STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 000	Initial Comments The Adult Care Licensure Section conducted an annual survey on 07/27/22 to 07/28/22.	D 000		
D 169	10A NCAC 13F .0509 Food Service Orientation 10A NCAC 13F .0509 Food Service Orientation The adult care home staff person in charge of the preparation and serving of food shall complete a food service orientation program established by the Department or an equivalent within 30 days of hire for those staff hired on or after July 1, 2004. Registered dietitians are exempt from this orientation. The orientation program is available on the internet website, http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Facility Services, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708. This Rule is not met as evidenced by: Based on observations and interview the facility failed to ensure staff who prepared and served meals completed a food service orientation training that provided an overview of food service in adult care homes. The findings are: Observation of the dining room on 07/27/22 at 8:24am revealed: -The dietary aide served a breakfast meal to three residents seated in the dining room. -There was not a posting of a food service orientation for the dietary staff. Interview with a dietary aide on 07/27/22 on 12:30pm revealed: -She returned back to worked as a dietary aide	D 169		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 169	Continued From page 1	D 169		

about two weeks ago.
-She prepped, prepared and cook meals for the residents including the residents' snacks.
-She had not completed the food service orientation.
-She was not aware of the required food service orientation.

Interview with a second dietary aide on 07/27/22 at 12:45pm revealed:
-She worked as a Personal Care Aide (PCA) and dietary aide for 5 years.
-She worked in dietary at least 2 to 3 times weekly.
-She prepped, prepared and cook meals for the residents including the residents' snacks.
-She completed the food service orientation on 07/26/22.

Interview with the Resident Care Coordinator (RCC) on 07/27/22 at 12:41pm revealed:
-She supervised the dietary staff.
-Her food handler's certification expired on 05/17/19.
-One of the dietary staff completed the food service orientation on 07/26/22.
-She had reviewed dietary procedures on cleanliness, sanitation and food preparations with the dietary staff at least bi-weekly.
-She was not aware there was any specific training course available by the state of North Carolina's Department of Health Service Regulation to use when training new dietary employees.

Interview with the Administrator on 07/27/22 at 12:44pm revealed:
-All dietary staff were to have completed some form of food handling training.
-She was not aware there was any specific

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 169	Continued From page 2 training course available by the state of North Carolina's Department of Health Service Regulation to use when training new dietary employees. -The RCC was the person responsible for supervising all dietary staff.	D 169		
D 273	10A NCAC 13F .0902(b) Health Care 10A NCAC 13F .0902 Health Care (b) The facility shall assure referral and follow-up to meet the routine and acute health care needs of residents. This Rule is not met as evidenced by: Based on interviews and record reviews, the facility failed to ensure referral and follow-up to meet the routine and acute health care needs for 1 of 3 sampled residents (#2) related to physical therapy (PT) appointments. The findings are: 1. Review of Resident #2's FL2 dated 09/27/21 revealed diagnoses included anxiety disorder, neurocognitive disorder, obesity and moyamaya syndrome. Review of Resident #2's Care Plan dated 10/04/21 revealed: -Resident #2 required the use of a cane. -Resident #2 required extensive assistance with ambulation and transfer. Review of Resident #2's Licensed Health Professional Support (LHPS) dated 07/23/22 revealed: -Resident #2 required assistance with transferring	D 273		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 3	D 273		

of semi ambulatory residents.
-Resident #2 required the use of a wheelchair for ambulation.

Review of the physical therapy (PT) discharge summary dated 06/03/22 revealed:
-Resident #2 PT services began on 03/24/22.
-Resident #2 had missed 3 scheduled appointments.
-Resident #2 was discharged due to noncompliance with skilled therapy.

Interview with Resident #2 on 07/27/22 at 8:58am revealed:
-She had resided at the facility for at least 1 year.
-She had a stroke in 2018 which affected her right side.
-She needed assistance transferring from the bed to her wheelchair.
-She was receiving PT for at least three months.
-She missed an appointment at the end of June 2022.
-She did not remember the reason for the missed PT appointments.
-She was told her insurance would no longer pay for PT.
-She could not remember the name of the staff who told her the PT had been canceled.
-The Resident Care Coordinator (RCC) or Medication Aide Supervisor (MAS) had scheduled her PT appointments.
-She felt the PT had helped because she had learned to take at least 4 steps using a walker.
-She had learned how to use her right side and could use her right hand "a little more".

Telephone interview with Resident #2's family member on 07/28/22 at 4:45pm revealed:
-Resident #2 had a stroke in 2018 and lost the usage of her right side.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 4	D 273		

-Resident #2 began PT in March 2022.
-She had been informed the PT had stopped because of insurance payment issues
-She had noticed slightly movement from Resident #2's right leg after beginning PT.
-She felt PT had helped Resident #2 because she had not been able to use her right side.

Telephone interview with Resident #2's Primary Care Physician (PCP) on 07/28/22 at 10:56am revealed:
-He had last seen Resident #2 on 06/14/22 for a routine visit.
-Resident #2 follow up visits were every 60 days.
-He had referred Resident #2 for PT services in February 2022.
-He had noticed Resident #2 could move her right leg slightly but still had issues using her right hand.

Telephone interview with the rehabilitation services facility on 07/28/22 at 11:42 am revealed:
-Resident #2 began PT service on 03/24/22.
-The PT service were mostly scheduled on the same day but at different times.
-Resident #2 was last seen for PT service on 05/23/22.
-Resident #2 had missed PT appointments on 04/22/22, 05/03/22 and 06/01/22.
-Calls had been made to the facility and voice messages where left but no return calls.
-Resident #2 was more receptive and had a greater need for PT.
-Resident #2 was discharged from PT services due to missing 3 scheduled appointments.

Interview with the RCC on 07/28/22 at 1:15pm revealed:
-Resident #2's PT ended due to noncompliance,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 273	Continued From page 5	D 273		

not wanting to complete tasks.
-The RCC was not aware of Resident #2 refusing any appointments.
-Resident #2's mobility had improved some on her right side since she had begun receiving PT.
-The RCC had been informed of the discharge of services from a MAS.
-The RCC had not followed up with the reason for discharges.
-Resident #2 was scheduled for PT at least twice weekly and within 45 minutes to 1 hour apart.
-The RCC had called about an appointment and learned Resident #2 had missed a scheduled appointment (date not given).
-The Medication Aides (MA) or Personal Care Aides (PCA) were responsible for transporting residents to their appointments.
-If a resident missed an appointment it was due to a no show and not arriving late.
-The RCC was responsible for scheduling residents' medical appointments and following up on appointments.
-She expected the MAs and PCAs to have all of the appointment information and Residents are taken to their appointments.

Interview with the Administrator on 07/28/22 at 2:39pm revealed:
-Resident #2 had shown improvement with PT but she later stopped giving it 100%.
-All phone messages were filtered to the RCC and/or the MAS.
-She had not been made aware of Resident #2 missed PT appointments.
-The RCC was responsible for scheduling appointments and ensuring transportation was available for the appointments.
-She expected residents to be taken to their scheduled appointments and missed appointments were to be rescheduled.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 282	10A NCAC 13F .0904(a)(1) Nutrition and Food Service 10A NCAC 13F .0904 Nutrition and Food Service (a) Food Procurement and Safety in Adult Care Homes: (1) The kitchen, dining and food storage areas shall be clean, orderly and protected from contamination. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to ensure the kitchen was clean and free of contamination related to uncovered food, plates, cups and eating utensils and the use of fresh mopping water and a clean mop head. The finding are: Review of the Food Establishment Inspection Report dated 06/27/22 revealed: -The score rating was 92.5. -There was a citation for controlling pests, flies present. -There was a citation for wiping cloths, use limitations, maintaining sanitized in wiping cloth bucket. -There was a citation for kitchenware and tableware: preventing contamination. Observation of the kitchen on 07/27/22 at 12:27pm revealed: -There were two uncovered pots on the stove of sweet potatoes and mixed vegetables. -The was an uncovered 10oz can of mandarin oranges placed on a serving table. -There were 8 uncovered plates placed on a	D 282		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 282	Continued From page 7	D 282		

serving table.
-There were 10 uncovered plates placed on a second serving table.
-There were flies that had landed on the uncovered mandarin oranges, four of the uncovered plates and the two serving tables.
-The 18 plates were uncovered and had mandarin oranges syrup on them.

Observation of the kitchen on 07/27/22 at 12:31pm revealed:
-There was a mop bucket with a mop placed by the door.
-The mop water was black in color and had a foul smell.
-The dietary aide used the mop to get up spilled mandarin orange juice from the floor.

Interview with the dietary aide on 07/27/22 at 12:34pm revealed:
-She would use paper plates because the flies had contaminated the regular serving plates.
-She cleaned the mop head daily.
-She changed the mop water daily.
-She had not prepared cleaned and sanitized mop water or changed the mop on 07/27/22.
-She could not remember the last time she had changed the mop head and prepared clean sanitized mop water.
-She had all of the materials she needed to keep the kitchen cleaned and sanitized.
-There was not a daily cleaning schedule to follow.

Interview with the Resident Care Coordinator (RCC) on 07/27/22 at 12:41pm revealed:
-The dietary aides were responsible for cleaning and sanitizing the entire kitchen.
-There was not a daily cleaning schedule.
-She expected the dietary aides to keep the food

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 282	Continued From page 8 free from contamination and to keep the kitchen clean and sanitized. Interview with the Administrator on 07/27/22 at 12:44pm revealed: -The dietary aides were responsible for cleaning the kitchen. -She expected the dietary aides to keep the food free from contamination and to keep the kitchen clean and sanitized. -The RCC supervised the dietary aides.	D 282		
D 344	10A NCAC 13F .1002(a) Medication Orders 10A NCAC 13F .1002 Medication Orders (a) An adult care home shall ensure contact with the resident's physician or prescribing practitioner for verification or clarification of orders for medications and treatments: (1) if orders for admission or readmission of the resident are not dated and signed within 24 hours of admission or readmission to the facility; (2) if orders are not clear or complete; or (3) if multiple admission forms are received upon admission or readmission and orders on the forms are not the same. The facility shall ensure that this verification or clarification is documented in the resident's record. This Rule is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to clarify the medication order for 1 of 4 sampled residents (#5) related to the dosage of a medication used for depression. The findings are:	D 344		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 9	D 344		

Review of Resident #5's current FL-2 dated 11/19/21 revealed:
-Diagnoses included hypertension, hyperlipidemia, and depression.
-The resident was intermittently disoriented.
-There was an order for sertraline 50mg daily.

Review of Resident #5's Resident Register revealed an admission date of 11/26/21.

Review of Resident #5's mental health provider visit report dated 01/05/22 revealed:
-There was an order to discontinue sertraline 50mg 1 tablet daily for depression.
-There was an order to start sertraline 100mg 1 tablet daily for depression.

Review of Resident #5's mental health provider visit report dated 06/28/22 revealed:
-Patient had active and ongoing symptoms related to current disease process that was not completely controlled.
-Diagnosis included patient's depression and crying spells have increased this month.
-There was an order to discontinue sertaline 100mg 1 tablet daily for depression.
-There was an order to start sertraline 100mg 2 tablets daily for depression.
-Any new orders were to be forwarded to the primary care provider for review.

Telephone interview with Resident #5's private pharmacist on 07/27/22 at 9:23am revealed:
-This pharmacist received and dispensed medication orders for the resident.
-The pharmacist received a medication order from the resident's primary care provider (PCP) for sertraline 100mg 2 tablets daily on 11/09/21.
-The pharmacist dispensed sertraline 100mg 2

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 10	D 344		

tablets daily for the resident on 11/09/21 for a 180-day supply.
-The pharmacist did not auto-refill medication orders.
-Medication orders were re-filled by the pharmacist upon request by the facility or the prescriber.
-If the medication order had expired and the facility requested a refill, the pharmacist would notify the prescriber for a new order.
-The pharmacist received a refill order request from the facility for sertraline 100mg 2 tablets daily on 01/18/22.
-The pharmacist dispensed sertraline 100mg 2 tablets for the resident on 01/18/22 for a 180-day supply.
-The pharmacist received a telephone refill order from the facility on 07/27/22 for the resident for sertraline HCL 100mg 2 tablets daily.
-The pharmacist dispensed sertraline 100mg 2 tablets daily for the resident on 07/27/22 for a 180-day supply.

Observation of the 8:00am medication pass on 07/27/22 at 8:45am revealed:
-Resident #5's medications were dispensed in individual medication bottles compared to other residents' medications which were dispensed in punch cards.
-The label on the resident's sertraline medication bottle showed the resident's primary care provider (PCP) was the prescriber.
-The label on the resident's sertraline medication bottle showed the medication was dispensed by the resident's pharmacist with a dispensed date of 01/18/22.
-The instruction on the label was for sertraline 100mg 2 tablets daily.
-Sertraline 100mg 2 tablets was not administered to Resident #5 because no tablets were in the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 11	D 344		

bottle.

Observation of medications on hand on 07/28/22 at 3:30pm revealed:
-The sertraline medication bottle received from the resident's pharmacist on 07/28/22 showed the PCP as the prescriber.
-The label showed instructions for sertraline 100mg 2 tablets daily.
-The dispensed date was 07/27/22.

Review of Resident #5's March 2022 eMAR (electronic medication record) revealed:
-There was an entry for sertraline 100mg 1 tablet daily for depression.
-There was an entry that showed the mental health provider was the prescriber.
-There was documentation that sertraline 100 mg 1 tablet was administered to the resident at the 8:00am medication pass from 03/01/22 to 03/31/22.

Review of Resident #5's April 2022 eMAR revealed:
-There was an entry for sertraline 100mg 1 tablet daily for depression.
-There was an entry that showed the mental health provider was the prescriber.
-There was documentation that sertraline 100mg 1 tablet was administered to the resident at the 8:00am medication pass from 04/01/22 to 04/30/22.

Review of Resident #5's May 2022 eMAR revealed:
-There was an entry for sertraline 100mg 1 tablet daily for depression.
-There was an entry that showed the mental health provider was the prescriber.
-There was documentation that sertraline 100mg

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 12	D 344		

1 tablet was administered to the resident at the 8:00am medication pass from 05/01/22 to 05/31/22.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry for sertraline 100mg 1 tablet daily for depression
-There was an entry that showed the mental health provider was the prescriber.
-There was documentation that sertraline 100mg 1 tablet was administered to the resident at the 8:00 medication pass from 06/01/22 to 06/28/22.
-There was an entry to discontinue sertraline 100mg 1 tablet on 06/28/22
-There was an entry for sertraline 100mg 2 tablets daily starting 06/29/22.
-There was documentation that sertraline 100mg 2 tablets were administered from 06/29/22 to 06/30/22.

Review of Resident #5's July 2022 eMAR revealed:
-There was an entry for sertraline 100mg 2 tablets daily for depression
-There was an entry that showed the mental health provider was the prescriber.
-There was documentation that sertraline 100mg 2 tablets were administered to the resident at the 8:00am medication pass from 07/01/22 to 07/26/22.
-Sertraline 100mg 2 tablets was not documented as administered on 07/27/22 at the medication pass because it was not available on the medication cart.

Interview with the medication aide (MA) on 07/28/22 at 12:51pm revealed:
-The medication aides (MAs) were responsible for conducting medication cart audits to ensure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 13	D 344		

medications were available on the medication cart and medication orders were accurate.
-The MAs were responsible for submitting medication orders and requesting medication refills to the resident's pharmacist.
-She called the pharmacist today to reorder the sertraline because it was not on the medication cart today for administration to Resident #5.
-Resident #5 had her own pharmacist and did not utilize the facility's contracted pharmacist.
-She had not noticed that the sertraline order for Resident #5 was 100mg 2 tablets daily on the label of the medication bottle dispensed by the resident's pharmacist.
-She administered sertraline 100mg 1 tablet daily based on the electronic medication record (eMAR) until the order was changed to 100mg 2 tablets by the resident's mental health provider in June 2022.
-It was important for Resident #5 to receive the correct medication dose for safety reasons.

Interview with the Resident Care Coordinator (RCC) on 07/28/22 at 1:15pm revealed:
-The MAs were responsible for conducting medication cart audits to ensure medications were on the cart and medication orders were accurate.
-It was her responsibility to ensure medication cart audits were done.
-Resident #5 used her preferred pharmacist to dispense medications.
-The process was for the facility to send medication orders to the facility's contracted pharmacist to be placed on the eMAR and to the resident's pharmacist for dispensing.
-Resident #5's pharmacist did not have anything to do with placing medication orders on the eMAR, they only dispensed the medication.
-Resident #5's PCP must have submitted the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
D 344	Continued From page 14	D 344		

sertraline medication order directly to the resident's preferred pharmacist.
-The medication order should have also been sent to the facility's contracted pharmacist to ensure the eMAR corresponded with the medication order dispensed by the resident's pharmacist.
-Her expectation was for all medication orders to be reviewed by the resident's primary care provider and to be accurate for safety reasons.
-It was her expectation that the instructions on the label of the medication bottle should be checked with the e-MAR prior to administration to the resident for accuracy.

Interview with the Administrator on 07/28/22 at 1:25pm revealed:
-Resident #5 had a different pharmacist than the facility's contracted pharmacist.
-Resident #5's pharmacist dispensed the medication.
-The facility's contracted pharmacist was responsible for placing the sertraline medication order on the eMAR.
-The facility needed to ensure medication orders for Resident #5 were submitted to both the resident's pharmacist and the facility's contracted pharmacist to ensure medications were accurate and verified.
-It was important that medications were administered as ordered for safety reasons.

Based on observation, record review and interviews, it was determined that Resident #5 was not interviewable.

Attempted telephone interview with Resident #5's PCP on 07/28/22 at 10:40am was unsuccessful.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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D 358	Continued From page 15	D 358		
D 358	10A NCAC 13F .1004(a) Medication Administration 10A NCAC 13F .1004 Medication Administration (a) An adult care home shall assure that the preparation and administration of medications, prescription and non-prescription, and treatments by staff are in accordance with: (1) orders by a licensed prescribing practitioner which are maintained in the resident's record; and (2) rules in this Section and the facility's policies and procedures. This Rule is not met as evidenced by: Based on observation, record reviews and interviews, that facility failed to ensure a medication was administered as ordered for 1 of 4 sampled residents (#5) related to a medication to treat urinary tract infection. The findings are: Review of Resident #5's current FL-2 dated 11/19/21 revealed: -Diagnoses included hypertension, hyperlipidemia, and depression. -The resident was intermittently disoriented. Review of Resident #5's Resident Register revealed an admission date of 11/26/21. Telephone interview with Resident #5's preferred pharmacist on 07/28/22 at 9:23am revealed: -This pharmacist dispensed medications for the resident. -The pharmacist received a medication order from the resident's primary care provider (PCP) for Nitrofurantoin MCR 50 mg 1 capsule daily on 11/23/21. -The pharmacist dispensed a 90-day supply of	D 358		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 358	Continued From page 16	D 358		

Nitrofurantoin on 11/23/21.
-The pharmacist received a refill order on 03/09/22 for Nitrofurantoin MCR 50 mg 1 capsule daily.
-The pharmacist last dispensed Nitrofurantoin for a 30-day supply on 03/09/22.
-The pharmacist did not auto refill medication orders.
-The facility had to contact the pharmacist to request a refill on a medication order.
-Nitrofurantoin should not have been available at the facility after mid-April 2022 if the medication was administered as ordered.

Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed:
-There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily.
-There was documentation that Nitrofurantoin 50 mg 1 capsule was administered at the 8:00am medication pass from 05/01/22 to 05/31/22.

Review of Resident #5's June 2022 eMAR revealed:
-There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily.
-There was documentation that Nitrofurantoin 50mg 1 capsule was administered daily at the 8:00am medication pass from 06/01/22 to 06/30/22.

Review of Resident #5 's July 2022 eMAR revealed:
-There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily.
-There was documentation that Nitrofurantoin 50 mg 1 capsule was administered at the 8:00am medication pass from 07/01/22 to 07/26/22.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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D 358	Continued From page 17	D 358		

Review of Resident #5's medication order from Resident #5's PCP revealed Nitrofurantoin MCR 50mg 1 capsule for chronic urinary tract infection was discontinued on 07/26/22.

Based on observation, record reviews and Interviews, it was determined that Resident #5 was not interviewable.

Interview with the medication aide (MA) on 07/28/22 at 12:57pm revealed.
-She worked at the facility on the day shift.
-The MAs were responsible for performing medication cart audits and ensuring medications were on the medication cart.
-The MAs were responsible for reordering medications.
-She usually reordered a medication when there were about 5 doses left.
-She must have " clicked" on the Nitrofurantoin medication displayed on the eMAR documenting that it was administered by mistake.

Interview with the Resident Care Coordinator (RCC) on 07/28/22 at 1:15pm revealed:
-The MAs were responsible for medication cart audits and ensuring medications were on the medication cart.
-She was responsible for ensuring medication cart audits were done.
-The MAs should pay attention to the medication they are documenting on the eMAR as administered
-If a medication was not available, it should be documented as not available on the eMAR.
-It was important that medications were administered as ordered.

Interview with the Administrator on 07/28/22 at 1:25pm revealed:

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	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 358	Continued From page 18 -The MAs were responsible for medication cart audits to ensure medications were on the cart. -The MAs were responsible for reordering medications from the pharmacist when needed. -She did not know why the medication was documented as administered when it was not available on the cart. -It was important that medications were administered as ordered. Attempted telephone interview with Resident #5's PCP on 07/28/22 at 10:40am was unsuccessful.	D 358		
D 367	10A NCAC 13F .1004(j) Medication Administration 10A NCAC 13F .1004 Medication Administration (j) The resident's medication administration record (MAR) shall be accurate and include the following: (1) resident's name; (2) name of the medication or treatment order; (3) strength and dosage or quantity of medication administered; (4) instructions for administering the medication or treatment; (5) reason or justification for the administration of medications or treatments as needed (PRN) and documenting the resulting effect on the resident; (6) date and time of administration; (7) documentation of any omission of medications or treatments and the reason for the omission, including refusals; and, (8) name or initials of the person administering the medication or treatment. If initials are used, a signature equivalent to those initials is to be documented and maintained with the medication administration record (MAR).	D 367		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	HAL072013	A. BUILDING: _____ B. WING _____	07/28/2022

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

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D 367	Continued From page 19	D 367		

This Rule is not met as evidenced by:
Based on observation, record reviews and interviews, the facility failed to ensure the electronic administraton record (eMAR) was accurate for 1 of 4 sampled residents (#5) related to a medication to treat urinary tract infection.

The findings are:

Review of Resident #5's current FL-2 dated 11/19/21 revealed:
-Diagnoses included hypertension, hyperlipidemia, and depression.
-The resident was intermittently disoriented.

Review of Resident #5's Resident Register revealed an admission date of 11/26/21.

Telephone interview with Resident #5's preferred pharmacist on 07/28/22 at 9:23am revealed:
-This pharmacist dispensed medications for the resident.
-The pharmacist received a medication order from the resident's primary care provider (PCP) for Nitrofurantoin MCR 50 mg 1 capsule daily on 11/23/21.
-The pharmacist dispensed a 90-day supply of Nitrofurantoin on 11/23/21.
-The pharmacist received a refill order on 03/09/22 for Nitrofurantoin MCR 50 mg 1 capsule daily.
-The pharmacist last dispensed Nitrofurantoin for a 30-day supply on 03/09/22.
-The pharmacist did not auto refill medication orders.
-The facility had to contact the pharmacist to request a refill on a medication order.
-Nitrofurantoin should not have been available at the facility after mid-April 2022 if the medication was administered as ordered.

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D 367	Continued From page 20 Review of Resident #5's May 2022 electronic medication administration record (eMAR) revealed: -There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily. -There was documentation that Nitrofurantoin 50 mg 1 capsule was administered at the 8:00am medication pass from 05/01/22 to 05/31/22. Review of Resident #5's June 2022 eMAR revealed: -There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily. -There was documentation that Nitrofurantoin 50mg 1 capsule was administered daily at the 8:00am medication pass from 06/01/22 to 06/30/22. Review of Resident #5 's July 2022 eMAR revealed: -There was an entry for Nitrofurantoin MCR 50 mg 1 capsule daily. -There was documentation that Nitrofurantoin 50 mg 1 capsule was administered at the 8:00am medication pass from 07/01/22 to 07/26/22. Review of Resident #5's medication order from Resident #5's PCP revealed Nitrofurantoin MCR 50mg 1 capsule for chronic urinary tract infection was discontinued on 07/26/22. Based on observation, record reviews and Interviews, it was determined that Resident #5 was not interviewable. Interview with the medication aide (MA) on 07/28/22 at 12:57pm revealed. -She worked at the facility on the day shift. -She must have " clicked" on the Nitrofurantoin	D 367		

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D 367	Continued From page 21 medication displayed on the eMAR documenting that it was administered by mistake. Interview with the Resident Care Coordinator (RCC) on 07/28/22 at 1:15pm revealed: -The MAs should pay attention to the medication they are documenting on the eMAR as administered -If a medication was not available, it should be documented as not available on the eMAR. -It was important that documentation on the e-MAR was correct. Interview with the Administrator on 07/28/22 at 1:25pm revealed: -The MAs were responsible for medication cart audits to ensure medications were on the cart. -The MAs were responsible for reordering medications from the pharmacist when needed. -She did not know why the medication was documented as administered when it was not available on the cart. -It was important that documentation of the administration of medications on the eMAR were accurate. Attempted telephone interview with Resident #5's PCP on 07/28/22 at 10:40am was unsuccessful.	D 367		