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 10/05/2023

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 from 10/3/23 through 10/5/23. Event ID #4SN211. The following intakes were investigated NC00207897, NC00207548, NC00206638, NC005860, NC00205022, NC00204464, NC00203539, and NC00203243. 1 of the 35 complaint allegations resulted in deficiency.	F 000		
F 636 SS=B	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication. (v) Vision. (vi) Mood and behavior patterns. (vii) Psychological well-being. (viii) Physical functioning and structural problems. (ix) Continence. (x) Disease diagnosis and health conditions. (xi) Dental and nutritional status.	F 636		10/28/23

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

Electronically Signed | 10/28/2023

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 10/05/2023

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 636	Continued From page 1 (xii) Skin Conditions. (xiii) Activity pursuit. (xiv) Medications. (xv) Special treatments and procedures. (xvi) Discharge planning. (xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS). (xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts. §483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs. (i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.) (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to complete a Minimum Data Set (MDS) admission assessment within the required timeframe for 1 of 1 resident (Resident #7) reviewed for Resident Assessments.	F 636	F636 □ Comprehensive Assessment and Timing Corrective Action: An audit was completed for the last 30 days of Comprehensive Minimum Data	

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 10/05/2023

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 636	Continued From page 2 Findings included. A review on 10/04/23 of Resident #7's admission assessment with the ARD (assessment reference date, which is the last day of the observation period) of 09/24/23 revealed the assessment was incomplete and was in progress. Resident #7 was admitted on 09/11/23. An interview was conducted on 10/04/23 at 2:40 PM with the MDS nurse. The MDS Nurse stated the admission assessment should have been completed by 09/24/23. The MDS Nurse indicated the reason the assessment was late was because she is the only MDS nurse and was often pulled from her duties to work on the floor. An interview was conducted with the Director of Nursing (DON) and Administrator on 10/05/23 at 11:50 AM. They both indicated they were aware some of the MDS assessments were behind, but not sure how many. The Administrator stated she expected MDS assessments to be completed within the required timeframes, and that they were in the process of hiring a full-time MDS nurse, and that a corporate MDS nurse was assisting their MDS nurse to get the assessments caught up.	F 636	Set assessment for affected residents that were identified as not being completed within the required 14 day timeframe. Corrections made as needed. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. A 100 % review of all current residents with a comprehensive assessment that has been completed and submitted in the last 30 days will be audited to review that assessments were completed in the 14 days timeframes. This audit will be completed by the regional Minimum data set consultant no later than 10/20/2023 " Effective 10/23/2023, the facility Minimum data set coordinator will review the Minimum Data Set (MDS) in progress list in PCC Software daily (Monday through Friday) and inform the interdisciplinary team members of the residents with Comprehensive assessment reference dates that are due for completion (Minimum data set assessment Z0500 date) on that date. These assessments have been added to the daily stand up meeting process. " The MDS nurse will be assisted by part time MDS Nurses. Systemic Changes	

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 10/05/2023

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 636	Continued From page 3	F 636	By 10/27/2023 the Regional MDS consultant will complete an in-service training with the facility Minimum Data Set Coordinator that includes the importance of ensuring that each resident receive a comprehensive assessment according to the rules stated in Chapter 2 of the RAI (resident assessment instrument) Manual. The monitoring procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with the regulatory requirements. The Director of Nursing or designee will begin auditing the facility□s compliance with comprehensive Minimum Data Set assessments completion time frames as stated in Chapter 2 of the RAI (resident assessment instrument) Manual using the quality assurance survey tool entitled Comprehensive Assessments and Timing Audit Tool to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and in compliance with the regulatory requirements. This audit will be completed on 5 residents□ completed assessments and will be done weekly x 4 weeks and then monthly x 2 months or until substantial compliance is achieved and maintained. Reports will be presented to the Quality Assurance committee to ensure corrective action for trends or ongoing concerns is initiated as appropriate. The title of the person responsible for implementing the acceptable plan of	

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 10/05/2023

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 636	Continued From page 4	F 636	correction; Administrator and /or Director of Nursing. Date of Compliance: 11/01/2023	
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to maintain a medication rate not greater than 5% when a medication was administered after a meal instead of the physician order to give at 7:30 AM on an empty stomach, and when one medication was omitted. The result of the medication errors could have resulted in a negative effect for 2 of 3 residents (Resident #8 and Resident #9) observed for medication administration. There were 2 errors in 25 opportunities observed resulting in a medication error rate of 8%. Findings included: 1. Resident #8 was admitted to the facility on 10/05/22. Diagnoses included, in part, gastroesophageal reflux disease (GERD). Review of physician orders for October 2023 revealed the following order: Lansoprazole Capsule Delayed release 30 mg-give one capsule by mouth one time a day for GERD. Give on empty stomach. Do not crush or chew.	F 759	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. F759 1. Corrective action for resident(s) affected by the alleged deficient practice: 1. On 10/05/2023, Physician Assistant #3 and Pharmacist #1 were made aware of the medication error. On 10/05/2023 the administration time was changed by the provider to ensure that medication was given at a time to ensure adequate absorption. There were no new orders provided or additional monitoring as a result of the medication error. On	10/28/23

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 10/05/2023

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 759	Continued From page 5 On 10/03/23 at 10:30 AM a medication administration pass was observed with Nurse #3 for Resident #8. Nurse #3 was observed preparing the following medications for administration: Lansoprazole 30 milligrams (mg) (medication to treat GERD), Hydroxyzine 25 mg (medication to treat chronic pruritus), Aspirin 81 mg (medication to treat cerebral infarction due to thrombosis), Cholecalciferol 1000 units (supplement), Decubi-Vite one capsule (medication to treat ulcer), Vimpat 200 mg (medication to treat seizures), Keppra 1000 mg (medication to treat epilepsy), Sennosides-Docusate Sodium 8.6-50mg (medication to treat constipation), Vitamin C 500 mg (supplement), Miralax Powder 17 grams (medication for bowel regimen), Timoptic Solution 0.5% (medication to treat elevated intraocular pressure). On 10/03/23 at 10:30 AM Nurse #3 was observed administering the medications she had prepared for Resident #8. In an interview with Nurse #3 on 10/05/23 at 9:04 AM she confirmed that she had administered Lansoprazole 30 mg to Resident #8 on 10/03/23 at 10:30 AM. She stated she had not realized that the medication was ordered to be given at 7:30 AM on an empty stomach. She noted that she had a lot of medications to give and did not always take time to read the instructions. In an interview with Resident #8 on 10/04/23 at 12:30 AM he stated he could not remember which meal he had just eaten, or what he had for breakfast today or yesterday. In an interview with Nurse Aide #8 on 10/04/23 at	F 759	10/27/2023, nurse #3 was educated on prevention of medication errors. 2. On 10/04/2023, Nurse #1 notified the provider of the medication omission and received an order to obtain a set of vital signs. On 10/04/2023, Nurse #1 assessed resident #9 for the medication omission and informed resident #9 of the omission and order to obtain a set of vital signs. On 10/12/2023, Nurse #1 was educated on prevention of medication errors. 2. Corrective action for residents with the potential to be affected by the deficient practice: All resident receiving medications have potential to be affected. On 10/27/2023, the Registered Nurse (RN) Supervisor and Unit Support Nurse initiated an audit of the last 7 days for all residents with active orders for Lansoprazole Capsule, Protonix, and Prilosec to to ensure that any instructions for administration was followed according to the physician's order. All results of the audit will be shared with the physician and corrections made where needed. On 10/27/2023, the RN Supervisor and designee completed random medication administration observations with RN's and Licensed Practical Nurse (LPN's) and Medication Aides (MA) to ensure the physician orders were followed. On 10/11/2023, the Director of Nursing (DON) initiated random staff competencies with medication	

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 10/05/2023

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 759	Continued From page 6 1:00 PM she stated she cared for Resident #8 and that he was on her regular daily assignment. She recalled around 8:00 AM on 10/03/23 he had eaten 100% of his breakfast. She noted whenever meals trays were delivered to the hall his tray was delivered first or he would complain, and he always ate 100% of his meals. The Point of Care (POC) Legend Report for Resident #8 documented on 10/03/23 he had eaten 75-100% of his breakfast. In an interview with Physician Assistant #3 on 10/05/23 at 10:38 AM she stated the instructions to administer Lansoprazole on an empty stomach was a default instruction by the pharmacy. She reported the medication was not detrimental if given with food because Resident #8 was on the medication long term. She concluded she did not know why the pharmacy instructed the medication be given on an empty stomach because she had patients who took this medication at all times of the day. In an interview with Pharmacist #1 on 10/05/23 at 12:38 PM she stated Lansoprazole is more effective when given on an empty stomach but would cause no danger to a resident if given after a meal was consumed. She added the medication would still be absorbed but would not be as effective. She suggested the medication be given before breakfast or changed to a medication that did not stipulate to be given on an empty stomach. 2. Resident #9 was admitted to the facility on 07/21/22 with diagnosis that included, in part, hypertensive heart and chronic kidney disease with heart failure, chronic systolic congestive	F 759	administration to validate understanding of the education. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 10/09/2022 the DON and designee began educating all full time, part time, and prn Registered Nurses (RN) and Licensed Practical Nurses (LPN), and Medication Aides (MA) including agency staff on the following topics: • Prevention of medication errors • Following Medication orders for parameters • Following the 6 rights of medication administration Beginning 10/11/2023, the DON or designee will validate competency of medication administration. This in-service was incorporated in the new employee facility orientation for the above-mentioned employees and also provided to agency staff working in the facility. This 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 by 10/31/2023 will not be allowed to work until training has been completed. 1. 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.	

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 10/05/2023

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 759	Continued From page 7 heart failure, presence of coronary angioplasty implant and graft, presence of automatic implantable cardiac defibrillator, ischemic cardiomyopathy, left bundle branch block, ventricular tachycardia and history of transient ischemic attack (TIA). On 10/04/23 at 9:50 AM a medication administration pass was observed with Nurse #1 for Resident #9. Nurse #1 was observed preparing the following medications for administration: Amiodarone 200 mg (medication to treat atrial fibrillation), Aspirin 81 mg (medication for antiplatelet), Cyanocobalamin 1000 mg (supplement), Furosemide 40 mg (medication to treat edema), Neurontin 300 mg (medication to treat neuropathy), Hydralazine 10mg (medication to treat hypertension), Metoprolol Tartrate 50 mg (medication to treat hypertension), and Miralax Powder 17 grams (medication for bowel regimen). On 10/04/23 at 9:50 AM Nurse #1 was observed administering the medications to Resident #9. When Nurse #1 presented his medications for him to take he asked her how many pills were in the medication cup. Nurse #1 counted the pills for a total of 7. Resident #9 stated, "OK", and took the medications one at a time. Review of the physician orders for Resident #9 revealed the following order: Isosorbide Mononitrate 10 mg by mouth two times a day for hypertension at 9:00 AM and 8:00 PM. In an interview with Nurse #1 on 10/04/23 at 1:15 PM she stated after she had administered Resident #9 his medications she returned to the computer and clicked on each medication due as	F 759	The DON or Designee will monitor compliance utilizing the F759 Medication Observation Tool for 4 observations weekly x 4 weeks then monthly x 2 months or until resolved. Monitoring will occur on various shifts and days of the week to include weekends to assure that we are free of a medication error rate of less than 5 percent. This will include monitoring medication to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/01/2023	

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 10/05/2023

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 759	Continued From page 8 given. She noted she had not realized she had not given the medication Isosorbide until it was brought to her attention. She reported she would contact the physician for guidance. In an additional interview on 10/04/23 Nurse #1 stated she had called the physician who instructed her to skip the missed dose and give the next dose scheduled for 8:00 PM. She added she had also corrected the MAR (Medication Administration Record) to document the 9:00 AM dose had been omitted. In an interview with the Medical Director on 10/05/23 at 12:48 PM she stated that Physician Assistant #1 covered the facility and to call her. She ended the call. An attempt was made to contact Physician Assistant #1 on 10/05/23 at 12:49 PM. A recorded message stated the consumer was not available. The Administrator reported she was on a plane traveling and could not be reached. In an interview with Pharmacist #1 on 10/05/23 at 12:38 PM she stated one missed dose of Isosorbide would not be harmful to the resident because some of the medication from the previous dose would remain in the resident's system until the next scheduled dose.	F 759		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when	F 761		10/28/23

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 10/05/2023

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 761	Continued From page 9 applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and staff interview the facility failed to: 1) Discard 2 vials of an expired controlled substance (Ativan) stored in a locked box in the medication room refrigerator on the 100 hall for 1 of 2 medication storage rooms inspected; and 2) failed to date an opened vial of insulin stored in the 100 hall medication cart for 1 of 3 medication carts inspected. Findings included: 1.a. On 10/03/23 at 11:15 AM the medication storage room on the 100 hall was inspected with the Director of Nursing (DON). A locked box inside the refrigerator contained 2 vials of Ativan. Both vials had an expiration date of 7/2023. In an interview with the DON on 10/03/23 at 11:15	F 761	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. F761 1. Corrective action for resident(s) affected by the alleged deficient practice: On 10/03/2023, the Director of Nurses (DON) initiated a cart review of 100% of all medication carts, the treatment carts,	

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 10/05/2023

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 761	Continued From page 10 AM she stated the Ativan vials in the refrigerator were for stock, were not assigned to a specific resident and therefore were not monitored by the hall nurses during change of shift controlled substance reconciliation counts. She explained this medication was monitored by Nurse Supervisor #1 who controlled the key to the medication refrigerator. She noted Nurse Supervisor #1 had resigned the previous week. She stated she herself did not monitor the medication in the refrigerator in the medication storage room. She concluded that medications were to be monitored and discarded if expired to make sure they were not in circulation for use. She removed the vials from the refrigerator to return to the pharmacy. A call was placed to Nurse Supervisor #1 on 10/04/23 at 3:40 PM. An automatic recorded message by the phone vendor stated the customer was not available. In an interview with the Administrator on 10/05/23 at 12:28 PM she stated expired medications were to be discarded per the facility policy. b. On 10/04/23 at 9:15 AM an inspection of the 100 hall medication cart revealed an open vial of Humulin R insulin that had no open date. The pharmacy label on the insulin read: "Expires 31 days after first use." In an interview with Medication Aide #1 on 10/04/23 at 9:15 AM she stated she did not give insulin and had not noticed the opened insulin did not have an opened date. She explained the nurse's administered the insulin because it was not in her scope of practice.	F 761	and medications rooms removing any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. 100% audits of the medication, treatment, and medication rooms continued until 10/05/2023. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents in the facility who take medications have the potential to be affected. Beginning on 10/05/2023, the DON and Unit Support Nurse audited random medication carts, treatment carts, and medication rooms and removed any drugs and biologicals used in the facility that were not labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. No resident was found to be affected by the deficient practice. In order to ensure that no resident was affected, a continued random audit of the facility medication carts, treatment carts, and medication room was conducted by the DON and Unit Support Nurse to ensure there were no drugs and biologicals that were not labeled in accordance with currently accepted professional principles, and included the appropriate accessory and	

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 10/05/2023

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 761	Continued From page 11 In an interview with the DON on 10/04/23 at 9:30 AM she stated all opened insulin was to be labeled with an opened date and discarded when it expired. She would not expect a nurse to use insulin that had been opened and not labeled with an opened date. In an interview with the Administrator on 10/05/23 at 12:28 PM she stated per the facility policy all insulin that was opened was to be labeled with an opened date.	F 761	cautionary instructions, and the expiration date when applicable. Corrections were made immediately where indicated. Random audits will continue through 10/31/2023 and included random monitoring on various shifts, days, including weekends. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: Education: On 10/04/2023, the DON began educating all full time, part time, agency staff, and PRN Nurses, Registered Nurses (RN□s), Licensed Practical Nurses (LPN□s), and Medication Aides on the following topics: " Checking medications for expiration date prior to administering the medication. " Labeling medications when opened with date open as indicated. This information has been integrated into the standard orientation training and will be reviewed by the Quality Assurance process to verify that the change has been sustained. As of 10/31/2023, any staff who does not receive scheduled in-service training will not be allowed to work until training has been completed. 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.	

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 10/05/2023

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 761	Continued From page 12	F 761	The Director of Nursing or designee will monitor compliance utilizing the F761 Quality Assurance Tools and Medication/Treatment Cart Audits weekly x 4 observations per week of each medication carts, treatment carts, and the medication room weekly x 4 weeks then monthly x 2 months. The DON or designee will monitor for compliance with labeling drugs and biologicals to ensure that they are labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. Reports will be presented to the weekly 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 weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager. Date of Compliance: 11/01/2023	
F 880 SS=D	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable	F 880		10/28/23

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 10/05/2023

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 880	Continued From page 13	F 880		

diseases and infections.

§483.80(a) Infection prevention and control program.
The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements:

§483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards;

§483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to:
(i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility;
(ii) When and to whom possible incidents of communicable disease or infections should be reported;
(iii) Standard and transmission-based precautions to be followed to prevent spread of infections;
(iv)When and how isolation should be used for a resident; including but not limited to:
(A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and
(B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances.
(v) The circumstances under which the facility

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 10/05/2023

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 880	Continued From page 14 must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents 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 observation and staff interviews the facility failed to sanitize scissors before and after use during wound care for one of one treatment nurse observed during wound care. The findings included: On 10/04/23 at 1:30 PM the Treatment Nurse was observed performing Resident #7's dressing change. After setting up her supplies on a clean barrier she had previously placed on the over bed table, she sanitized her hands, removed the resident's old sacral dressing, removed her gloves then sanitized her hands and re-gloved, then cleaned around the site with wound cleaner, and then applied Santyl ointment to the wound. The Treatment Nurse then removed her scissors from her pocket and cut off a strip of Alginate and	F 880	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. F 880 1. How corrective action will be accomplished for those residents found to have been by the deficient practice: On 10/05/2023 the Director of Nurses	

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 10/05/2023

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 880	Continued From page 15 placed it directly on the resident's sacral wound site without first sanitizing her scissors. After the Alginate was placed on the sacral wound the nurse covered the site with a foam silicone border dressing, then placed the scissors back into her pocket without sanitizing them. An interview was conducted on 10/04/23 at 1:40 PM, with the Treatment Nurse and Corporate Nurse. The Treatment Nurse and Corporate Nurse stated the treatment nurse's scissors should have been sanitized and placed on the clean barrier before using them. The treatment nurse said she did know her treatment scissors should be sanitized before and after each use, but just forgot. The corporate nurse said she was standing right behind the treatment nurse during the dressing change and observed the treatment nurse pull out her scissors out of her pocket and use them to cut the Alginate without sanitizing them first. An interview was conducted on 10/05/23 at 11:50 AM with the Administrator and Director of Nursing (DON) on 10/05/23 at 11:50 AM. They both stated that during wound care scissors should be sanitized before and after each use, to prevent cross contamination.	F 880	(DON) educated the Treatment nurse on the expectation to sanitize scissors before and after use during wound care. On 10/09/2023, resident #7's wound was assessed by the wound doctor with no changes in the wound related to not sanitizing the scissors. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice: On 10/19/2023, the Registered Nurse (RN) Supervisor initiated random wound care observations on various days, shifts to identify that infection control prevention measures were being utilized to sanitize scissors before and after use during wound care. Random wound care observations will continue through 10/31/2023. Results of the random wound care observations have not identified any other incidents where the scissors or any equipment was not sanitized before or after use. 3. Address what measures will be put in place or systematic changes made to ensure that the deficient practice will not reoccur: On 10/19/2023, the RN Supervisor initiated education for all RN's and licensed practical nurses (LPN's): • Facility Infection Prevention and Control Standards. • Prevention of Infection with Wound Care. • Clean Dressing Change Procedures.	

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 10/05/2023

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 880	Continued From page 16	F 880	• The facility must establish and maintain an infection prevention and control program The training will be validated with random return demonstration: Clean Dressing Change Procedures. Validation of skills will be completed by through 10/31/2023. 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 using F880 Quality Assurance Tool by completing 3 wound care observations on random days, shifts weekly x 4 weeks then monthly x 2 months to ensure infection control prevention guidelines are being observed. Reports will be presented to the weekly Quality Assurance committee by the Director of Nursing to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, Infection Preventionist, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, and the Dietary Manager.	