**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

- **A. BUILDING** __________  
- **B. WING** __________

**DATE SURVEY COMPLETED**  
C 10/01/2021

**NAME OF PROVIDER OR SUPPLIER**  
LOUISBURG HEALTHCARE & REHABILITATION CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**  
202 SMOKETREE WAY  
LOUISBURG, NC 27549

**ID PREFIX TAG**  
SUMMARY STATEMENT OF DEFICIENCIES  
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>PROVIDER'S PLAN OF CORRECTION</td>
<td>CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY</td>
</tr>
</tbody>
</table>

A complaint investigation survey was conducted from 9/29/21 through 10/01/21. Event ID# V1F911.

6 of the 6 complaint allegations were not substantiated.

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**  
Electronically Signed  
10/08/2021

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.