	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 · ·			TE SURVEY MPLETED
		345262	B. WING			C 1 0/26/2021
NAME OF PF	ROVIDER OR SUPPLIER			TREET ADDRESS, CITY, STATE, ZIP CODE	1 1	0/20/2021
			1	300 DON JUAN ROAD		
BRIAN CE	NTER HEALTH & REHA	B/HERTFORD	- F	IERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
E 000	Initial Comments		E 000			
F 000		3.73, Emergency t ID 7CJI11.	F 000			
	survey was conducte 10/26/21. Event ID#	allegations was substantiated				
	Immediate Jeopardy					
	(K)	835 at a scope and severity 880 at a scope and severity				
F 550	Immediate Jeopardy removed on 10/22/2 Resident Rights/Exe		F 550			11/17/21
SS=E	CFR(s): 483.10(a)(1) §483.10(a) Resident	(2)(b)(1)(2)	F 350			11/17/21
	The resident has a ri self-determination, a access to persons ar	ght to a dignified existence, nd communication with and nd services inside and cluding those specified in				
	with respect and digr resident in a manner promotes maintenan	ity must treat each resident nity and care for each and in an environment that ce or enhancement of his or ognizing each resident's				
		SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE		(X6) DATE

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.

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED . 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345262	B. WING				_ 26/2021
NAME OF PF	ROVIDER OR SUPPLIER	I		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHAI	B/HERTFORD		1300 DON JUAN ROAD HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/ DEFICIENCY)		(X5) COMPLETION DATE
F 550	access to quality care severity of condition, must establish and m practices regarding tr provision of services of residents regardless of §483.10(b) Exercise of The resident has the rights as a resident of or resident of the Unit §483.10(b)(1) The fac resident can exercise interference, coercion from the facility. §483.10(b)(2) The res free of interference, cor reprisal from the facili rights and to be supple exercise of his or her subpart. This REQUIREMENT by: Based on observatio and resident interview maintain dignity of res doors or ask permissi for 5 of 15 residents of	ity must protect and the resident. cility must provide equal a regardless of diagnosis, or payment source. A facility aintain identical policies and ansfer, discharge, and the under the State plan for all of payment source. of Rights. right to exercise his or her f the facility and as a citizen ted States. cility must ensure that the his or her rights without n, discrimination, or reprisal sident has the right to be oercion, discrimination, and ity in exercising his or her orted by the facility in the rights as required under this is not met as evidenced n, record review, and staff	F	550	F 550 What corrective action will be accomplished for those residents found have be affected by the deficient practi Element #1 Per the 2567, on 10/17/2021, NA #3 w	ce:	
	Findings included:				Per the 2567, on 10/17/2021, NA #3 w observed entering 3 separate resident	as	

Facility ID: 943003

If continuation sheet Page 2 of 35

		ND HUMAN SERVICES MEDICAID SERVICES				RM APPROVE IO. 0938-039
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· · ·	PLE CONSTRUCTION		E SURVEY IPLETED
		345262	B. WING		1	C 0/26/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
	NTER HEALTH & REHA	PUIEDTEODD		1300 DON JUAN ROAD		
	NIER NEALIN & RENA	BINERTFORD		HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 550	Continued From page	e 2	F 55	50		
	1. Resident #2 was a 5/14/20.	admitted to the facility on ecent quarterly minimum		rooms during lunch tray pass; #32, resident # 26, and residen did not knock or wait prior to e resident room. Upon identifica	nt #33; and ntering the	
	was significantly cogr	dated 10/15/21 revealed he nitively impaired. n on 10/17/21 at 11:55 AM		#1 entering resident rooms pri- knocking and waiting, NA #1 w out and determined to not be i or reachable. The decision wa	or to vas sought n the facility	
	NA#3 entered Reside knocking to deliver hi	ent #2' s room without is lunch tray.		take this agency aide off the se to concerns of non compliance forward The Agency scheduler	chedule due e moving r was	
	#3 stated she did not enter. She stated sh	on 10/17/21 at 12:42 PM NA knock or ask permission to ne was aware she should do culate why she did not.		notified of the concern and nee education over resident dignity knocking on doors and waiting communication. No adverse of	/ specific to I for	
	on 10/20/21 at 9:47 A	with the Director of Nursing AM who stated staff should nemselves when entering a		were identified. How the facility will identify oth having potential to be affected same deficient practice.		
		nducted with the Assistant n 10/20/21 at 10:52 AM and		Element #2		
		should always knock and s when entering a resident's		All residents have the potentia affected by the deficient practi- residents were found to be adv affected by this deficient practi	ce. No versely	
	10/20/21 at 2:22 PM to knock prior to ente	ducted with Resident #2 on who stated he wanted staff ring his room. He stated he aff just walked into his room		What measures will be put into systematic changes made to e deficient practice does not rec	ensure the	
				Element #3		
	10/20/21 at 3:38 PM trained on resident rig NA #3 should have ki	vith the Administrator on he stated staff have been ghts and dignity. He stated nocked and announced		Education was done by the Din Nursing or Designee on Resid include knocking on resident re	ent rights to oom doors	
	herself prior to entering	ng a resident's room.		with announcement of themse entrance into a resident s roo		

Facility ID: 943003

		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/202 MAPPROVEI D. 0938-039
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345262	B. WING _				C 1 26/2021
	ROVIDER OR SUPPLIER	B/HERTFORD		13	REET ADDRESS, CITY, STATE, ZIP CODE 00 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE	(X5) COMPLETION DATE
F 550	 Resident #31's most data set assessment was significantly cogr During an observation NA#3 entered Reside knocking to deliver hi During an interview o #3 stated she did not enter Resident #31's aware she should do why she did not. During an interview w on 10/20/21 at 9:47 A knock or announce th resident's room. An interview was con Director of Nursing of she stated that staff s introduce themselves room. During an interview w 10/20/21 at 1:52 PM or announce themsel room. During an interview w 10/20/21 at 3:38 PM trained on resident rig 	admitted to the facility on recent quarterly minimum dated 9/17/21 revealed he nitively impaired. In on 10/17/21 at 11:55 AM ent #31's room without s lunch tray. In 10/17/21 at 12:42 PM NA knock or ask permission to room. She stated she was so and could not articulate with the Director of Nursing AM who stated staff should hemselves when entering a inducted with the Assistant in 10/20/21 at 10:52 AM and should always knock and s when entering a resident's with Resident #31 on he stated staff should knock ves prior to entering his with the Administrator on he stated staff have been ghts and dignity. He stated nocked and announced	F 5	550	education was started on 10/22/21 an follow up education completed by 11/17/21 for all staff. This education will be implemented as part of orientation for new employees including new agency staff by the Dire of Nursing or designee. How the corrective actions will be monitored to ensure the deficient prace will not recur, and what quality assura program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing and/or designee w conduct compliance audits weekly x 1 weeks to ensure staff are knocking on resident doors and waiting to enter pri entering a resident room. The facility w provide education on any areas of concern. The results of the audits will be report at the monthly QAPI meeting until suc time that substantial compliance has t achieved x 3 months.	ector tice nce ill 2 or to will ed h	

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMP	
		345262	B. WING				_ 26/2021
NAME OF P	ROVIDER OR SUPPLIER		•	9	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD			1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 550	 Resident #7 was a 7/30/21. Resident #7's most re assessment, an admi 10/15/21 revealed he During an observation NA#3 entered Reside knocking to deliver his During an interview o #3 stated she did not enter. She stated sh so and could not artice During an interview w on 10/20/21 at 9:47 A knock or announce the resident's room. An interview was con Director of Nursing or she stated that staff s introduce themselves room. During an interview w 10/20/21 at 3:38 PM trained on resident rig NA #3 should have kr herself prior to enterin Attempts to interview unsuccessful 	admitted to the facility on ecent minimum data set ssion assessment dated was cognitively intact. In on 10/17/21 at 11:57 AM ent #7's room without is lunch tray. In 10/17/21 at 12:42 PM NA knock or ask permission to e was aware she should do ulate why she did not. Who stated staff should remselves when entering a ducted with the Assistant in 10/20/21 at 10:52 AM and hould always knock and when entering a resident's with the Administrator on the stated staff have been ghts and dignity. He stated nocked and announced ng a resident's room.	F	550			

Facility ID: 943003

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345262	B. WING				C 26/2021
NAME OF PI	ROVIDER OR SUPPLIER		•	S	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HEALTH & REHAI	B/HERTFORD			1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD F CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE
F 550	Resident #20's most i data set assessment was significantly cogr assessed as not being During an observation NA#3 entered Reside knocking to deliver his During an interview of #3 stated she did not enter Resident #31's aware she should do why she did not. During an interview w on 10/20/21 at 9:47 A knock or announce the resident's room. An interview was com- Director of Nursing or she stated that staff s introduce themselves room. During an interview w 10/20/21 at 3:38 PM I trained on resident rig NA #3 should have kr herself prior to enterir 5. Resident #17 was 5/30/13. Resident #17's most i	recent quarterly minimum dated 9/1/21 revealed he nitively impaired. He was g interviewable. In on 10/17/21 at 11:55 AM ent #31's room without is lunch tray. In 10/17/21 at 12:42 PM NA knock or ask permission to room. She stated she was so and could not articulate with the Director of Nursing M who stated staff should remselves when entering a ducted with the Assistant in 10/20/21 at 10:52 AM and hould always knock and when entering a resident's with the Administrator on he stated staff have been ghts and dignity. He stated nocked and announced ing a resident's room. admitted to the facility on recent quarterly minimum dated 9/1/21 revealed she	F	550			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED C	
		345262	B. WING				26/2021
NAME OF PI	ROVIDER OR SUPPLIER			SI	IREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHAI	B/HERTFORD			300 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 550	During an observation NA#3 entered Reside knocking to deliver his During an interview of #3 stated she did not enter Resident #17's aware she should do why she did not. During an interview w on 10/20/21 at 9:47 A knock or announce the resident's room. An interview was com- Director of Nursing or she stated that staff s	n on 10/17/21 at 11:55 AM ent #31's room without	F	550			
F 582 SS=B	10/20/21 at 3:38 PM I trained on resident rig NA #3 should have kr herself prior to enterin Attempts to interview unsuccessful. Medicaid/Medicare Cr CFR(s): 483.10(g)(17) §483.10(g)(17) The fa (i) Inform each Medica writing, at the time of facility and when the in Medicaid of-	Resident #17 were overage/Liability Notice)(18)(i)-(v)	F	582			11/17/21

Facility ID: 943003

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		ND HUMAN SERVICES			FOF	ED: 12/08/202 RM APPROVEI
STATEMENT (S FOR MEDICARE & DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345262	B. WING		1	C 0/26/2021
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1300 DON JUAN ROAD		
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD		HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 582	nursing facility service for which the resident (B) Those other items facility offers and for charged, and the amo- services; and (ii) Inform each Media changes are made to specified in §483.10(section. §483.10(g)(18) The fa- resident before, or at periodically during the available in the facility services, including ar covered under Medic facility's per diem rate (i) Where changes in and services covered Medicaid State plan, notice to residents of reasonably possible. (ii) Where changes an items and services the facility must inform the 60 days prior to imple (iii) If a resident dies transferred and does facility must refund to representative, or est deposit or charges al per diem rate, for the resided or reserved of facility, regardless of discharge notice requ (iv) The facility must in	es under the State plan and t may not be charged; s and services that the which the resident may be ount of charges for those caid-eligible resident when the items and services g)(17)(i)(A) and (B) of this acility must inform each the time of admission, and e resident's stay, of services y and of charges for those hy charges for services not care/ Medicaid or by the the facility must provide the change as soon as is re made to charges for other tat the facility offers, the re resident in writing at least ementation of the change. or is hospitalized or is not return to the facility, the o the resident, resident tate, as applicable, any ready paid, less the facility's days the resident actually or retained a bed in the any minimum stay or	F 58	32		

Facility ID: 943003

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		ID HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/08/202 M APPROVE D. 0938-039
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE A. BUILDING _	COM	E SURVEY PLETED C	
		345262	B. WING			/26/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE		20,2021
BRIAN CE	ENTER HEALTH & REHA	B/HERTFORD		300 DON JUAN ROAD IERTFORD, NC 27944		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOL			(X5) COMPLETION DATE
F 582 Continued From pag the resident within 3 date of discharge fro (v) The terms of an a behalf of an individual facility must not conf these regulations. This REQUIREMEN by: Based on record rev facility failed to provi for Medicare and Me Skilled Nursing Facil Notice (SNF ABN) (f residents reviewed for protection review (Re #16). The findings included 1. Resident #3 was		 days from the resident's m the facility. dmission contract by or on all seeking admission to the ict with the requirements of is not met as evidenced iew and staff interviews, the de an acknowledged Centers dicaid Services (CMS) ty Advanced Beneficiary form 10055) for 2 of 3 or beneficiary notification esident #3 and Resident 	F 582	F 582 Medicaid/Medicare Coverage/Liability Notice What corrective action will be accomplished for those resident have be affected by the deficient Element #1 The facility failed to provide an acknowledged Centers for Medic Medicaid Services (CMS) Skilled Facility Advanced Beneficiary (S	t practice : care and d Nursing SNF ABN)	
	services on 7/14/21. Resident #3's significant change Minimum Data Set assessment dated 7/18/21 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.			for resident #3 and #16. Reside were notified of the by the Socia and both residents/RPs Acknow they understood the end of Med A coverage and had no concern How the facility will identify other having potential to be affected b same deficient practice. Element #2 Any residents receiving Medicar services has the potential to be a by this concern. All current resid discharged residents who had a stayed since October 1, 2021, w ABN required have been audited	I Worker ledged icare Part s. r residents y the e Part A affected lents and part A vith an	

Facility ID: 943003

	-	ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/20 FORM APPROVE OMB NO. 0938-039
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		(X3) DATE SURVEY COMPLETED
		345262	B. WING		C 10/26/2021
NAME OF PI	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2021
BRIAN CE	NTER HEALTH & REHAI	B/HERTFORD		300 DON JUAN ROAD IERTFORD, NC 27944	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE COMPLETION
F 582	Continued From page	<u> </u>	F 582		
		ducted with Social Worker	F 302		Δον
		3 PM. She stated there		completeness of the ABN form. / problems identified will be review	
		hecked for the decision		the resident/RP and concerns ac	
		ig Medicare Part A services.		if indicated. The Business Office	
		ated she reviewed options		and Social Services Director we	0
		ailed to ensure an option for		in-serviced on completing ABN	S
	continuing services w	as checked by Resident #3.		completely by the Administrator	on
	She stated that there	should have been		10/25/21.	
	documentation on the	e form about the discussion.			
				What measures will be put into p	
		ducted with Resident #3 on		systematic changes made to ens	
	10/20/21 at 1:52 PM remember signing the			deficient practice does not recur	:
				Element #3	
	An interview with the				
		at 3:38 PM who stated the		Any current resident whose Med	
		have ensured the SNF-ABN		benefit has ended since Septem audited to ensure the resident ha	
	form had been compl #3.	eted accurately by Resident		addited to ensure the resident had acknowledged the notification.	
	#3.			was completed on 11/17/21 by the	
	2 Resident #16 was	admitted to the facility on		Worker and Business Office Mar	
		ses including dementia. She			
		care Part A skilled services		The Administrator will track all Pa	art A
	on 5/13/21.			service days for residents with M	
				services in place. The Administra	
	Resident #16's quarte	erly Minimum Data Set		monitor the completion of the AE	3N ⊡s for
	assessment dated 8/2	20/21 revealed she was		residents and receive a copy of a	all
	cognitively intact.			completed ABN a. Additional ec	
				has been provided to the Busine	
		are Part A skilled services		Manager and Social Services Di	
	ended on 5/31/21.			the District Director, Business O Services on 11/16/21.	пісе
	Record review reveal	ed Resident #16's SNF-ABN			
	was reviewed over th			How the corrective actions will b	e
	representative on 5/2			monitored to ensure the deficien	
	-	nt #78's name and the date		will not recur, and what quality a	
		There were no options		program will be put into place:	
	checked for the decis				
	continuing Medicare	Part A skilled services.		Element #4	

Facility ID: 943003

	-	D HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/202 FORM APPROVE OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, <i>,</i>	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345262	B. WING		C 10/26/2021	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	NTER HEALTH & REHAI	3/HERTFORD		1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE COMPLETION	
F 582	Continued From page	2 10	F 58	2		
F 745 SS=D	An interview was conducted with Social Worker #1 on 10/19/21 at 1:13 PM. She stated there should have been an option checked for the decision made about continuing Medicare Part A services for Resident #16. She stated she spoke with Resident #15's resident representative on 5/28/21 about Medicare Part A services ending and appeal rights. She stated there should have been documentation on the form about the discussion. An interview with the Administrator was conducted 10/20/21 at 3:38 PM who stated the SNF-ABN form should have been completed for Resident #16. 745 Provision of Medically Related Social Service		F 74	To ensure ongoing compliance, the Administrator will do compliance aud weekly x 12 weeks to ensure the Medicare SNF ABN process is compl accurately when a residents Medicar benefit is ending. The facility will proveducation on any areas of concern. The results of the audits will be repor at the monthly QAPI meeting until su time that substantial compliance has achieved x 3 months.	eted e ride ted ch	
				F 745 What corrective action will be accomplished for those residents fou have be affected by the deficient prace Element #1		
	The findings included Resident #7 was adm 7/30/21 with diagnose kidney disease.			Resident #7 did not have an outpatie nephrologist appointment scheduled recommended by the discharge sum dated 7/30/21. The attending physicia was informed of this on 10/20/21 and	as mary an	

Event ID: 7CJI11

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		ID HUMAN SERVICES MEDICAID SERVICES			FORI	D: 12/08/2021 MAPPROVED D. 0938-0391
STATEMENT O	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE COMF	SURVEY PLETED
		345262	B. WING			C /26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO		
				1300 DON JUAN ROAD		
BRIAN CE	NTER HEALTH & REHA	BINERTFORD		HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TH DEFICIENC'	ION SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 745	Continued From page	e 11	F 74	5		
F 745	7/30/21 read in part, ' referral/follow up with provider to continue to (chronic kidney disea acidosis from ileal coo drainage created after supplemental sodium the secretion of sodiu urine having contact of Resident #7's most re (MDS) assessment, of resident was cognitive required extensive as of daily living includin and personal hygiene A review of Resident revealed no appointm nephrology since his During an interview w Director of Nursing of stated that she was u documentation of an during the period from nephrology. She indi admitted Resident #7 appointment. The nurse who admitt unavailable for interview An interview was con Nursing (DON) on 10 stated Resident #7 sh	 I discharge summary dated 'Patient will need o help manage his CKD3 se) and chronic metabolic nduit (a system of urinary 'r bladder removal) requiring 'bicarbonate." This refers to 'm and bicarbonate due with the bowel wall. ecent Minimum Data Set dated 8/6/21, indicated the ely intact. Resident #7 sistance with most activities g transfer, toileting, dressing e. #7's medical record hents scheduled with admission. with the facility's Assistant h 10/20/21 at 8:55 AM, she nable to locate appointment for Resident #7 n July 2021 to present with cated the nurse who 'should have made this ted Resident #7 was ted Resident #7 was tew. ducted with the Director of /20/21 at 9:03 AM. She	F 74	 indicated that there had bee a result of the appointment scheduled. The resident an notified of the missed appoi 10/20/21. The Nephrology a was rescheduled for resider transported to the appointm 11/10/21. How the facility will identify having potential to be affect same deficient practice. Element #2 All residents admitted to the the potential for a scheduled from their hospitalization to residents admitted since Ju audited for missed appointm in hospital Discharge orders concerns were identified. Th completed on 11/17/21 by th Administrative nursing team responsible for completing of the admission process and transportation/appointment in-serviced on 10/25/21 ove scheduling and communica appointments as indicated to discharge paperwork. What measures will be put it systematic changes made to deficient practice does not re Element #3 The discharge summaries v 	not being d RP were intment on appointment appointment appointment appointment other residents ted by the e facility have d appointment be missed. All ly 1st were ments indicated s. No other he audit was he DON. n members or reviewing the aide were er identifying, ting by hospital into place or to ensure the recur:	
		r expectation when a nurse		for all admits/readmits since		

Facility ID: 943003

If continuation sheet Page 12 of 35

		MEDICAID SERVICES			OMB NO. 0938-039	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,		(X3) DATE SURVEY COMPLETED	
		345262	B. WING		C 10/26/2021	
NAME OF PI	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B/HERTFORD		300 DON JUAN ROAD IERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 745	Continued From page	e 12	F 745			
	made. An interview was con AM with Resident #7' He indicated Residen up with an outpatient hospital discharge su stated Resident #7 ha result of the lack of for An interview was con Administrator on 10/2	ducted with the 20/21 at 3:38 PM who 7 should have been referred		by the Director of Nursing or the Direct of nursing to ensure any referenced necessary appointments have been scheduled. This audit was completed 11/17/21. The current licensed nursing staff received education by the Director of Nursing or ADON regarding reading the discharge summaries with new admits/readmits to ensure any referen necessary appointments are schedule This education was completed on 11/17/21. This education will be part of new nurs	on e ced d.	
	discharge summary.			and agency nurse □s orientation. How the corrective actions will be monitored to ensure the deficient prac will not recur, and what quality assuran program will be put into place: Element #4		
				To ensure ongoing compliance, the Director of Nursing and/or designee w review all new admit/readmit discharge summaries to ensure that any reference necessary appointments have been scheduled. These audits will be conducted once a week x 12 weeks. T results of the audits will be reported at monthly QAPI meeting until such time substantial compliance has been achieved x 3 months.	e ced 'he the	
F 835 SS=K			F 835		11/17/21	

		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12/08/2021 FORM APPROVED OMB NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345262	B. WING		C 10/26/2021
NAME OF P	ROVIDER OR SUPPLIER		s	TREET ADDRESS, CITY, STATE, ZIP CODE	10/20/2021
			1	300 DON JUAN ROAD	
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD	н	IERTFORD, NC 27944	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 835	Continued From page	9 13	F 835		
	enables it to use its re efficiently to attain or practicable physical, it well-being of each res This REQUIREMENT by: Based on observatio review the facility faile systems for administr were educated and co disinfect a shared glu medication aides obs blood glucose tests w glucometer (Med Aide Immediate Jeopardy I administration did not or systems were in pl aides were educated disinfect a shared glu for 2 of 2 medication a fingerstick blood gluco Med Aide #2). There ensure this training at was not a protocol in medication aides. The show that a skills che 2 medication aides. In removed on 10/22/21 and implemented an allegation of Immedia facility will remain out scope and severity le with a potential for mi Immediate Jeopardy)	hinistered in a manner that esources effectively and maintain the highest mental, and psychosocial sident. I is not met as evidenced an, staff interview and record ed to implement effective ation to ensure that all staff competent to clean and cometer for 2 of 2 erved to perform fingerstick with the use of a shared e #1 and Med Aide #2). began on 10/19/21 when the ensure effective protocols ace to ensure medication and competent to clean and cometer. This was evident aides observed to perform ose tests (Med Aide #1 and was no protocol in place to and competency and there place to orient new e facility was not able to cklist was completed for the nmediate Jeopardy was when the facility provided		F 835 Administration What corrective action will be accomplished for those residents four have be affected by the deficient prace Element #1 The facility failed to implement effecti systems for administration to ensure the staff assigned to perform Fingerst blood sugars were educated and competent as Certified Medication aid (#1 and #2), failed to disinfect a share glucometer according to manufacture instructions when used for multiple residents. Resident # 15,2,50,38 and 1 have no an identified outcome related to this. Med Aide #1 and #2 were observed r disinfecting the glucometer in betwee residents on 10/19/21. They receive education by the Director of Nursing related to cleaning and disinfecting glucometers with a required return demonstration on 10/19/21. How the facility will identify other resid having potential to be affected by the same deficient practice. Element #2 All residents that receive Fingerstick I	ctice: ve that tick des ed ed er⊡s t had not n d dents

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		ID HUMAN SERVICES MEDICAID SERVICES			PRINTED: 12 FORM AP OMB NO. 09	PROVE
	F DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SUR COMPLETE	
		345262	B. WING		C 10/26/2	2021
NAME OF PF	ROVIDER OR SUPPLIER	·	·	STREET ADDRESS, CITY, STATE, ZIP	CODE	
	NTER HEALTH & REHA			1300 DON JUAN ROAD		
DIVIAN CE		BINERTIORD		HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE CC THE APPROPRIATE	(X5) DMPLETIO DATE
F 835	Continued From page	e 14	F 83	5		
		y staff in-service orientation		sugars are at risk if staff th procedure are not trained	and competent	
	The findings included	l:		to perform the Fingerstick resident has had an identi related to this.	<u> </u>	
	This tag is cross refe			What measures will be pu systematic changes made	to ensure the	
		ervations, staff interviews		deficient practice does no	t recur:	
		e facility failed to use an		Element #3		
		to clean and disinfect a		The District Director of Cli		
	•	sed for 5 of 5 residents		educated the administrativ	,	
	-	50, #38 and #1). Shared contaminated with blood and		Administrator, DON, ADO Manager, over the Infection		
	•	disinfected after each use		Manual Glucometer De		
		duct and procedure. Failure		policy and procedures for		
		ntal Protection Agency (EPA)		stick blood glucose check		
		t in accordance with the		management of glucomete		
		lucometer increased the		requirements. This was co		
	likelihood of the sprea	ad of blood borne infections		10/20/2021. The Infection	Control Manual	
	between residents. F	ailure to disinfect a shared		Glucometer Decontamin	nation policy	
	•	erved when 2 of 2 medication		was revised on 10/20/21 t		
		to perform a fingerstick		individual use glucometers		
	•	residents and did not		each resident versus shar	-	
		ter per manufacturer 's		The use of shared glucom	leters has been	
	specifications (wed A	vide #1 and Med Aide #2).		removed from our policy. On 10/20/21, the Administ	rator Director of	
	On 10/19/21 at 12.10	PM an interview was		Nursing and Assistant Dire		
		ssistant Director of Nursing		worked with the District Di	-	
		o the Infection Control Nurse		Services and the county F		
	. ,	ON stated she was also was		Department nurse to revie		
	-	raining in the facility. The		procedure for the use of g	-	
		ed Aide #1 had recently		residents, reviewed the m		
		tion and had just started		recommendations for clea	0	
	-	le. The ADON further stated		disinfecting, and develope	-	
		eived orientation on the		action and an education to	-	
	. ,	t for 2-3 days with a nurse		nurses and certified Medic		
		as comfortable. The ADON #2 was from an agency and		the facility⊡s corrective ac over the proper managem	-	
I						

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		ND HUMAN SERVICES MEDICAID SERVICES			FOR	D: 12/08/202 MAPPROVE: 0. 0938-039
TATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G	(X3) DAT	E SURVEY PLETED
		345262	B. WING		10	C // 26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (
BRIAN CE	NTER HEALTH & REHA	B/HERTFORD		1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETIO DATE
F 835	agency staff received the facility but did not medications or the gl On 10/20/21 at 1:20 interview that Med Ai Med Aide in the facili worked under the gu ADON further stated protocol in place for t Med Aide. The ADON worked on the med c worked and would fre during her shift. The #2 had worked in the months and always v would frequently use shift to check a finger residents on her assi stated that Med Aide shift and Med Aide #2 PM but had worked s On 10/21/21 at 2:20 conducted with Nurse on the med cart with The Nurse further sta protocol for this orien that came up during	The ADON further stated that I some general orientation to a receive training related to ucometer. PM the ADON stated in an de #1 started working as a ty on 9/23/21 and had dance of Nurse #1. The there was not a training he nurse that trained the N stated Med Aide #1 had art most of the time she equently use the glucometer ADON stated that Med Aide facility for at least several worked on the med cart and a glucometer during her restick blood glucose for the gned hall. The ADON further #1 worked the 7 AM to 7 PM 2 worked mostly 7 AM to 7 some 7 PM to 7 AM shifts.	F 83	35 The administrative correcti action is to ensure that each has a blood sugar glucose an individually assigned gl was implemented by placin glucometers at each reside as of 10/19/21 by the Direct (DON) and this has continu- time. The previously shar were removed from the met Glucometers are available the finger stick blood suga ensure new admissions or new orders for FSBS□s has glucometer. Current medication aides a nurses received training in 10/19/21 by the DON or All policy change that all resid an individually assigned gl training included the impor cleaning and disinfecting th per manufactures guideling facility will use the micro-ki bleach wipes for cleaning, contact time required is 3 r cleaning. The education ir purpose for following clear disinfecting the glucometer likelihood of cross contami spread of Blood Borne Pat	ch resident that has been given ucometer. This ng individual ent □s bedside ctor of Nursing ued since that red glucometers ed carts. Extra for staff that do r (FSBS) to residents with ave their own and licensed itiated on DON on the lents will have ucometer. The tance of he glucometer es, that the ill germicidal and that the minutes when hcluded the hing and r is due to the ination and the	
	do they did that. The physically wipe the g then let it air dry. The observed Med Aide # glucometer for 3-5 m	Nurse stated she would lucometer for 3-5 minutes, Nurse further stated she to clean and disinfect the inutes while they were ings related to the med pass		residents. This education on 10/20/21 by the Directo and Assistant Director of N Effective 10/20/21; no med licensed nurse will do a fin sugar check without the va blood glucose monitoring of been completed. This will i	was completed or of Nursing Jursing. Jication aide or ger stick Blood alidation of the checklist has	

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		ND HUMAN SERVICES MEDICAID SERVICES					FORM APPROVE <u>B NO. 0938-03</u>
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '				DATE SURVEY COMPLETED
		345262	B. WING _				C 10/26/2021
NAME OF PI	ROVIDER OR SUPPLIER			STF	REET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B/HERTEORD		130	00 DON JUAN ROAD		
				HE	RTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETIO DATE
F 835	stated they had educ agency for Med Aide the cleaning or disinfe glucometer. On 10/20/21 at 11:42 interview that Med Aid for 2-3 days when sh The ADON further sta documentation that M cleaning and disinfect On 10/20/21 at 10:45 notified of the Immed The facility provided a Immediate Jeopardy allegation of Immedia indicated: The problem identifie and certified medicat appropriate procedur shared glucometer us #2, #50, #38 and #1) sugar glucose. The fa Aides (#1 and #2) we the glucometer in bet	AM the Nurse Consultant ation records from the #2, but they did not address ecting procedures for the AM the ADON stated in an de #1 trained with Nurse #1 e first started as a med aide. ated she had no Med Aide #1 was trained on ting the glucometer. AM the Administrator was liate Jeopardy. a credible allegation of removal on 10/21/21. The ate Jeopardy removal ate Jeopardy removal	F	335	and new staff as part of orientation. How the corrective actions will be monitored to ensure the deficient pra- will not recur, and what quality assur program will be put into place: Element #4 To ensure ongoing compliance, the Director of Nursing or Assistant direc nursing will conduct random audits weeks to observe staff while doing glucometer checks . This will include observations to verify glucometers a not shared and that they are cleaned disinfected per the manufactured guidelines. The results of the audits reported at the monthly QAPI meetin until such time that substantial comp has been achieved x 3 months. The facility alleges removal of immed jeopardy 10/22/21 The QA-QAPI Committee met on 11/17/21 and reviewed the findings of immediate jeopardy sited on 10/19/2 The Plan of Correction was accepted the QA-QAPI committee.	ance tor of for 12 are l and will be g liance diate	
	Every resident that re sugar check is at risk	eceives a fingerstick blood					
	Administrator, Director Director of Nurses an	ation team, including the or of Nurses, Assistant nd Unit Manager failed to policy and procedure for the					

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		ID HUMAN SERVICES MEDICAID SERVICES				F	TED: 12/08/2021 ORM APPROVED NO. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) E	DATE SURVEY OMPLETED
		345262	B. WING				C 10/26/2021
NAME OF P	ROVIDER OR SUPPLIER			STI	REET ADDRESS, CITY, STATE, ZIP CODE	•	
				130	00 DON JUAN ROAD		
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD		HE	ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 835	use of fingerstick bloc to educate the license medication aides of th procedures. The adm training was provided and failed to have a p staff or agency staff of procedures for blood Medical Director was with the steps taken a correction. The District Director of the administrative tea ADON and Unit Mana Control Manual-Gluco policy and procedure blood glucose checks glucometers and clea completed on 10/20/21 Manual-Glucometer I revised on 10/20/21 tf glucometers will be u shared glucometers. glucometers has bee On 10/20/21 the Adm Nursing and the Assis worked with the Distr Services and the cou nurse to review the p use of glucometers w manufacturer ' s reco and disinfecting and a corrective action plan management of the re	bd glucose checks and failed ed nurses and certified hese policies and inistration failed to ensure I before tasks were assigned process in place to train new over these policy and glucose management. The made aware and agreed as indicated in our plan of of Clinical Services educated am, Administrator, DON, ager, over the Infection ometer Decontamination s for the use of fingerstick and the management of aning requirements. This was 21. The Infection Control Decontamination policy was o reflect individual use sed for each resident versus The use of shared n removed from our policy. Aninistrator, Director of stant Director of Nursing ict Director of Clinical nty Health Department olicy and procedure for the with residents, reviewed the mmendations for cleaning developed a plan of action I for training nurses and ides over the facility ' s and over the proper	F	835			

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		ND HUMAN SERVICES MEDICAID SERVICES				FOI	ED: 12/08/2021 RM APPROVED NO. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		ONSTRUCTION		TE SURVEY MPLETED C
		345262	B. WING			1	0/26/2021
NAME OF P	ROVIDER OR SUPPLIER			STR	EET ADDRESS, CITY, STATE, ZIP CODE		
				130	0 DON JUAN ROAD		
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD		HE	RTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 835	blood sugar glucose individually assigned placed at their bedsic Director of Nursing (E glucometers were ren Extra glucometers and the fingerstick blood sugar admissions or resident FSBS have their own completed on 10/20/2 On 10/21/21, respons residents and those r fingerstick blood sugar by the Assistant Direct Nursing of the potent pathogens due to not shared glucometer. T will be using individua resident. RPs and rest the local Health Depart and we will be follow that they provide regar to blood borne pathog Department Nurse, o that her recommendar and provided to the far week. The Administra Department Nurse th the Health Department Current medication a have received training the importance of cle glucometer per manu- the blood glucose mo-	ach resident that has a has been given an glucometer that has been le as of 10/19/21 by the DON). The previously shared moved from the med carts. e available for staff that do sugar (FSBS) to ensure new ints with new orders for a glucometer. This was 21. sible parties (RP) for residents that receive ar checks have been notified ctor of Nursing or Director of ial exposure of blood borne t properly disinfecting a They were informed that we al glucometers for each sidents were informed that artment had been notified ng any recommendations arding the potential exposure gens. The Health n site 10/21/21, indicated ations would be completed acility in approximately 1 ator indicated to the Health at the facility would follow	F	335			

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CENTERS FOR MEDICARE & MEDICAID SERV STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPI IDENTIFICATION	PLIER/CLIA (X2				0. 0938-0391
		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE COMF	SURVEY PLETED
345	2 62 B.	. WING			C /26/2021
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
			1300 DON JUAN ROAD		
BRIAN CENTER HEALTH & REHAB/HERTFORD			HERTFORD, NC 27944		
(X4) ID SUMMARY STATEMENT OF DEFICIEN PREFIX (EACH DEFICIENCY MUST BE PRECEDED TAG REGULATORY OR LSC IDENTIFYING INFO	D BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROI DEFICIENCY)	D BE	(X5) COMPLETION DATE
 F 835 Continued From page 19 and return demonstration. This checklist the facility will use the (name of) germinibleach wipes and the contact time requiminutes. The education includes the pufollowing cleaning check list process for glucometers due to the likelihood of crocontamination and the spread of blood pathogens among residents. The education pathogens among residents. The education aides regarding the proceduc cleaning and disinfecting glucometers, will continue to clean and disinfect the lissued glucometers before and after uses stored at the residents ' bedside. This was completed on 10/20/21 by the Dire Nursing and the Assistant Director of N Effective 10/20/21, no medication aide nurse will do a fingerstick blood sugar of without the validation of the blood glucomonitoring checklist. This will include a new staff. The Director of Nursing will be response ensure licensed nurses and certified maide staff are oriented and trained befor performing the task of a fingerstick blood glucos are done. The training/education check the process of cleaning and will include observation and return demonstration. checklist indicates the facility will use the of) germicidal bleach wipes and the contrequired is 3 minutes. The education in purpose for following cleaning check list for glucometers due to the likelihood of contamination and the spread of blood 	cidal ired is 3 irpose for r sss borne ation has ind certified ure for that they individually se that are education ector of ursing. or licensed check ose gency and ible to edication re od sugar formed by my new d agency se checks clist covers This he (name ntact time cludes the st process foross	F 83	5		

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		MEDICAID SERVICES				IO. 0938-039
	OF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	· · ·	E SURVEY
						С
		345262	B. WING		1	0/26/2021
NAME OF P	ROVIDER OR SUPPLIER		S	TREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	NTER HEALTH & REHA	B/HERTFORD		300 DON JUAN ROAD IERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETIO DATE
F 835	pathogens among res The facility alleges re	sidents.	F 835			
	staff members were in nurses and certified r interviewed staff mem attended in-service tr glucometers and infe- staff members were a glucometers for each glucose checks. Staff was stored in the resid of test strips. Three s observed to perform 1 performed hand hygie with a disinfecting wip time and waited for th After testing the resid followed the same pro- glucometer. The gluc a storage case and s room. A resident who reported the staff clea testing her blood gluc The facility provided of training for the nurses training/education cho of cleaning and include demonstration. This of would use (name of) the contact time requ education included th cleaning check list pr- due to the likelihood of	hbers validated they had aining regarding ction control. Interviewed aware of the individual resident that required blood f stated each glucometer ident 's room with a supply taff members were blood glucose checks. Staff ene, cleaned the glucometer be for the required amount of he glucometer to air dry. lent 's blood glucose, staff ocedure to clean the ometer was then returned to tored in each resident 's was cognitively intact aned the glucometer prior to cose and again afterwards. documentation of in-service s and the med aides. The ecklist covered the process ded observation and return checklist indicated the facility germicidal bleach wipes and ired was 3 minutes. The he purpose for following the ocess for glucometers was of cross contamination and orne pathogens among				

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TATEMENT (DF DEFICIENCIES CORRECTION	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	CONSTRUCTION	(X3) DA	IO. 0938-039 TE SURVEY MPLETED
		345262	B. WING		1	C 0/26/2021
	ROVIDER OR SUPPLIER	B/HERTFORD	1	TREET ADDRESS, CITY, STATE, ZIP CO 300 DON JUAN ROAD IERTFORD, NC 27944	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 835	Continued From page compliance.	e 21	F 835			
F 880 SS=K	facility on 10/21/21. D Director of Nursing (D PM, the DON stated s local Health Departm additional recommend had not received an of Department. Review of the facility policy that stated no s perform blood glucos required training and Training and return de licensed nurses and r reviewed. The facility 's credible and the Immediate Je 10/22/21. Infection Prevention & CFR(s): 483.80(a)(1) §483.80 Infection Con The facility must esta infection prevention a designed to provide a comfortable environm development and trar diseases and infection p program. The facility must esta	dations. She reported they official report from the Health documentation revealed a staff would be allowed to e monitoring without the a return demonstration. emonstration evidence for all medication aides was e allegation was validated, eopardy was removed on & Control (2)(4)(e)(f) ntrol blish and maintain an and control program a safe, sanitary and nent and to help prevent the nsmission of communicable ns. prevention and control blish an infection prevention (IPCP) that must include, at	F 880			11/19/21

Facility ID: 943003

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		ID HUMAN SERVICES MEDICAID SERVICES				FORI	M APPROVED D. 0938-0391
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			E CONSTRUCTION	(X3) DATE COMF	E SURVEY PLETED C
		345262	B. WING				/26/2021
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE		
BRIAN CE	INTER HEALTH & REHAI	B/HERTFORD			1300 DON JUAN ROAD HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	§483.80(a)(1) A syster reporting, investigatin and communicable di staff, volunteers, visite providing services und arrangement based und conducted according accepted national star §483.80(a)(2) Written procedures for the pro- but are not limited to: (i) A system of surveil possible communicable infections before they persons in the facility; (ii) When and to whow communicable disease reported; (iii) Standard and transit to be followed to prev (iv)When and how iscon resident; including bu (A) The type and durate depending upon the in involved, and (B) A requirement that least restrictive possile circumstances. (v) The circumstances must prohibit employed disease or infected ske contact with residents contact with residents contact will transmit the (vi)The hand hygiene by staff involved in dire	em for preventing, identifying, g, and controlling infections seases for all residents, ors, and other individuals der a contractual pon the facility assessment to §483.70(e) and following indards; standards, policies, and ogram, which must include, lance designed to identify le diseases or can spread to other can spread to other se or infections should be issmission-based precautions ent spread of infections; lation should be used for a t not limited to: at not limited to: at not limited to: at not limited to: at the isolation should be the oble for the resident under the s under which the facility ees with a communicable cin lesions from direct o or their food, if direct ne disease; and procedures to be followed	F	880			

Facility ID: 943003

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OF DEFICIENCIES				OMB NO. 0938-0391
- CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345262	B. WING		C 10/26/2021
ROVIDER OR SUPPLIER	I	S	TREET ADDRESS, CITY, STATE, ZIP CODE	
		1:	300 DON JUAN ROAD	
	BALKHORD	н	IERTFORD, NC 27944	
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD	BE COMPLETION
- 15		F 880		
corrective actions tak	en by the facility.			
The facility will condu IPCP and update thei This REQUIREMENT	ct an annual review of its ir program, as necessary.			
record review the fact approved procedure it shared glucometer us (Resident #15, #2, #5 fingerstick blood gluc glucometers can be of must be cleaned and with an approved pro- to use an Environmer approved disinfectant manufacturer of the g likelihood of the sprea	ility failed to use an to clean and disinfect a sed for 5 of 5 residents 50, #38 and #1) reviewed for ose tests. Shared contaminated with blood and disinfected after each use duct and procedure. Failure ntal Protection Agency (EPA) t in accordance with the plucometer increased the ad of blood borne infections		What corrective action will be accomplished for those residents four have be affected by the deficient prace Element #1 on Glucometers The facility failed to use the appropria procedure to clean and disinfect a sha glucometer used for five residents, #1 #2, #50, #38 and #1, required to have blood sugar glucose. An individual glucometer was provided for each resident on 10/19/21 by the Director of	tice: te ared 5, e a
glucometer was obse aides were observed blood glucose test on Med Aide #2). The fa staff performed hand to 8 of 8 resident roor #203, #210, #209, #2 Immediate Jeopardy Med Aide #1 perform glucose test for a resi	rved when 2 of 2 medication to perform a fingerstick residents (Med Aide #1 and acility also failed to ensure hygiene when passing trays ms (Rooms #306, #204, 12, #200, and #202). began on 10/19/21 when ed a fingerstick blood ident on her assigned hall		responsible party and the resident received notification about the risk of spread of blood borne pathogens rela to the failure to appropriately disinfect glucometer and that individualized glucometers had been issued. This notification was completed on 10/19/2 ADON. No negative outcomes have been for the identified residents. Med Aide #1 and #2 were observed in disinfecting the glucometer in betwee	ted the 21 by ot
	SUMMARY ST (EACH DEFICIENC REGULATORY OR I Continued From page identified under the fa corrective actions tak §483.80(e) Linens. Personnel must hand transport linens so as infection. §483.80(f) Annual rev The facility will condu IPCP and update the This REQUIREMENT by: Based on observatio record review the fac approved procedure fa shared glucometer us (Resident #15, #2, #5 fingerstick blood gluc glucometers can be co must be cleaned and with an approved pro to use an Environmen approved disinfectant manufacturer of the g likelihood of the sprea between residents. Fi glucometer was obser aides were observed blood glucose test on Med Aide #2). The fa staff performed hand to 8 of 8 resident roor #203, #210, #209, #2 Immediate Jeopardy Med Aide #1 perform glucose test for a res	ROVIDER OR SUPPLIER ENTER HEALTH & REHAB/HERTFORD SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 23 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to use an approved procedure to clean and disinfect a shared glucometer used for 5 of 5 residents (Resident #15, #2, #50, #38 and #1) reviewed for fingerstick blood glucose tests. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer increased the likelihood of the spread of blood borne infections between residents. Failure to disinfect a shared glucometer was observed when 2 of 2 medication aides were observed to perform a fingerstick blood glucose test on residents (Med Aide #1 and Med Aide #2). The facility also failed to ensure staff performed hand hygiene when passing trays to 8 of 8 resident rooms (Rooms #306, #204, #203, #210, #209, #212, #200, and #202). Immediate Jeopardy began on 10/19/21 when Med Aide #1 performed a fingerstick blood glucose test for a resident on her assigned hall using a shared glucometer and did not follow the	ROVIDER OR SUPPLIER S ENTER HEALTH & REHAB/HERTFORD ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) ID Continued From page 23 Identified under the facility's IPCP and the corrective actions taken by the facility. F 880 §483.80(e) Linens. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. F 880 §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review the facility failed to use an approved procedure to clean and disinfect a shared glucometer used for 5 of 5 residents (Resident #15, #2, #50, #38 and #1) reviewed for fingerstick blood glucose tests. Shared glucometers can be contaminated with blood and must be cleaned and disinfected after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer increased the likelihood of the spread of blood borne infections between residents. Failure to disinfect a shared glucometer was observed when 2 of 2 medication aides were observed to perform a fingerstick blood glucose test on residents (Med Aide #1 and Med Aide #2). The facility also failed to ensure staff performed hand hygiene when passing trays to 8 of 8 resident rooms (Rooms #306, #204, #203, #210, #209, #212, #200, and #202). Immediate Jeopardy began on 10/19/21 when Med Aide #1 performed a fingerstick blood glucose test for a resident on her ass	ROVIDER OR SUPPLIER STREET ADDRESS. CITY. STATE. 2P CODE INTER HEALTH & REHAB/HERTFORD ID SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LISC DENTIFYING INFORMATION) ID Continued From page 23 identified under the facility. PREFIX \$483.80(e) Linens. F880 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. F 880 \$483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: F 880 Infection Control Based on observations, staff interviews and record review the facility failed to use an approved procedure to clean and disinfect a shared glucometer sca be contaminated with blood and must be cleaned and disinfect after each use with an approved product and procedure. Failure to use an Environmental Protection Agency (EPA) approved disinfectant in accordance with the manufacturer of the glucometer was observed they environmental Protection residents between residents (Med Aide #1 and Med Aide #2). The facility also failed to ensure staff performed hand hygiene when p assing trays to 8 of 8 resident rooms (Rooms #306, #204, #203, #210, #209, #212, #200, and #202). F 880 Infection Control Immediate Jeopardy began on 10/19/21 when Med Aide #1 performed a fingerstick blood glucometer was observed to perform a fingerstick blood glucometer and blogingen sela to the failure to appropriately disinfect glucometers and been issued. This notification was completed on 10/16/2 ADON. No negative outcom

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/202 MAPPROVEI D. 0938-039
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345262	B. WING _				C 26/2021
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD			00 DON JUAN ROAD ERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	K	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 880	manufacturer 's instr glucometer between Jeopardy was remove facility provided and i credible allegation of removal. The facility at a lower scope and harm with a potential Immediate Jeopardy) systems are put in pla employee in-service to cited at a scope and s The findings included Review of the facility Decontamination date of the policy was to in effective process for glucometers after use policy statement read glucometers are shar glucometers are shar glucometer: E. Wipe visibly wet (May wrap order to ensure wet for Allow the monitor to a The manufacturer ins used by the facility in procedure as follows: clean the meter with of disinfecting wipes list wipe used by the faci manufacturer 's list.'	uctions to disinfect the residents. Immediate ed on 10/22/21 when the mplemented an acceptable Immediate Jeopardy will remain out of compliance severity level of E (no actual for minimal harm that is not to ensure monitoring of ace and to complete training. Example #2 was severity of D. : policy titled Glucometer ed 02/18 listed the purpose nplement a safe and decontaminating e on each resident. The I: "In the event that ed within a facility, the lecontaminated with the es following use on each and disinfecting the the monitor and ensure it is o glucometer with wipe in or entire time instructed. G. air dry."	F	380	education by the Director of Nursing related to cleaning and disinfecting glucometers with a required return demonstration on 10/19/21. How the facility will identify other resi having potential to be affected by the same deficient practice. Element #1 on handwashing The facility failed to ensure staff performed hand hygiene when passin trays to residents in Room #306/204/203/210/209/221/200 and 2 No negative outcomes have been identified for these residents. How the facility will identify other resi having potential to be affected by the same deficient practice. Element #2 on glucometers All residents that receive blood sugar glucose checks are at risk . Element #2 on handwashing All residents are identified at risk if st not perform hand hygiene when indic for infection control purposes to incl passing of resident⊟s trays. What measures will be put into place systematic changes made to ensure deficient practice does not recur: Element #3 on Glucometers Each resident that has a blood sugar glucose was given an individually assigned glucometer that has was pla at their bedside as of 10/19/21 by the Director of Nursing (DON). The previously shared glucometers were removed from the med carts. Extra Glucometers are available for staff th the finger stick blood sugar (FSBS) to ensure new admissions or residents	ng 202. dents aff do ated ude or the aced	

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		(X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIP	LE CONSTRUCTION	· · · ·	NO. 0938-039	
NNU PLAN OF	CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	3		OMPLETED	
		345262	B. WING		10/26/2021		
NAME OF P	ROVIDER OR SUPPLIER	l		STREET ADDRESS, CITY, STATE, ZIP COL)E		
BRIAN CE	INTER HEALTH & REHA	B/HERTFORD		1300 DON JUAN ROAD HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE APPROPRIATE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 25	F 88	0			
	time listed on the wip meter dry or allow to The directions on the bleach wipes used by pre-saturated towelet to be disinfected." Th container as the time and viruses was 3 mi The blood glucose me checklist provided by "6. Wipe the monitor visibly wet and place Follow the wipe many the length of time the Wrap the monitor with necessary, to ensure required time. 8. Onc time has elapsed, allo clean surface."	On 10/19/21 at 11:40 AM, Med Aide #1 was served to check a fingerstick blood glucose for		orders for FSBS □s have their own glucometer. The Director of Nursing completed another audit of all residents receiving blood sugar checks to ensure there was an individual glucometer at bedside and that the medication carts did not have any glucometers that were being shared on them on 10/25/21. Current medication aides and licensed nurses received training on the importance of cleaning and disinfecting the glucometer per manufactures guidelines using the Blood glucose monitoring Cleaning, and included observation and return demonstration. This checklist indicates the facility will use the micro-kill 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 manufacturer□s instructions. The			
	front and back for app disposed of the wipe, tissue, wrapped the g placed it back on the observation, Med Aid residents did not have the one she used, wa residents. The Med A she had no further blo	be and wiped the glucometer proximately three seconds, dried the glucometer with a glucometer in the tissue and medication cart. During the e #1 stated that the e their own glucometer and as shared between other dide stated that at this time		following cleaning check list p glucometers due to the likelih contamination and the spread Borne Pathogens among resi education was started on 10/ Director of Nursing and Assis of Nursing. Effective 10/20/2 ⁻ medication aide or licensed n finger stick Blood sugar chec validation of the blood glucos checklist. This will include ag new staff. The Health Department Nurs	ood of cross d of Blood idents. This 19/21 by the tant Director 1 no urse will do a k without the e monitoring ency and		

Facility ID: 943003

	-	ND HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 MAPPROVED D: 0938-0391	
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ´		CONSTRUCTION	(X3) DATE SURVEY COMPLETED C		
		345262	B. WING				26/2021	
NAME OF P	ROVIDER OR SUPPLIER	•		STI	REET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	ENTER HEALTH & REHA	B/HERTFORD			00 DON JUAN ROAD ERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ЗE	(X5) COMPLETION DATE	
F 880	 #1 on 10/19/21 at 2:1 she took a med aide they were taught to w before and after each further stated the gluw wet for 15-20 second minutes. On 10/19/21 at 4:00 H knew how to clean th nervous when being a fingerstick blood gluc A review of each resirecord revealed the for In addition to the bloc to be checked by Mei 11:40 AM, Resident # glucose results docur 10/14/21 at 12 Noon In addition, Resider documented as check AM and prior to lunch glucose was also doc 10/14/21 at 12 Noon #1. In addition, Resider documented as check 10/19/21 at 8:00 AM and 4:00 PM. On 10/19/21 at 12:10 Nursing (ADON) who Control Nurse stated Aide #1 was oriented 	5 PM. The Med Aide stated class at a local college and vipe off the glucometer in resident. The Med Aide cometer was supposed to be is and sit and dry for 3-5 PM, Med Aide #1 stated she e glucometer but was observed to do the losse. dent ' s electronic medical ollowing: bod glucose level observed d Aide #1 on 10/19/21 at #15 also had her blood mented by Med Aide #1 on	F 8	80	onsite visit on 10/21/21 and reviewed residents Medical Records that receiv Finger stick blood sugars. The Health Department nurse agreed with the facilities systemic change not to share glucometers and to use the manufacturers guidelines to clean and disinfect the glucometers. No addition recommendations were made. Element #3 on Handwashing Education was started on 10/22/21 for current staff relate to proper hand hyg to include performing hand hygiene in between delivery of trays before each resident is served by the Director of nursing and Assistant Director of Nurs This education was expanded, continu and completed on 11/16/21 for all nurs staff. This education will be part be part of orientation for new hires, contract stand agency staff. How the corrective actions will be monitored to ensure the deficient prace will not recur, and what quality assura program will be put into place: Element #4 On Glucometer To ensure ongoing compliance, the Director of Nursing or Assistant director nursing will conduct random audits for weeks to observe staff while doing glucometer checks. This will include observations to verify glucometers are shared and that they are cleaned and disinfected per the manufactured guidelines. The results of the audits w reported at the monthly QAPI meeting until such time that substantial complia has been achieved x 3 months. The QA-QAPI Committee met on 11/17/21	ed any la al iene ing. ued sing art taff, tice nce or of 12 a not ill be ance		

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		MEDICAID SERVICES					<u>O. 0938-03</u>	
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •	LE CONSTRUC			E SURVEY IPLETED	
	CONNECTION	IDENTIFICATION NOMBER.	A. BUILDING	i				
			D MINO				С	
		345262	B. WING		RESS, CITY, STATE, ZIP CODE	10/26/2021		
NAME OF P	ROVIDER OR SUPPLIER							
BRIAN CE	ENTER HEALTH & REHA	B/HERTFORD		1300 DON JL				
				HERTFORD), NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETIO DATE	
F 880	Continued From page	e 27	F 88	0				
		ADON stated the staff was	1.00		ed the findings of the immediat	te		
		meter before and after use			ly sited on 10/19/21, as per be			
		eter was shared between			an of Correction was accepted			
	9	I further stated the staff were			-QAPI committee.	5		
	to use the wipes to cl	ean the glucometer and wait						
	for 5 minutes to dry.				nt #4 on Handwashing			
					ure ongoing compliance, the			
	On 10/19/21 at 2:00 l				r of Nursing or Assistant direct	tor of		
		t Med Aide #1 started on the			will conduct random audits	4		
	medication cart as be	ang 9/23/21.			all departments for 12 weeks	to		
	The Nurse Consultan	t stated in an interview on			proper infection control hand e performance (to include hand	Ч		
	-	that the glucometer was			e when passing trays). The res			
	supposed to be disinf			audits will be reported at the	Juito			
	and the contact time			y QAPI meeting until such time	e that			
	bleach wipe containe		-	ntial compliance has been				
		ther stated the glucometer		achieve	ed x 3 months. The QA-QAPI			
	was shared between				tee will be led by the Administ			
		y would begin in-services			e Committee will review finding			
	· ·	te the staff on the proper			ke recommendations as need	led.		
		lucometer. The Nurse			A-QAPI Committee met on	6 4h a		
		y had ordered and received s for residents that required			21 and reviewed the findings of iate jeopardy sited on 10/19/2 ²			
	fingerstick blood gluc				ow. The Plan of Correction wa			
	Ingerstion blood gide			·	ed by the QA-QAPI committee			
				· ·	edical Director was informed b			
	2. On 10/19/21 at 11:	48 AM, Med Aide #2			Director of Clinical services of	•		
		ed to do a fingerstick blood		10/20/2	21 of the Immediate Jeopardy			
	•	#38. The Med Aide was			to shared glucometers and th			
		the medication cart and			g disinfecting procedures requ			
	removed an approved				nufactures guidelines were no	t		
	glucometer for approx	-			d. The Medical Director was			
		and wrapped the glucometer			ed that the Health Department vould review the affected resid			
	in a tissue and placed medication cart.	a in a drawer on the			to evaluate the risk for possib			
	medication cart.				re for Blood Borne Pathogen			
	On 10/19/21 at 2.15	PM Med Aide #2 stated in an			ination and need for follow up			
		en a Med Aide for 7 years			The Medical Director was als			
		ne agency for 1 year. The			ed that we are using individual			

Facility ID: 943003

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		MEDICAID SERVICES				OMB NC		
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED	
		345262	B. WING			C 10/26/2021		
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		20/2021	
	NTER HEALTH & REHA	B/HERTFORD		13	00 DON JUAN ROAD			
					ERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETIO DATE	
F 880	Continued From page	e 28	F 88	80				
		ed she did not receive			assigned glucometers for residents as	of		
		an a glucometer from the			10/20/21; and, that education will be			
	-	of the buildings she had			provided to all Licensed nurses and			
		to wipe off the glucometer			Certified Medication Aides regarding the			
		and it needed to be wet for			procedure for cleaning and disinfecting			
	2-3 minutes.				glucometers, that they will continue to	ad		
	On 10/20/21 at 8:26 /	AM, Med Aide #2 stated in			clean and disinfect the individually issu glucometers before and after use that a			
		w the glucometer needed to			stored at the resident s bedside.			
		s, but she had medications			On $10/20/21$, the nurse at the local Heat	alth		
	to pass and she did n				Department was informed by the Distric			
					Director of Clinical Services of on the			
		ood glucose level checked			Immediate Jeopardy related to shared			
	on 10/19/21 at 11:48				glucometers and the cleaning disinfecti	ng		
	documented a blood			procedures required per manufactures	th			
		h. There was also a blood on Resident #1 by Med Aide			guidelines were not followed. The Heal Department nurse recommended to	un		
	0	0/6/21 at 11:30 AM and 4:30			proceed with the issuance of individual	lv		
	PM.				assigned glucometers. She was inform	•		
					that this had already been put in place.			
	On 10/19/21 at 12:10	PM the Assistant Director of			She did indicate she was going to spea	ık		
		ed in an interview that Med			to her supervisor and would give an			
	Aide #2 was an agen	-			update of any additional			
	ADON stated the staf	for several months. The			recommendations. She was informed on the conversation with the medical	DT		
		id after use because they			Director, and, that education will be			
	•	glucometer. The ADON			provided to all Licensed nurses and			
		ff were to use the wipes to			Certified Medication Aides regarding the	е		
		and wait for 5 minutes to			procedure for cleaning and disinfecting			
	dry.				glucometers. The Health Department			
					nurse was informed by the Administrate	or		
		It stated in an interview on			that the facility will follow any			
		that the glucometer was fected with the bleach wipe			recommendations made by the Health Department nurse.			
		was the time listed on the			Responsible parties of the affected			
		r which was 3 minutes. The			residents have been notified as of			
	-	ther stated the glucometer			10/21/21 of the potential for exposure to	0		
	was shared between	the residents. The Nurse			blood borne pathogens through the use			
	Consultant stated the	y would begin in-services			shared blood glucose glucometers.			

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FOR	D: 12/08/2021 MAPPROVED O. 0938-0391	
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345262	B. WING			C 10/26/2021		
NAME OF P	ROVIDER OR SUPPLIER	•	- I	ST	REET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	ENTER HEALTH & REHA	B/HERTFORD			00 DON JUAN ROAD ERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 880	immediately to educat way to disinfect the g Consultant stated the individual glucometer required a fingerstick not yet put them in the used. On 10/20/21 at 10:45 informed of the Imme The facility provided a Immediate Jeopardy allegation of immedia indicated: Credible Allegation of Removal: The facility failed to u procedure to clean at glucometers used for #38 and #1, required glucose. The facility f #1 and Med Aide #2 a shared glucometer s instructions when u Med Aide #1 and #2 disinfecting the gluco on 10/19/21. Each resident that ha been given an, individ that has been placed 10/19/21 by the Direct previously shared glu from the medication of available for staff that sugar (FSBS) to ensu	te the staff on the proper lucometer. The Nurse ey had ordered and received 's for residents that blood glucose test but had e resident 's rooms to be 6 AM, the Administrator was ediate Jeopardy. a credible allegation of removal on 10/21/21. The te jeopardy removal f Immediate Jeopardy ese the appropriate and disinfect shared '5 residents, #15, #2, #50, to have a blood sugar failed to educate Med Aide on how to clean and disinfect according to manufacturer ' sed for multiple residents.	F 8	80	The Health Department Nurse is on as of 10/21/21 to evaluate the need f any testing for the affected residents Administrator has informed the Healt Department nurse that her recommendations will be followed. The facility alleges removal of immed jeopardy 10/22/21 11/17/21 and reviewed the findings o immediate jeopardy sited on 10/19/2 per below. The Plan of Correction wa accepted by the QA-QAPI committee	for . The h Jiate f the 1, as as		

	-	D HUMAN SERVICES MEDICAID SERVICES				FORM): 12/08/2021 / APPROVED). 0938-0391
STATEMENT O	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í			(X3) DATE	
		345262	B. WING				C 26/2021
NAME OF PI	ROVIDER OR SUPPLIER			:	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	NTER HEALTH & REHA				1300 DON JUAN ROAD		
		5/HERTFORD			HERTFORD, NC 27944		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			(X5) COMPLETION DATE
TAG F 880	Continued From page glucometer. Current medication ai receive training on the and disinfecting the g s guidelines using the Monitoring/Cleaning of indicates the facility w germicidal bleach wip required is 3 minutes. staff understand, even their own glucometers disinfect them after even manufacturer ' s instru- The education include cleaning check list pro- to the likelihood of cro- spread of blood borner residents. This educa by the Director of Nursing. E medication aide or lico- fingerstick blood suga validation of the blood checklist. This will inc The Director of Nursir keeping up the list of the blood glucose mo-	e 30 des and licensed nurses will e importance of cleaning lucometer per manufacture ' e Blood Glucose checklist. This checklist vill use the (name of) es and the contact time Education ensures that in though the residents have s, they still have to clean and very use according to the uctions. es the purpose for following boess for glucometers due oss contamination and the e pathogens among tion was started on 10/19/21 sing and the Assistant iffective 10/20/21 no ensed nurse will do a ar check without the d glucose monitoring lude agency and new staff. ng will be responsible for staff training completion of nitoring checklist. was informed by the District rvices on 10/20/21 of the		880	DEFICIENCY)	ΔΤΕ	DATE
	Nurse recommended	ber manufacturer ' s bllowed. The Medical I that the Health Department					

Facility ID: 943003

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 M APPROVED D. 0938-0391		
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '			(X3) DATE			
		345262	B. WING				C / 26/2021		
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE	•			
			1300 DON JUAN ROAD						
BRIAN CE	ENTER HEALTH & REHAI	B/HERTFORD		1	HERTFORD, NC 27944				
(X4) ID PREFIX		ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL	ID PREF	IX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I		(X5) COMPLETION		
TAG	REGULATORY OR I	SC IDENTIFYING INFORMATION)	TAG	i	CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	ATE	DATE		
F 880	Continued From page	• 31	Í F	880					
		at this had already been put			-				
		cate she was going to speak							
	to her supervisor and	would give an update of any							
		dations. She was informed							
		ith the Medical Director and							
		provided to all licensed nedication aides regarding							
	the procedure for clea								
		alth Department Nurse was							
		nistrator that the facility will							
	-	dations made by the Health							
	Department Nurse.								
		of the affected residents							
		of 10/21/21 of the potential							
	-	borne pathogens through							
	the use of shared blo	od glucose glucometers.							
	The Health Departme	ent Nurse is on site as of							
		the need for any testing for							
		a. The Administrator has							
		Department Nurse that her							
	recommendations wil	•							
	The facility alleges re								
	Jeopardy on 10/22/21	I.							
	On 10/21/21 at 1:55 F	PM the Health Department							
		erview that she had looked							
		who got fingerstick blood							
	-	d no one that had orders for							
		and there were no residents							
	in the facility with a di	agnosis of Human							
		rus (HIV) that required a							
		ose. The Nurse further							
		s her findings on to the city							
		ake the recommendations.							
		ould take up to a week at							
		t the recommendations							
	pack to the facility, bu	It it would probably not take							

Facility ID: 943003

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	-	D HUMAN SERVICES MEDICAID SERVICES					FORM	D: 12/08/2021 APPROVED D: 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /		E CONSTRUCTION		(X3) DATE COMF	SURVEY LETED
		345262	B. WING			_		C 26/2021
NAME OF P	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, ST	ATE, ZIP CODE		
				·	1300 DON JUAN ROAD			
	INTER HEALTH & REHAI	3/HERTFORD		1	HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		(EACH CORREC CROSS-REFEREN	EPLAN OF CORRECTION CTIVE ACTION SHOULD BI NCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 880	staff members were in nurses and medication members validated the training regarding gluc control. The interview aware of individual glut that required blood glut the glucometer was s room in a case with a staff members were of glucose checks. The hygiene, cleaned the amount of time and w air dry. After testing the glucose, staff follower disinfect the glucometer then returned to the s the resident 's room. cognitively intact repor glucometer prior to the again afterwards. The documentation of in-s nurses and medication training/education che of cleaning, observati demonstration. This of would use the (name and the contact time ne education included the cleaning check list pro- due to the likelihood of the spread of blood bor residents. The facility evidence of audits co- allegation of compliant	00 AM to 12:45 PM multiple hterviewed. This included n aides. All interviewed staff ey had attended in-service cometers and infection ed staff members were acometers for each resident ucose checks. Staff stated tored in the resident 's supply of test strips. Three bserved to perform blood staff performed hand glucometer the required aited for the glucometer to he resident 's blood d the same procedure to ter. The glucometer was torage case and stored in A resident who was rted staff cleaned her sting her blood glucose and e facility provided ervice training for the n aides. The ecklist covered the process on and return hecklist indicated the facility of) germicidal bleach wipes required was 3 minutes. The e purpose for following the pocess for glucometers was of cross contamination and porne pathogens among also had documented mpleted per their credible	F	880				

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	-	D HUMAN SERVICES MEDICAID SERVICES				FORM	D: 12/08/2021 MAPPROVED D. 0938-0391	
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· ,		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345262	B. WING				C 26/2021	
NAME OF P	ROVIDER OR SUPPLIER			5	STREET ADDRESS, CITY, STATE, ZIP CODE			
BRIAN CE	NTER HEALTH & REHA	3/HERTFORD			1300 DON JUAN ROAD			
				I	HERTFORD, NC 27944			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	EIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE	
F 880	jeopardy removal was Immediate Jeopardy v 2. During an observa on 10/17/21 at 11:55 J tray from the food car the resident hall, enter food tray directly in frouncovered the food. without washing her h NA#3 returned to the meal tray, entered root tray on the table besid the room without perfer #3 returned to the foor meal tray, entered root #200, and #202 and co without performing hat During an interview w 12:42 PM, she stated hygiene prior to or up deliver meal trays. Sta after she passed all m performed hand hygiene was not necessary to between residents. During an interview w on 10/20/21 at 9:47 A perform hand hygiene each meal tray. An interview was conto Director of Nursing or she stated that she w facility's infection conto explained staff were in sanitizer every time th	a validated, and the was removed on 10/22/21. ation of Nurse Aide (NA) #3 AM, she retrieved a meal t positioned in the middle of red room #206 and set the ont of the resident and She then exited the room ands or using sanitizer. food cart, retrieved another om #204, placed the meal de the resident, and exited orming hand hygiene. NA d cart, retrieved another oms # 203, #209, #212, completed the same process nd hygiene. ith NA #3 on 10/17/21 at she did not perform hand on exiting resident rooms to ne stated she waited until neal trays and then ene. NA #3 stated that it perform hand hygiene ith the Director of Nursing M who stated staff are to e before and after delivering	F	880				

Facility ID: 943003

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		ID HUMAN SERVICES				FORM	APPROVED			
			()(0) 14111				0.0938-0391			
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	LETED			
			A. DOILDI			(C			
		345262	B. WING				26/2021			
NAME OF PI	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE					
	NTER HEALTH & REHAI									
DRIAN CE		DINEKTFURD		HI	ERTFORD, NC 27944					
(X4) ID		ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION					
PREFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	х	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI/		COMPLETION DATE			
					DEFICIENCY)					
F 880	F 880 Continued From page 34		F	880						
		have performed hygiene								
	before and after deliv	ering each meal tray.								
	During an interview w	vith the Administrator on								
		he stated staff have been								
		nd hygiene when passing								
		should have performed bassing resident meal trays.								
	nanu nyglene when p	assing resident mear trays.								

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