STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
{D 000}	Initial Comments The Adult Care Licensure Section conducted a follow-up survey and a COVID-19 focused Infection Control survey, with an onsite visit on September 4, 2020 and a desk review survey from September 8, 2020 to September 10, 2020. A telephone exit was conducted on September 10, 2020.	{D 000}		
D 338	10A NCAC 13F .0909 Resident Rights 10A NCAC 13F .0909 Resident Rights An adult care home shall assure that the rights of all residents guaranteed under G.S. 131D-21, Declaration of Residents' Rights, are maintained and may be exercised without hindrance. This Rule is not met as evidenced by: TYPE A2 VIOLATION Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to use of personal protective equipment (PPE) for a newly admitted resident; practicing social distancing and isolating the newly admitted resident and residents post hospital discharge in their assigned rooms for 14 days; practicing infection control procedures and maintaining safety precautions to reduce the risk of transmission and infection. The findings are: Review of the Centers for Disease Control (CDC)	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 1	D 338		

guidelines for the prevention and spread of the coronavirus disease in long term care (LTC) facilities revealed:
-Residents can be transferred out of the observation area to the main facility if they remain afebrile (without a fever) and without symptoms for 14 days after their admission.
-Ensure that environmental cleaning and disinfection procedures are followed consistently and correctly.

Review of notification from the North Carolina Department of Health and Human Services dated 08/11/20 revealed:
-Residents with negative or unknown COVID-19 status should be kept in quarantine until 14 days after admission/readmission.
-Incoming residents should be placed in quarantine, away from the general facility population, for 14 days after admission to assure they are not in the incubation phase (the time from the moment of exposure to an infectious agent until signs and symptoms of the disease appear).

Review of the facility's Policy and Procedure for Infection Control dated 09/04/20 revealed:
-All new admissions with no documentation of a negative COVID-19 test are to quarantine for 14 days in an isolation room with isolation posted on the doors to the bathroom and the resident's room.
-Also residents were reminded to ring the bell when help was needed with anything.
-Residents were to wear a mask when outside of their room.
-Staff were to clear the hallway and walk resident to and from the bathroom.
-The common bathroom door was to remain locked at all times when not in use by the isolated

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 2	D 338		

resident.
-Staff stayed by the bathroom door and waited to walk the resident back to their room.
-Staff were to disinfect the bathroom after each use and lock the door until next use was needed by the isolated resident.
-Staff were also to remind the resident that he was in quarantine and to stay in his room and to ring the bell if staff was needed.
-If COVID-19 testing was completed within the 14 days of quarantine and was negative the resident may come out of quarantine.
-Whenever out of quarantine the resident was still required to wear a mask when outside of their room.

1.Review of Resident #1's FL2 dated 09/02/20 revealed diagnosis of mild intellectual disability and attention deficit disorder.

Review of Resident #1's resident register revealed Resident #1 was admitted on 09/03/20.

Interview with the Administrator on 09/04/20 at 10:51 am revealed:
-There were no residents in the facility awaiting COVID-19 testing or COVID-19 test results.
-There were no residents on isolation in the facility.

Observation of Resident #1's bedroom on 09/04/20 at 11:26am and 11:59am revealed:
-The bedroom door was opened.
-There was no isolation signage posted on the room door.

Observation of the men's hallway of the facility on 09/04/20 at 11:38am revealed:
-Resident #1 walked the entire length of the men's hallway to the ice cart near the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 3	D 338		

Administrator's office with no mask on.
-Resident #1 approached a staff member standing in the hallway beside the ice cart and began to talk to her with no mask on.
-There was not six feet between Resident #1 and the staff member as they talked.
-The staff escorted Resident #1 through the TV room in to an office near the entrance of the facility to retrieve a mask.
-The staff did not direct Resident #1 back to his room.

Observation of the TV room at the facility on 09/04/20 at 11:09am revealed there were 3 residents in the TV room wearing mask and social distancing.

Observation of Resident #1 on 09/04/20 at 12:13pm revealed:
-Resident #1 walked the entire length of the men's hallway and the women's hallway to exit the facility out the exit door on the women's hallway with his mask on.
-Resident #1 walked passed staff that did not direct him back to his room.

Interview with Resident #1 on 09/04/20 at 11:26am revealed:
-He was admitted to the facility on 09/03/20.
-He had never had a COVID-19 test done.
-His mask from the previous facility was left in the transport van when he arrived.
-No one at the facility had talked to him about COVID-19 at the facility.
-He could go anywhere inside the facility and outside the facility as long as he did not "wander off".
-He was not given a mask to wear at this facility.

Second interview with Resident #1 on 09/04/20 at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 4 11:59am revealed: -He had gone to the bathroom. -He had asked staff for toilet paper. -Staff told him he had to wear a mask when outside of his room. -That was the first time staff had given him a mask. -Staff told him that he had to wear a mask when he left his room. -Staff did not tell him he had to stay in his room. Interview with a medication aide (MA) on 09/04/20 at 11:49am revealed: -Resident #1 was admitted on 09/03/20. -She noticed Resident #1 did not have a mask on while walking down the men's hallway. -She had just given Resident #1 a mask to wear when outside of his room on 09/04/20 at 11:38am. -This was the first time she noticed he did not have a mask. -She told Resident #1 to ask staff if he needed another mask. Interview with a personal care aide (PCA) on 09/04/09 at 12:03pm revealed: -Resident #1 was admitted on 09/03/20. -She did not know if the resident was on isolation or not. Interview with a second PCA on 09/04/20 at 12:06pm revealed Resident #1 could come and go in the facility as long as he had on a mask. Interview with the transport staff on 09/04/20 at 12:27pm revealed: -Resident #1 was transported to the facility on 09/03/20. -He did not give Resident #1 a mask during transport.	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 5	D 338		

-Resident #1 had a negative COVID-19 test (not sure of date).
-All new admission that he picked up had to have a negative COVID-19 test.

Interview with the Resident Care Coordinator (RCC) on 09/04/20 at 12:14pm revealed:
-Residents with a negative COVID-19 test prior to admission did not need to be quarantined.
-She thought new admissions were to be isolated to their room for 10 to 14 days if they did not have a negative COVID-19 test.
-The facility had just started the new admissions policy on 09/04/20.
-The facility had just got a new resident on 09/03/20.
-She did not think she saw a COVID-19 test for Resident #1.
-She did not have a COVID-19 test for Resident #1.
-Since Resident #1 did not have a COVID-19 test he would be quarantined and monitored for signs and symptoms of COVID-19 for 10 to 14 days.
-Isolation signs would be posted on Resident #1's bedroom door and on the men's hall bathroom door.

Observation of the bathroom on the men's hall of the facility on 09/04/20 at 11:02am revealed:
-The bathroom door was open.
-There was a resident in the bathroom washing his hands.
-There was no isolation signage post on the bathroom door.
-There was no staff present.

Observation of the bathroom on the men's hall of the facility on 09/04/20 at 11:19am revealed:
-The bathroom door was open.
-There was no isolation signage posted on the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 6	D 338		

door.

Interview with the Administrator on 09/04/20 at 12:56pm revealed:
-Resident #1 was admitted to the facility on 09/03/20.
-She thought Resident #1 had a negative COVID-19 test prior to admission.
-Resident #1 did not have a COVID-19 test in his record.
-Resident #1 was not on isolation because she assumed Resident #1 had a negative COVID-19 test.
-The Marketing and Admission Director was responsible for making sure the new admissions had a negative COVID-19 test prior to admission to the facility.
-She had contacted the Marketing and Admission Director on 09/04/20 to see if Resident #1 had a negative COVID-19 test.
-Resident #1 should have been on a 10 to 14 day quarantine upon admission on 09/03/20.

Telephone interview with Administrator on 09/08/20 at 9:15am revealed:
-New admissions with a negative COVID-19 test did not need to be quarantined.
-She thought Resident #1 had a negative COVID-19 test prior to admission.

Telephone interview with the Marketing and Admission Director on 09/10/20 at 10:36am revealed:
-Per the facility's policy new admissions to the facility were to be quarantined for 14 day regardless of having a negative COVID-19 or not.
-The facility's policy for new admissions had been sent to the facility.
2. Review of Resident #2's FL2 dated 01/13/20 revealed diagnosis of schizophrenia and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 7	D 338		

hypertension.

Review of Resident #2's hospital discharge summary dated 08/26/20 revealed there had not been a COVID-19 test completed during her hospital stay from 08/24/20 to 08/26/20.

Interview with Resident #2 on 09/09/20 at 1:41pm revealed:
-She was released from the hospital about two weeks ago.
-She was not placed on quarantine for 14 days after she returned from the hospital.

Telephone interview with a medication aide (MA) on 09/09/20 at 1:04pm revealed:
-Resident #2 had been hospitalized two weeks ago.
-Residents who returned from the hospital to the facility were quarantined for 14 days.

Telephone interview with a second MA on 08/09/20 at 1:32pm revealed:
-Resident #2 was hospitalized about three weeks ago.
-Resident #2 was quarantined for 3 days (not 14 days) after she returned from the hospital.
-She was told by the Administrator that residents who returned from the hospital would be quarantined for 3 days.

Telephone interview with the Resident Care Coordinator (RCC) on 09/10/20 at 1:18pm revealed:
-Resident #2 was hospitalized the end of August 2020.
-Resident #2 was quarantined for 3 days (not 14 days) after she returned from the hospital.
-She received guidance for the facility's COVID-19 policies from corporate office (not sure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 8 of date). Telephone interview with the Marketing and Admission Director on 09/10/20 at 10:36am. -Residents who returned to the facility after a hospital stay were placed on quarantine for 14 days. -The facility's COVID-19 policy was effective in March 2020. Telephone interview with the Administrator on 09/10/20 at 1:43pm revealed: -Resident #2 had been placed on quarantine for 3 days (not 14 days) after her hospital stay. -She received guidance and information on COVID-19 precautions from the corporate office (not sure of date). _____ The facility failed to maintain the guidelines and recommendations established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) for infection prevention and transmission during the COVID-19 pandemic as evidence by newly admitted and readmitted residents were not quarantined for 14 days, newly admitted residents were not provided the proper personal protective equipment (PPE), a face mask to wear when outside of their room and not practicing social distancing. The facility's failure resulted in substantial risk of death and serious neglect to the health, safety and welfare of the residents for transmission and infection from COVID-19 which constitutes a Type A2 Violation. _____ The facility provided a plan of protection in accordance with G.S. 131D-34 on 09/08/20 for this violation. CORRECTION DATE FOR THE TYPE A2	D 338		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 338	Continued From page 9 VIOLATION SHALL NOT EXCEED OCTOBER 10, 2020.	D 338		
{D914}	G.S. 131D-21(4) Declaration of Residents' Rights G.S. 131D-21 Declaration of Residents' Rights Every resident shall have the following rights: 4. To be free of mental and physical abuse, neglect, and exploitation. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure residents were free from harm as related to resident rights during the COVID-19 pandemic. The findings are: 1. Based on observations, record reviews, and interviews, the facility failed to ensure recommendations and guidance established by the Centers for Disease Control (CDC) and the North Carolina Department of Health and Human Services (NC DHHS) were implemented and maintained to provide protection of the residents during the global coronavirus (COVID-19) pandemic as related to use of personal protective equipment (PPE) for a newly admitted resident; practicing social distancing and isolating the newly admitted resident and residents post hospital discharge in their assigned rooms for 14 days; practicing infection control procedures and maintaining safety precautions to reduce the risk of transmission and infection. [Refer to Tag D338, 10A NCAC 13F .0909 Resident Rights (Type A2 Violation)].	{D914}		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	R-C 09/10/2020

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HERTFORD MANOR	464 TWO MILE DESERT ROAD HERTFORD, NC 27944

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