STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 000	INITIAL COMMENTS A complaint investigation survey was conducted onsite from 8/23/23 through 8/24/23 with additional information obtained remotely 8/25/23 through 8/31/23. Onsite validation of Immediate Jeopardy removal was conducted on 9/1/23. Therefore the exit date was 9/1/23. Event ID# QYC811. The following intakes were investigated: NC00205892 and NC00205999. Intake NC00205892 resulted in Immediate Jeopardy. 2 of the 11 complaint allegations resulted in deficiency. Immediate Jeopardy was identified at: CFR 483.25 at tag F684 at a scope and severity J The tag F684 constituted Substandard Quality of Care. Immediate Jeopardy began on 8/12/23 and was removed on 8/31/23. A partial extended survey was conducted. The Statement of Deficiencies was amended on 9/20/23 at tag F684.	F 000		
F 684 SS=J	Quality of Care CFR(s): 483.25 § 483.25 Quality of care Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure	F 684		9/2/23

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 09/15/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 1 that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices. This REQUIREMENT is not met as evidenced by: Based on record review, and staff, Emergency Medical Services (EMS) personnel, and Medical Director interviews, the facility failed to identify the urgent need for medical attention for a resident with new onset seizure activity on 8/12/23 at approximately 10:30 am which is a medical emergency. They did not immediately initiate EMS (Emergency Medical Services) to transfer the resident to an acute care hospital for medical evaluation and interventions for 1 of 2 residents reviewed with a medical emergency. EMS was contacted at 10:58 am and upon their arrival Resident #1 continued with seizure activity and required 3 doses of Versed (a medication used to stop a seizure) for seizure activity to cease. Upon arrival at the hospital Resident #1 was unresponsive and in status epilepticus (a seizure lasting for more than 5 minutes), a medical emergency that may lead to brain damage or death. A CT (computerized tomography) scan revealed a subarachnoid hemorrhage (bleeding in the space that surrounds the brain), Resident #1 required intubation (a tube inserted into the airway) and was admitted to the ICU (intensive care unit). Immediate Jeopardy began on Saturday, 8/12/23, when the facility failed to initiate EMS immediately when Resident #1 was observed with onset of seizure activity. The immediate jeopardy was removed on 8/31/23 when the facility provided an acceptable credible allegation for immediate jeopardy removal. The facility will remain out of	F 684	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F684 1. Corrective action for resident(s) affected by the alleged deficient practice: Resident #1 was discharged to the care of Emergency Medical Service on 08/12/2023 and is no longer a resident of the facility. No further corrective action could be completed specific to Resident #1. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents are at risk of requiring emergency medical services. On 08/30/2023, the Nurse Consultant, Interim Director of Nursing (DON), and Licensed Practical Support Nurse (LPN) completed an audit of 100% of hospital transfers for	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 2 compliance at a lower scope and severity level of a "D" (no actual harm with potential for more than minimal harm that is not immediate jeopardy) to ensure completion of education and that monitoring systems put into place are effective. The findings included: Resident #1 was admitted to the facility on 4/25/23. Resident #1's diagnoses did not indicate any history of seizures. Review of the quarterly Minimum Data Set (MDS) completed on 7/1/23 identified Resident #1 as severely cognitively impaired. The MDS did not reveal a diagnosis of seizures. Resident #1's physician's order summary for August 2023 revealed Resident #1 had no orders for seizure medication. On 8/23/23 at 9:47 AM Nurse Aide (NA) #2 (agency staff) was interviewed and stated on Saturday 8/12/23 she took Resident #1's breakfast meal tray away around 9:30 AM and did not remember anything unusual with Resident #1. On 8/29/23 at 9:24 AM NA #1 was interviewed and stated she was coming up the hall on 8/12/23 at 10:30 AM and saw Resident #1 had movement of her head, like a seizure. The NA stated she had never worked with the resident before but knew she did not look right and went to tell Nurse #2 right away. A phone interview was conducted with Nurse #1 (agency staff) on 8/23/23 at 3:48 PM. She indicated on 8/12/23 she saw Resident #1 with a mild twitch of her lips and continued to observe	F 684	current and discharged residents for the last 3 months from 05/30/2023 □ 08/31/2023. This audit consisted of review of each hospital transfer to identify any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn□t be met at the facility. This audit was completed on 08/30/2023. The audit identified that 1 of 30 hospital transfers had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn□t be met at the facility. Resident #1 was the resident identified as a result of the audit. No corrective actions were required for the resident #1 as resident remains out at the hospital. Additionlly, On 08/30/2023 the Interim DON met with all floor nurses and initiated assessment of all current residents to identify any residents with any acute change in condition to include: Any	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 3	F 684		

her for about one minute. When the twitch did not stop she stepped to the doorway and saw Nurse #2 (who was the weekend Supervisor) on the hall and reported the resident's head was moving like a little twitch. Nurse #1 revealed she could not remember what time she observed the resident and notified Nurse #2. Nurse #1 indicated that Nurse #2 took over and contacted the On Call Physician. Nurse #1 indicated Resident #1's breathing was normal/regular and she denied observing any other changes with the resident.

Nurse #2 was interviewed on 8/23/23 at 11:13 AM. She indicated on 8/12/23 around 10:30 AM, NA #1 came and reported to her Resident #1 was twitching. Nurse #2 stated she went to Resident #1's room and when she saw the resident her head was twitching left to right. Nurse #2 revealed Nurse #1 joined her in the resident's room and she (Nurse #2) indicated it appeared the resident was having a seizure. Nurse #2 stated the resident did not have a diagnosis of seizures. She reported she told Nurse #1 to stay with resident until she returned with her electronic tablet to contact the On Call Physician.

Nurse #2's triage note documentation for 8/12/23 revealed the following information related to Resident #1:
- At 10:38 AM Nurse #2 contacted the on-call physician group via electronic tablet communication. The On Call Physician requested information on any history of seizures and if the resident was on seizure medication. Nurse #2 indicated "no" to both questions and was instructed to get vital signs (VS) to include blood pressure (BP).
- At 10:46 AM Nurse #2 responded back to the On Call Physician with VS as heart rate 118 and

symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn□t be met at the facility. No current residents were identified as having any acute change in condition. No other residents were impacted.

3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:

On 08/30/2023 the DON began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additionally, education included activation of emergency services when physician response time was delayed, or if emergent care needs couldn□t be met at the facility. Additional education included that if conditions worsened and nurse□s assessment warrants, activate emergency medical services, call the attending physician and resident's family or

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 4 temperature of 96.9. The nurse indicated she was not able to get a BP due to Resident #1's arm movement. The On Call Physician ordered Ativan intramuscular (IM) (used as a rescue medication to stop a seizure). Ativan IM was not available in the facility and the order was given to send Resident #1 to the Emergency Room (ER). The EMS report dated 8/12/23 indicated a call was received from the facility at 10:58 AM and they were dispatched to the facility at 10:59 AM. A Health Status note completed by Nurse #2 dated 8/12/23 at 11:03 AM revealed the writer observed Resident #1 having constant seizure like activity. Nurse #2 contacted the On Call Physician through tablet communication and an order to send to the ER was obtained. In a follow up phone interview on 8/24/23 at 1:21 PM Nurse #2 indicated on 8/12/23 she followed the facility's normal protocol for physician communication and used her tablet to email the On Call Physician. She indicated the resident was laying on her back with her head turned to the right and her head was twitching back and forth. Nurse #2 indicated the resident was not having convulsions, her body was shaking more like a tick, and had no thrashing. She reported this information to the On Call Physician. Nurse #2 indicated the On Call Physician asked for VS and BP, she indicated she was able to get VS but not able to obtain BP as Resident #1 had to be completely still for an accurate BP. After providing information on the VS and inability to obtain a BP, the On Call Physician wanted to know if the resident was on any seizure medications. She revealed at first she answered yes to the On Call Physician and then checked	F 684	responsible party, as appropriate to ensure resident receives emergent care needs to address the change in condition. The DON will ensure that all licensed nurses, RN□s, LPN□s, and CNA□s (full time, part time, and prn including agency) who do not complete the in-service training by 08/31/2023 will not be allowed to work until the training is completed. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff identified above and will be reviewed by the Quality Assurance process to verify that the change has been sustained. Any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed by 08/31/2023. 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. The DON or designee will monitor compliance utilizing the F684 Quality Assurance Tool weekly x 4 weeks then monthly x 3 months. The DON or designee will monitor compliance reviewing 4 hospital transfers to identify any residents with an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 5 the medical record and realized Resident #1 was not ordered any seizure medication and informed the On Call Physican of the correct information (no ordered seizure medication). Nurse #2 indicated the On call Physician ordered Ativan IM, but the facility did not have any in stock and she received the order to send Resident #1 to the ER prior to calling EMS. A phone interview was conducted on 8/28/23 at 11:02 AM with the On Call Physician who took the call from the facility related to Resident #1 on 8/12/23. The On Call Physician revealed the facility called to report Resident #1 was having seizure activity. The On Call Physician indicated staff were asked to get VS, BP and if the resident was receiving any seizure medications. Staff reported VS and there was initially some confusion with staff as to whether the resident did or did not receive seizure medication. She indicated when staff clarified the resident did not have orders for seizure medication an order was given for Ativan IM. Staff reported back that there was no Ativan IM in the facility. The On Call Physician stated if the resident had received Ativan IM, it could have resolved her seizures. The On Call Physician indicated that most facilities had liquid Ativan available for emergency situations. The EMS Report dated 8/12/23 indicated they arrived at the facility at 11:07 AM. The report revealed on arrival at the facility, "Nurse stated that [Resident #1] had been seizing for approximately an hour and they had no standing orders or medication. [Resident #1] was found sitting [on] her bed obvious seizure, right side, facial droop, irregular, respirations." Staff advised that Resident #1 was seen at approximately 9:30	F 684	sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn□t be met at the facility. Reports will be presented to the Quality Assurance committee by the DON to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the Quality Assurance Meeting. The Quality Assurance Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Unit Support Nurses, Therapy Manager, Health Information Manager, and the Dietary Manager. The Medical Director and Pharmacist attend the quarterly Quality Assurance Meeting. Date of Compliance: 09/02/2023	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 6	F 684		

AM this morning for medication administration. A 2.5 mg dose of Versed was first administered in a previously established IV (intravenous) at 11:13 AM and the Resident 's response was documented as unchanged. A second 2.5 mg dose was administered at 11:22 AM and the Resident's response was documented as unchanged. Oxygen was applied via a non-rebreather mask (a face mask that gives you oxygen). Resident #1 left the facility with EMS at 11:20 AM. The resident was noted to continue to seize and a third 2.5 mg dose of Versed was administered at 11:30 AM (while enroute to the hospital) and the Resident's response was documented as improved. During transport Resident #1 continued to have irregular breathing and a nasopharyngeal airway (NPA) was inserted (a thin, clear, flexible tube that is inserted into a patient's nostril to bypass upper airway obstruction) and breathing became more regular. EMS arrived at the hospital at 12:01 PM.

In a phone interview on 8/28/23 at 2:57 PM EMS personnel revealed on arrival at the facility on 8/12/23, she observed Resident #1 with seizure activity. EMS reported that Nurse #2 indicated the resident had been having seizures for about an hour. EMS stated the resident had an established IV line and had facial droop on her right side. She indicated she gave the Resident a dose of medication (Versed) to help with seizures and moved the resident onto their ambulance. EMS stated before they left the facility she administered a second dose of seizure medication, and while on route to the hospital, she gave a third dose. She indicated after the third dose Resident #1's condition improved.

The hospital record revealed Resident #1

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 7	F 684		

presented on 8/12/23 for status epilepticus. She was noted with tonic-clonic seizure activity (involves a loss of consciousness with stiffening of muscles and twitching/jerking muscle contractions) with duration of one hour and right-sided gaze deviation (abnormal movement of the eyes). On arrival she had a Glasgow Coma Scale (scale used to describe the extent of impaired consciousness) score of 3 (the lowest possible score indicating the resident was completely unresponsive). Resident #1 was intubated for airway protection. A CT scan showed an acute subarachnoid hemorrhage. The hospital course indicated on 8/13/23 Resident #1's gaze deviation that was previously to the right was now on the left. An MRI (magnetic resonance imaging) of Resident #1's brain was conducted on 8/14/23 and showed no acute signs of stroke. Resident #1 was hospitalized until 8/23/23 at which time she was transferred to an inpatient hospice.

On 8/28/23 at 12:12 PM during a phone interview the Medical Director indicated that the conversation on 8/12/23 with the On Call Physician group was through electronic messaging/tablet (emailing back and forth) and not on the phone. The Medical Director further stated that this was a new onset of seizures for Resident #1, and the delay was in trying to see if there was anything staff could do to stop or treat the seizures in the facility. The Medical Director said they did treat the situation as a medical emergency and the nurse called the On Call Physician group and followed their directions/orders to send Resident #1 out. The On Call Physician was trying to do the right thing for a resident with first time seizures which included getting the resident's history and trying

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 8	F 684		

to see if they could treat/resolve in house before sending out. She indicated she believed their response was appropriate.

An interview on 8/24/23 at 1:11 PM the Nurse Support Staff stated if a resident were having seizures, staff should call the physician and send the resident out immediately.

The Administrator was notified of immediate jeopardy on 8/30/23 at 11:00 AM.

The facility provided the following credible allegation of immediate jeopardy removal:

Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as a result of the noncompliance.

Resident #1 was discharged to the care of Emergency Medical Service on 08/12/2023 and is no longer a resident of the facility. No further corrective action could be completed specific to Resident #1.
All residents are at risk of requiring emergency medical services. On 08/30/2023, the Nurse Consultant, Interim Director of Nursing (DON), and Licensed Practical Support Nurse (LPN) completed an audit of 100% of hospital transfers for current and discharged residents for the last 3 months from 05/30/2023 - 08/30/2023. This audit consisted of review of each hospital transfer to identify any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 9	F 684		

services was required and not initiated when physician response time was delayed, or if emergent care needs couldn't be met at the facility. This audit was completed on 08/30/2023. The audit identified that 1 of 30 hospital transfers had an acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn't be met at the facility. Resident #1 was the resident identified as a result of the audit. No corrective actions were required for Resident #1 as the resident remains out at the hospital.

On 08/30/2023, the Interim DON met with all floor nurses and initiated assessment of all current residents to identify any residents with any acute change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed and where immediate emergency medical services was required and not initiated when physician response time was delayed, or if emergent care needs couldn't be met at the facility. No current residents were identified as having any acute change in condition. No other residents were impacted.

Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 10	F 684		

On 08/30/2023 the DON began in servicing all licensed nurses, Registered Nurses (RN) and Licensed Practical Nurses (LPN) and certified nursing assistants (full time, part time, and prn including agency) on any change in condition to include: Any symptom, sign or apparent discomfort that is: acute or sudden in onset, and is a marked change (i.e., more severe) in relation to usual symptoms and signs, or unrelieved by measures already prescribed. Additionally, education included activation of emergency services when physician response time was delayed, or if emergent care needs couldn't be met at the facility. Additional education included that if conditions worsened and nurse's assessment warrants, activate emergency medical services, call the attending physician and resident's family or responsible party, as appropriate to ensure resident receives emergent care needs to address the change in condition.

The DON will ensure that all licensed nurses, RN's, LPN's, and CNA's (full time, part time, and prn including agency) who do not complete the in-service training by 08/30/2023 will not be allowed to work until the training is completed.

This in-service was incorporated into the new employee facility and agency orientation for all licensed nurses and certified nursing assistants (full time, part time, and prn including agency.)

Alleged date of immediate jeopardy removal: 08/31/2023

Onsite validation was completed on 9/1/23 through interviews and record review. Inservice sign in sheets and staff interviews verifed

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 09/01/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

(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) COMPLETION DATE
F 684	Continued From page 11 in-services were completed on any change in condition and activation of emergency services when physician response time was delayed, or if emergent care needs couldn't be met at the facility. Education was confirmed for agency nursing staff, facility nursing staff through interviews and any staff who did not complete the in-service training by 8/30/23 will not be allowed to work until the training is completed. Evidence of audits were reviewed for hospital transfers for current and discharged residents. Resident interviews were conducted with no issues identified. The facility's immediate jeopardy removal date was validated as 8/31/23.	F 684		