff members wand hygiene, cleaned the glucometer was for the glucometer to air dry. After test to clean the glucometer. The glucometer is room. A resident who was cognitively blood glucose and again afterwards. The and the med aides. The training/education and return demonstration. This check and the contact time required was 3 metheck list process for glucometers was ood borne pathogens among residents	certified medication aide staff are ar check. Continued education will sees of certified med aides and aining/education checklist covers ition. This checklist indicates the required is 3 minutes. The or glucometers due to the likelihood esidents. Berviewed. This included nurses and ad attended in-service training ere aware of the individual sated each glucometer was stored ere observed to perform blood ith a disinfecting wipe for the ting the resident's blood glucose, er was then returned to a storage intact reported the staff cleaned he facility provided documentation ation checklist covered the process klist indicated the facility would use inutes. The education included the due to the likelihood of cross. The facility also had documented ing an interview with the Director of a with the local Health Department received an official report from the would be allowed to perform blood on. Training and return reviewed.	

			NO. 0936-0391
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 10/26/2021
NAME OF PROVIDER OR SUPPLIF		STREET ADDRESS, CITY, STATE, ZI 1300 Don Juan Road Hertford, NC 27944	P CODE
For information on the nursing home's	plan to correct this deficiency, please con	tact 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	Provide and implement an infection **NOTE- TERMS IN BRACKETS IN Based on observations, staff intervice clean and disinfect a shared glucor reviewed for fingerstick blood glucobe cleaned and disinfected after earner commental Protection Agency (glucometer increased the likelihood disinfect a shared glucometer was fingerstick blood glucose test on restaff performed hand hygiene where #209, #212, #200, and #202). Immediate Jeopardy began on 10/resident on her assigned hall using to disinfect the glucometer between facility provided and implemented a facility will remain out of compliance for minimal harm that is not Immediate complete employee in-service trains. The findings included: Review of the facility policy titled G was to implement a safe and effect. The policy statement read: In the effect and the glucometer: E. Wipe the monite ensure wet for entire time instructe. The manufacturer instructions for the follows: To disinfect your meter, cledisinfecting wipe used by the facility meter including both front and back at room temperature for the contact air dry. The directions on the container of second container of secon	in prevention and control program. HAVE BEEN EDITED TO PROTECT Contiews and record review the facility faile meter used for 5 of 5 residents (Reside use tests. Shared glucometers can be continued as a shared glucometer of the spread of blood borne infection observed when 2 of 2 medication aided of the spread of blood borne infection observed when 2 of 2 medication aided sidents (Med Aide #1 and Med Aide #2 in passing trays to 8 of 8 resident rooms and a shared glucometer and did not follow in residents. Immediate Jeopardy was rean acceptable credible allegation of Immediate Jeopardy to ensure monitoring of ing. Example #2 was cited at a scope as a lucometer Decontamination dated 02/1 give process for decontaminating glucon vent that glucometers are shared within proved wipes following use on each resonant ensure it is visibly wet (May wrang). Allow the monitor to air dry. The glucometer used by the facility instruction of the validated y was included in the manufacturer's in a surfaces until visibly clean. Allow the time listed on the wipe's directions for the disinfected. The contact time listed to be disinfected. The contact time listed to be disinfected. The contact time listed to the	d to use an approved procedure to nt #15, #2, #50, #38 and #1) contaminated with blood and must procedure. Failure to use an ince with the manufacturer of the size between residents. Failure to sewere observed to perform a common with the size of the facility also failed to ensure so (Rooms #306, #204, #203, #210, ringerstick blood glucose test for a with the manufacturer is instructions emoved on 10/22/21 when the mediate Jeopardy removal. The facility also failed to ensure so (Rooms #306, #204, #203, #210, ringerstick blood glucose test for a with the manufacturer is instructions emoved on 10/22/21 when the mediate Jeopardy removal. The facility are greatly in place and to and severity of D. 8 listed the purpose of the policy meters after use on each resident. In a facility, the glucometer shall be sident. If Cleaning and disinfecting of glucometer with wipe in order to conclude the disinfection procedure as disinfecting wipes listed below. The list. Wipe all external areas of the surface of the meter to remain wet or use. Wipe meter dry or allow to cility read: Apply pre-saturated

s instructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe jeopardy to resident health or safety Residents Affected - Some 1. On 10/19/21 at 11:40 AM, Med Aide #1 was observed to check a fingerstick blood glucose for Resident #15. The Med Aide was observed to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer front and back for approximately three seconds, disposed of the wipe, dried the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication cart. During the observation, Med Aide #1 stated that the residents did not have their own glucometer and the c she used, was shared between other residents. The Med Aide stated that at this time she had no further blood glucose checks. A second interview was conducted with Med Aide #1 on 10/19/21 at 2:15 PM. The Med Aide stated she to a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit a dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous whe being observed to do the fingerstick blood glucose. A review of each resident 's electronic medical record revealed the following: —In addition to the blood glucose level observed to be checked by Med Aide #1 on 10/19/21 at 11:40 AM, Resident #15 also had her blood glucose results documented by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. —In addition, Resident #2 had a blood glucose documented as checked by Med Aide #1 at 8:00 AM and p to lunch on 10/19/21. A blood glucose was also documented for Resident #2 on 10/14/21 at 12 Noon and 4:00 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) who was also the Infection Control Nu stated in an interview that Med Aide #1 was oriented on the medication cart for 2-3 days by one of the nure until the Med Aide felt co		1			
NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center 1300 Don Juan Read 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) The blood glucose monitor cleaning skills checklist provided by the facility read as follows: 6, Wipe the monitor thoroughly, ensuring it is vitably wat and place on a clean surface. 7, Follow the wipe manufacture is instructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe necessary, to ensure it remains wet for the required time. 8. Once the appropriate length of time has elapsed, allow the monitor to air dry on a clean surface. 1. On 10/19/21 at 1.140 AM, Med Aidé #1 was observed to return to the propriate length of time has elapsed, allow the monitor to air dry on a clean surface. 1. On 10/19/21 at 1.140 AM, Med Aidé #1 was observed to the propriate length blood glucose for Resident #15. The Med Aide sostered to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer front and back for approximately three seconds, disposed of the wipe. dried the glucometer with a tissue, was paped the glucometer in the tissue and placed it back on the medication cart. During the observation, Med Aidé #1 stated that the residents did not have their own glucometer and the c she used, was shared between other residents. The Med Aide atta at this time she had no further blood glucose checks. A second interview was conducted with Med Aide #1 on 10/19/21 at 2.15 PM. The Med Aide stated she to a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide #1 on 10/19/21 at 2.10 PM. Med Aide #1 on 1		IDENTIFICATION NUMBER:	A. Building	COMPLETED	
Hertford Rehabilitation and Heatthcare Center 1300 Don Juan Road Hertford, No 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) The blood glucose monitor cleaning skills checklist provided by the facility read as follows: 6. Wipe the monitor thoroughly, ensuring it is visibly wet and place on a clean surface. 7. Follow the wipe manufacture is instructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe necessary, to ensure it remains wet for the required time. 6. Once the appropriate length of time has elapsed, allow the monitor to air dry on a clean surface. 1. On 10/19/21 at 11/40.0 M. Med Ald aff at state the required time. 6. Once the appropriate length of time has elapsed, allow the monitor to air dry on a clean surface. 1. On 10/19/21 at 11/40.0 M. Med Ald aff at state that the residents and used a germical bleach wipe and wiped the glucometer manufacture is a state of the state		343202	B. Wing	10/20/2021	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency. SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) The blood glucose monitor cleaning skills checklist provided by the facility read as follows: 6. Wipe the monitor thoroughly, ensuring it is visibly wet and place on a clean surface. 7. Follow the wipe manufacture sinstructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe necessary, to ensure it remains wet for the required time. 8. Once the appropriate length of time has elepsed, allow the monitor to air dry on a clean surface. 1. On 10/19/21 at 11.40 AM, Med Aide #1 was observed to check a fingerstick blood glucose for Resident #15. The Med Aide was observed to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication and back for approximately three seconds, disposed of the wipe, dired the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication and back of a placed that the recibilities of the following of the used, was shared between other residents. The Med Aide stated that at this time be had no further blood glucose checks. A second interview was conducted with Med Aide #1 on 10/19/21 at 2:15 PM. The Med Aide stated she to a med aide class at all colar collegies and they were taught to wipe of the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit a dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous whe being observed to do the fingerstick blood glucose to be checked by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. -In addition to the blood glucose level observed to be checked by Med Aide #1 on 1	NAME OF PROVIDER OR SUPPLI	ER	STREET ADDRESS, CITY, STATE, ZI	P CODE	
EVALUATION OF CONTROLL OF CONT	Hertford Rehabilitation and Healthcare Center 1300 Don Juan Road				
F 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Residents Affected - Some 1. On 10/19/21 at 11:40 AM, Med Aide #1 was observed to check a fingerstick blood glucose for Resident was networker with a died class at a local college and they were taught to wise their observed to the six and some died class at a local college and they were taught to wise observed to the six and they glucometer with a tissue, wrapped the glucometer with a tissue, wrapped the glucometer with a tissue and place of the wipe, dried the she used, was shared between other residents. The Med Aide #1 stated that the residents did not have their own glucometer and the check and the six	For information on the nursing home's	plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some Residents Affected - Some 1. On 10/19/21 at 11:40 AM, Med Aide #1 was observed to check a fingerstick blood glucose for Resident #15. The Med Aide was observed to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer front and back for approximately three seconds, disposed of the wipe, dried the glucometer with a tissue, wrapped the glucometer in the tissue and paced it back on the medication cart and used a germicidal bleach wipe and wiped the glucometer with a tissue, wrapped the glucometer in the tissue and leaded it back on the medication cart. During the observation, Med Aide #1 stated that the residents did not have their own glucometer and the c she used, was shared between other residents. The Med Aide stated that at this time she had no further blood glucose checks. A second interview was conducted with Med Aide #1 on 10/19/21 at 2:15 PM. The Med Aide stated she to a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit a dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous whe being observed to do the fingerstick blood glucose. A review of each resident 's electronic medical record revealed the following: —In addition to the blood glucose level observed to be checked by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. —In addition, Resident #2 had a blood glucose documented as checked by Med Aide #1 at 8:00 AM and pt to lunch on 10/19/21 at 0.10 AM, Resident #2 had a blood glucose was also documented for Resident #2 on 10/14/21 at 12 Noon and 4:00 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) who was also the infection Control Nu stated in an interview that Med Aide #1 was oriented on the medication cart for 2-3 days by one of the nur u	(X4) ID PREFIX TAG				
#15. The Med Aide was observed to return to the medication cart and used a germicidal bleach wipe and wiped the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication cart. During the observation, Med Aide #1 stated that the residents did not have their own glucometer and the c she used, was shared between other residents. The Med Aide stated that at this time she had no further blood glucose checks. A second interview was conducted with Med Aide #1 on 10/19/21 at 2:15 PM. The Med Aide stated she to a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit a dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous whe being observed to do the fingerstick blood glucose. A review of each resident 's electronic medical record revealed the following: —In addition to the blood glucose level observed to be checked by Med Aide #1 on 10/19/21 at 11:40 AM, Resident #15 also had her blood glucose results documented by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. —In addition, Resident #2 had a blood glucose documented as checked by Med Aide #1 at 8:00 AM and problems to 10/19/21. A blood glucose was also documented for Resident #2 on 10/14/21 at 12 Noon and 4:00 PM by Med Aide #1. —In addition, Resident #50 had a blood glucose documented as checked by Med Aide #1 on 10/19/21 at 8 AM and on 10/14/21 at 12 Noon and 4:00 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) who was also the Infection Control Nurstated in an interview that Med Aide #1 was oriented on the medication cart for 2-3 days by one of the nursuniti the Med Aide felt comfortable. The ADON stated the staff was to disinfect the glucometer before and after use because the glucometer was shared between residents. The ADON further stated the staff were use the wipes to clean the gl	Level of Harm - Immediate jeopardy to resident health or	monitor thoroughly, ensuring it is visibly wet and place on a clean surface. 7. Follow the wipe manufacturer 's instructions for the length of time the monitor must remain wet. Wrap the monitor with an additional wipe, if necessary, to ensure it remains wet for the required time. 8. Once the appropriate length of time has			
a med aide class at a local college and they were taught to wipe off the glucometer before and after each resident. The Med Aide further stated the glucometer was supposed to be wet for 15-20 seconds and sit a dry for 3-5 minutes. On 10/19/21 at 4:00 PM, Med Aide #1 stated she knew how to clean the glucometer but was nervous whe being observed to do the fingerstick blood glucose. A review of each resident 's electronic medical record revealed the following: In addition to the blood glucose level observed to be checked by Med Aide #1 on 10/19/21 at 11:40 AM, Resident #15 also had her blood glucose results documented by Med Aide #1 on 10/14/21 at 12 Noon and 4:00 PM. In addition, Resident #2 had a blood glucose documented as checked by Med Aide #1 at 8:00 AM and problem to lunch on 10/19/21. A blood glucose was also documented for Resident #2 on 10/14/21 at 12 Noon and 4:00 PM by Med Aide #1. In addition, Resident #50 had a blood glucose documented as checked by Med Aide #1 on 10/19/21 at 8 AM and on 10/14/21 at 12 Noon and 4:00 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) who was also the Infection Control Nurstated in an interview that Med Aide #1 was oriented on the medication cart for 2-3 days by one of the nursuntil the Med Aide felt comfortable. The ADON stated the staff was to disinfect the glucometer before and after use because the glucometer was shared between residents. The ADON further stated the staff were use the wipes to clean the glucometer and wait for 5 minutes to dry. On 10/19/21 at 2:00 PM the Administrator provided the date that Med Aide #1 started on the medication cas being 9/23/21.	Residents Affected - Some	wiped the glucometer front and back for approximately three seconds, disposed of the wipe, dried the glucometer with a tissue, wrapped the glucometer in the tissue and placed it back on the medication cart. During the observation, Med Aide #1 stated that the residents did not have their own glucometer and the one she used, was shared between other residents. The Med Aide stated that at this time she had no further			
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(continued on next page)		On 10/19/21 at 2:00 PM the Administrator provided the date that Med Aide #1 started on the medication cart as being 9/23/21.			
		(continued on next page)			

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2021	
-D	STREET ADDRESS CITY STATE 71	P CODE	
NAME OF PROVIDER OR SUPPLIER Hertford Rehabilitation and Healthcare Center		1300 Don Juan Road	
plan to correct this deficiency, please con	tact the nursing home or the state survey	agency.	
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)			
be disinfected with the bleach wipe and the contact time was the time li which was 3 minutes. The Nurse Consultant further stated the glucometer The Nurse Consultant stated they would begin in-services immediately way to disinfect the glucometer. The Nurse Consultant stated they had glucometers for residents that required fingerstick blood glucose tests. 2. On 10/19/21 at 11:48 AM, Med Aide #2 (agency) was observed to de Resident #38. The Med Aide was observed to return to the medication and wiped the glucometer for approximately 5 seconds, disposed of the a tissue and placed in a drawer on the medication cart. On 10/19/21 at 2:15 PM Med Aide #2 stated in an interview she had be worked for the agency for 1 year. The Med Aide further stated she did in glucometer from the agency but in some of the buildings she had worked glucometer with the bleach wipe and it needed to be wet for 2-3 minutes. On 10/20/21 at 8:26 AM, Med Aide #2 stated in an interview she knew 3 minutes, but she had medications to pass and she did not do it. —In addition to the blood glucose level checked on 10/19/21 at 11:48 A glucose for Resident #1 on 10/19/21 prior to lunch. There was also a bl #1 by Med Aide #2 on 10/1/21 and 10/6/21 at 11:30 AM and 4:30 PM.		the glucometer was supposed to ed on the bleach wipe container was shared between residents. educate the staff on the proper dered and received individual fingerstick blood glucose on and removed an approved wipe ripe and wrapped the glucometer in a Med Aide for 7 years and had receive training on how to clean a she was told to wipe off the e glucometer needed to stay wet for Med Aide #2 documented a blood d glucose documented on Resident Lin an interview that Med Aide #2	
to clean the glucometer before and further stated the staff were to use The Nurse Consultant stated in an disinfected with the bleach wipe an was 3 minutes. The Nurse Consultant Nurse Consultant stated they would disinfect the glucometer. The Nurse for residents that required a fingers to be used. On 10/20/21 at 10:45 AM, the Adm The facility provided a credible allegimmediate jeopardy removal indica	after use because they were using a sthe wipes to clean the glucometer and interview on 10/19/21 at 2:10 PM that to the contact time was the time listed cant further stated the glucometer was stop begin in-services immediately to educe Consultant stated they had ordered a tick blood glucose test but had not yet inistrator was informed of the Immediategation of Immediate Jeopardy removal ted:	chared glucometer. The ADON wait for 5 minutes to dry. The glucometer was supposed to be on the bleach wipe container which chared between the residents. The cate the staff on the proper way to not received individual glucometers put them in the resident 's rooms the Jeopardy.	
	IDENTIFICATION NUMBER: 345262 ER care Center plan to correct this deficiency, please con SUMMARY STATEMENT OF DEFIC (Each deficiency must be preceded by) The Nurse Consultant stated in an be disinfected with the bleach wipe which was 3 minutes. The Nurse C The Nurse Consultant stated they way to disinfect the glucometer. Th glucometers for residents that requive a tissue and placed in a drawer on On 10/19/21 at 2:15 PM Med Aide worked for the agency for 1 year. T glucometer from the agency but in glucometer with the bleach wipe ar On 10/20/21 at 8:26 AM, Med Aide worked for the had medications with the state of the same and placed in a drawer on On 10/19/21 at 12:10 PM the Assis was an agency Med Aide that had to clean the glucometer before and further stated the staff were to use The Nurse Consultant stated in an disinfected with the bleach wipe an was 3 minutes. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse Consultant stated they would disinfect the glucometer. The Nurse for residents that required a fingers to be used. On 10/20/21 at 10:45 AM, the Adm The facility provided a credible alle immediate jeopardy removal indicated. Credible Allegation of Immediate Jeopardy removal indicated.	IDENTIFICATION NUMBER: 345262 A. Building B. Wing STREET ADDRESS, CITY, STATE, ZI 1300 Don Juan Road Hertford, NC 27944 plan to correct this deficiency, please contact the nursing home or the state survey SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying informati The Nurse Consultant stated in an interview on 10/19/21 at 2:10 PM, that be disinfected with the bleach wipe and the contact time was the time liste which was 3 minutes. The Nurse Consultant further stated the glucometer The Nurse Consultant stated they would begin in-services immediately to way to disinfect the glucometer. The Nurse Consultant stated they had or glucometers for residents that required fingerstick blood glucose tests. 2. On 10/19/21 at 11:48 AM, Med Aide #2 (agency) was observed to do a Resident #38. The Med Aide was observed to return to the medication ca and wiped the glucometer for approximately 5 seconds, disposed of the w at issue and placed in a drawer on the medication cart. On 10/19/21 at 2:15 PM Med Aide #2 stated in an interview she had been worked for the agency for 1 year. The Med Aide further stated she did not glucometer with the bleach wipe and it needed to be wet for 2-3 minutes. On 10/20/21 at 8:26 AM, Med Aide #2 stated in an interview she knew the 3 minutes, but she had medications to pass and she did not do it. In addition to the blood glucose level checked on 10/19/21 at 11:48 AM, glucose for Resident #1 on 10/19/21 prior to lunch. There was also a bloo #1 by Med Aide #2 on 10/1/21 and 10/6/21 at 11:30 AM and 4:30 PM. On 10/19/21 at 12:10 PM the Assistant Director of Nursing (ADON) stated was an agency Med Aide that had worked in the facility for several month to clean the glucometer before and after use because they were using a s further stated the staff were to use the wipes to clean the glucometer and The Nurse Consultant stated in an interview on 10/19/21 at 2:10 PM that it disinfected with the bleach wipe and the contact time was the time	

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TATEMENT OF DEFIC by must be preceded by illed to use the approp 5, #2, #50, #38 and # and Med Aide #2 on	1300 Don Juan Road Hertford, NC 27944 Intact the nursing home or the state survey CIENCIES Yould regulatory or LSC identifying information	agency.
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iled to use the approp 5, #2, #50, #38 and # and Med Aide #2 on	full regulatory or LSC identifying informati	on)
5, #2, #50, #38 and # and Med Aide #2 on	- data and a data data data data data dat	
SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information) The facility failed to use the appropriate procedure to clean and disinfect shared glucometers used for 5 residents, #15, #2, #50, #38 and #1, required to have a blood sugar glucose. The facility failed to educate Med Aide #1 and Med Aide #2 on how to clean and disinfect a shared glucometer according to manufacture is instructions when used for multiple residents. Med Aide #1 and #2 were observed not disinfecting the glucometer in between residents on 10/19/21. Each resident that has a blood sugar glucose has been given an, individually assigned glucometer that he been placed at their bedside as of 10/19/21 by the Director of Nursing (DON). The previously shared glucometers were removed from the medication carts. Extra glucometers are available for staff that do the fingerstick blood sugar (FSBS) to ensure new admissions or residents with orders for FSBS 's have their own glucometer. Current medication aides and licensed nurses will receive training on the importance of cleaning and disinfecting the glucometer per manufacture's guidelines using the Blood Glucose Monitoring/Cleaning checklist. This checklist indicates the facility will use the (name of) germicidal bleach wipes and the contact time required is 3 minutes. Education ensures that staff understand, even though the residents have their own glucometers, they still have to clean and disinfect them after every use according to the manufacture instructions. The education includes the purpose for following cleaning check list process for glucometers due to the likelihood of cross contamination and the spread of blood borne pathogens among residents. This education was started on 10/19/21 by the Director of Nursing and the Assistant Director of Nursing. Effective 10/20/2 no medication aide or licensed nurses will do a fingerstick blood sugar check without the validation of the blood glucose monitoring checklist. This will include agen		ween residents on 10/19/21. ally assigned glucometer that has DN). The previously shared are available for staff that do the horders for FSBS's have their importance of cleaning and I Glucose Monitoring/Cleaning idal bleach wipes and the contact though the residents have their se according to the manufacturer's among residents. This education cor of Nursing. Effective 10/20/21 ck without the validation of the Interest of the Interest of Nursing will be glucose monitoring checklist. Interest of Nursing will be glucose monitoring checklist.
1 N C O / C	ted to shared glucomyere not followed. The droproceed with the een put in place. She additional recommendation will be provided cleaning and disinfer that the facility will for parties of the affected pathogens through epartment Nurse is one Administrator has in eges removal of Immediate pathogens and the partment of	ted to shared glucometers and the cleaning/disinfecting proceer not followed. The Medical Director was informed that the drop proceed with the issuance of individually assigned glucometer put in place. She did indicate she was going to speak to additional recommendations. She was informed of the convation will be provided to all licensed nurses and certified me cleaning and disinfecting glucometers. The Health Department that the facility will follow any recommendations made by the parties of the affected residents have been notified as of 10/2 apathogens through the use of shared blood glucose glucometers. The Health Department Nurse is on site as of 10/21/21 to evaluate the new Administrator has informed the Health Department Nurse to egge removal of Immediate Jeopardy on 10/22/21.

			NO. 0936-0391
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 10/26/2021
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 con	tact 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345262	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 10/26/2021	
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 con	tact 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 0880 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Some	An interview was conducted with the Assistant Director of Nursing on 10/20/21 at 10:52 AM and she stated that she was responsible for the facility's infection control program. She explained staff were instructed to use hand sanitizer every time they went in a resident's room and to wash their hands after direct care. She stated NA #3 should have performed hygiene before and after delivering each meal tray. During an interview with the Administrator on 10/20/21 at 3:38 PM he stated staff have been trained to			
Residents Affected - Some	perform hand hygiene when passing meal trays and NA #3 should have performed hand hygiene when passing resident meal trays.			