PRINTED: 01/04/2023 FORM APPROVED OMB NO. 0938-0391

AND DI AN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION (X3) DA A. BUILDING CO		
		345358	B. WING		С
NAME OF P	ROVIDER OR SUPPLIER	345356	B. WING	STREET ADDRESS, CITY, STATE, ZIP CODE	12/14/2022
LOUISBUI	RG HEALTHCARE & RE	HABILITATION CENTER		202 SMOKETREE WAY LOUISBURG, NC 27549	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
E 000	Initial Comments		E 00	0	
F 000	investigation survey through 12/14/22. The compliance with the Emergency Prepared	certification and complaint was conducted on 12/11/22 the facility was found in requirement CFR 483.73, dness. Event ID #UYDL11.	F 00	0	
	survey were conduct	complaint investigation ed from 12/11/22 through UYDL11. The following lated NC00195685.			
	4 of the 4 complaint a substantiated.				
F 695 SS=D		stomy Care and Suctioning	F 69	5	12/16/22
	The facility must ensineeds respiratory care and tracheal succare, consistent with practice, the comprel care plan, the reside and 483.65 of this suth This REQUIREMENty:	nd tracheal suctioning. ure that a resident who re, including tracheostomy ctioning, is provided such professional standards of hensive person-centered nts' goals and preferences, libpart. T is not met as evidenced			
				1The statements made on this plan of correction are not an admission to and not constitute an agreement with the alleged deficiencies.	
	(Resident #14) revie			To remain in compliance with all federa and state regulations the facility has ta	
	The findings included			or will take the actions set forth in this plan of correction. The plan of correction	
ADODATODY		Imitted to the facility on SUPPLIER REPRESENTATIVE'S SIGNATU	DE.	constitutes the facility ☐s allegation of	(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

12/30/2022 **Electronically Signed**

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.

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345358	B. WING				C
NAME OF P	ROVIDER OR SUPPLIER	0.0000	 		REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	14/2022
TVAIVIL OF T	TOVIDER OR GOLT EIER				2 SMOKETREE WAY		
LOUISBUI	RG HEALTHCARE & REI	ABILITATION CENTER					
				L	DUISBURG, NC 27549		
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F 695	Continued From page	∍ 1	F 6	695			
	acute respiratory failuand pleural effusion (tissues lining the lung	,			compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 1. Corrective action for resident(s)		
		tal discharge summary led no orders for oxygen			On 12/12/2022 a corrective action was obtained for Resident #14 when an ord		
	Resident #14's Nursing Admission Assessment dated 10/21/22 revealed the Resident required oxygen at 2 liters per minute (lpm) via nasal cannula.				as entered for oxygen use.2. Corrective action for residents with the potential to be affected by the alleg	1	
	assessment dated 10	ssion Minimum Data Set (MDS) sent dated 10/28/22 revealed the t was severely cognitively impaired. The			deficient practice. All residents have the potential to be affected by the alleged deficient practic	ce.	
		g the assessment period.			On 12/12/2022, the Director of Nurses (DON) and Assistant Director of Nurses	s	
	#14 required oxygen included observe for respiratory distress (r	11/2/22 indicated Resident therapy. Interventions signs and symptoms of restlessness, increased and provide oxygen therapy			(ADON) began identification of residenthat were potentially impacted by this practice. This audit consisted of a wall round to identify 100% of current residents who were identified as receiv oxygen therapy and ensuring that orde for oxygen were present in the resident	king ring ers	
	revealed Resident #1 order for supplemental A review of the facility				record. This audit was completed on 12/12/2022. Results included: 8 out of residents who receive oxygen therapy have orders for oxygen. On 12/12/202 the Director of Nursing and Staff Development Coordinator implemented	· 8	
	upon admission, did is supplemental oxygen During observations of	not reveal an order for			corrective action for those residents whincluded: entering orders for oxygen. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	nich	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345358	B. WING _			1	C 14/2022
NAME OF PI	ROVIDER OR SUPPLIER		<u>'</u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE		
				20	02 SMOKETREE WAY		
LOUISBUI	RG HEALTHCARE & REI	HABILITATION CENTER		LC	OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	An interview was con pm with Nurse #1. The Resident #14's Physic discharge summary. It unable to recall if he required supplementary and interview was comed and was unaware who in the group orders, so Resident #14's Physic new resident admission accuracy during the farm and was unaware who in the group orders, so Resident #14's Physic new resident admission accuracy during the farm was unaware who in the FNP indicated required a Physician were to contact the order of th	ducted on 12/12/22 at 3:15 e Nurse indicated he input cian orders per the hospital Nurse #1 stated he was received a phone report from tal indicating the Resident al oxygen. Inpleted with the Director of /12/22 at 3:28 pm. The DON ted Resident #14's Int. She stated she was Resident had a Physician oxygen. The DON indicated of have not been confirmed of it was not added to cian orders. The DON stated on orders are reviewed for acility's daily clinical meeting by the oxygen order was Inpleted with the Family NP) on 12/13/22 at 11:00 The de supplemental oxygen order. She stated nurses Incelled with the Incelled with t	F	695	On 12/14/22, the Staff Development Coordinator began reeducating Licenses Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency licensed nurses on oxygen use education. (See Education All new hires will receive the in-service training during orientation. "policy and procedures related Oxy use "The need for orders for any reside receiving oxygen therapy Additionally, on 12/13/22, the Nurse Consultant educated the DON and the ADON on the admission order review process. This education included: Admission order process Admission checklist 4. Monitoring Procedure to ensure th the plan of correction is effective and th specific deficiency cited remains correct and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consi of monitoring 5 random residents who a	d n). rgen nt at nat cted	
					currently receiving oxygen therapy to ensure that orders for oxygen are presented.	ent	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	IPLE CONSTRUCTION NG		(X3) DATE S	
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	201/1252 02 01 1221 152	345356	B. WING_			12/1	14/2022
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL	JE		
LOUISBUI	RG HEALTHCARE & REI	HABILITATION CENTER		202 SMOKETREE WAY			
				LOUISBURG, NC 27549			
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F 695	Continued From page	e 3	Fé	to assure compliance. The D Nursing will audit new and re for accuracy of oxygen order. Admission/Readmission Aud Monitoring will be completed weeks on various days and v Reports will be presented to QA committee by the DON of ensure corrective action is in appropriate. Compliance will and the ongoing auditing pro- reviewed at the weekly QA M weekly QA Meeting is attended Administrator, Director of Nur Coordinator, Therapy Manag Information Manager, and the Manager. Deficiencies that a during the monitoring proces- addressed through the facility. Assurance process. Date of Compliance: 12/16/2 Corrective action for resi affected by the alleged deficient On 12/12/2022 a corrective a obtained for Resident #14 wh as entered for oxygen use. 2. Corrective action for resi the potential to be affected by deficient practice. All residents have the potential affected by the alleged deficient On 12/12/2022, the Director of (DON) and Assistant Director (DON) began identification	eadmission s utilizing a it tool weekly x s various shi the weekly r designee itiated as be monito gram fleeting. The ed by the rsing, MDS ger, Health e Dietary re identifie s will be y Quality 1022 ident(s) ent practic action was then an ord idents with y the alleg ial to be ent practic of Nurses r of Nurses	ss a s a s a s a s a s a s a s a s a s	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(>	(3) DATE SURVEY COMPLETED
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	ROVIDER OR SUPPLIER	EHABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549	I_	12/14/2022
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 695	Continued From page	ge 4	F 69	that were potentially impacted practice. This audit consisted round to identify 100% of curre residents who were identified a oxygen therapy and ensuring the for oxygen were present in the record. This audit was completed 12/12/2022. Results included: residents who receive oxygen have orders for oxygen. On 12 the Director of Nursing and State Development Coordinator implecorrective action for those residents action for those residents are reconstructed. 3. Measures /Systemic characteristics. On 12/14/22, the Staff Develop Coordinator began reeducating Nurses, Registered Nurses (Reduced Practical Nurses (Lettering agency licensed nurses oxygen use education. (See Eall new hires will receive the intraining during orientation. "policy and procedures related in the need for orders for an receiving oxygen therapy.	of a walking of a walking ent as receiving that orders as resident as resident as each on a sout of 8 therapy 2/12/2022 aff allemented adents which as the end deficient as a sout of 8 therapy 2/12/2022 aff allemented and as the end deficient as a sout of 8 therapy 2/12/2022 aff allemented as the end deficient as a southern	g s sh
				Additionally, on 12/13/22, the I Consultant educated the DON		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION ING		(X3) DATE SURVEY COMPLETED		
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NAME OF P	ROVIDER OR SUPPLIER				FREET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBU	RG HEALTHCARE & REI	HABILITATION CENTER			12 SMOKETREE WAY OUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 695	Continued From page	÷ 5	F	695	ADON on the admission order review process. This education included: Admission order process Admission checklist 4. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consition of monitoring 5 random residents who currently receiving oxygen therapy to ensure that orders for oxygen are present to assure compliance. The Director on Nursing will audit new and readmission for accuracy of oxygen orders utilizing Admission/Readmission Audit tool Monitoring will be completed weekly as weeks on various days and various shift Reports will be presented to the weekly QA committee by the DON or designeed ensure corrective action is initiated as appropriate. Compliance will be monitor and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	sts are ent ss a fts. deto	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		CONSTRUCTION		PLETED	
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F 695	Continued From pag			695	Date of Compliance: 12/16/2022			
F 732 SS=C	§483.35(g) Nurse St §483.35(g)(1) Data in must post the follow basis: (i) Facility name. (ii) The current date. (iii) The total number by the following cate unlicensed nursing sizes resident care per shit (A) Registered nurses (B) Licensed practical vocational nurses (at (C) Certified nurses (iv) Resident census §483.35(g)(2) Posting (i) The facility must proposed in paragraphic paragrap	taffing Information. requirements. The facility ing information on a daily ar and the actual hours worked regories of licensed and staff directly responsible for iff: es. al nurses or licensed s defined under State law). ides. ar and the actual hours worked regories of licensed and staff directly responsible for iff: es. al nurses or licensed s defined under State law). ides. are grequirements. bost the nurse staffing data on (g)(1) of this section on a reginning of each shift. sted as follows: ble format. lace readily accessible to s. access to posted nurse acility must, upon oral or the nurse staffing data ic for review at a cost not to	F 7	732	Bate of Compilation. 12/10/2022		12/16/22	

	OF DEFICIENCIES CORRECTION	IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345358	B. WING			C 12/14/2022	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	I	12/14/2022	
				202 SMOKETREE WAY			
LOUISBU	RG HEALTHCARE & I	REHABILITATION CENTER		LOUISBURG, NC 27549			
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F 732	Continued From p	age 7	F 7	32			
	is greater. This REQUIREME	equired by State law, whichever					
	facility failed to post staffing Information for 1 of 4 days durn failed to post accur for 42 of 42 days or reviewed from 11/1. The findings include 1. An observation of Nursing (DON) revealed Nurse Streadily displayed windicated daily Nurposted on the week any administrative An interview was a Assurance (QA) stages 1:39 PM, and she	and interview with the Director on 12/11/22 at 10:32 AM affing Information was not within the facility. The DON rese Staffing Information was not kends because there was not staff in the building to post it.		Corrective action for reaffected by the alleged def The Daily Nurse Staff Post December 11, 2002 was ported 12/11/22 by the Director of On 12/13/2022 □ 12/14/20 Assistant Director of Nurse the Support through Decertor reflect the assigned staff each day. This was complet 12/14/2022. On 12/14/2022, the Adminitation reviewed the daily nurse staff from November 2022 throut 13, 2022 to ensure a daily posting was completed and accurate to reflect the assignment of the staff worked each day. Measures /Systemics.	ricient practice: ting for osted on f Nurses. 222, The es (ADON) and mber 13, 2022 f who worked eted on istrator taff postings ugh December nurse staff d that it was gned staff who		
	weekends. 2. A review of the Information sheets Staffing Hours ass both nurse and nu and shifts worked. licensed and unlice recorded accurate 11/1/22 through 12 11/3/22, 11/4/22, 11/8/22, 11/9/22, 1	posted Nurse Staffing was compared with the Daily ignment sheets which included rese aide actual assignments. The comparison revealed ensed nursing staff were not ly for all shifts and days from 2/12/22 (11/1/22, 11/2/22, 1/5/22, 11/6/22, 11/17/22, 1/10/22, 11/11/22, 11/15/22, 11/15/22, 11/16/22, 11/17/22, 1/1/15/22, 1/1/16/22, 11/17/22, 1/1/15/22, 1/1/16/22, 11/17/22, 1/1/15/22, 1/1/15/22, 1/1/15/22, 1/1/16/22, 1/1/17/22, 1/1/15/22, 1/1/		2. Measures /Systemic concepted prevent reoccurrence of all practice: There were no resident affection practice. The Administrator or designates responsible for ensuring a staff posting was completed was accurate to reflect the who worked each day. The will be reviewed weekly for On 12/13/2022, the Quality	leged deficient fected by this nee will be daily nurse ed and that it assigned staff e daily posting r accuracy.		

NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER X49 ID PREFIX TAG TAG TAG TAG TAG TO Information or support of the proportion of the following staffing Information was incorrect. The QA support nurse was interviewed on 12/13/22 at 1:55 PM. She reviewed all the Nurse Staffing Information was incorrect. During an interview on 12/14/22 at 9:13 AM, the DON revealed the reason why all the daily version of the proportion of the propor		OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) F 732 Continued From page 8 11/18/122, 11/19/122, 11/20/122, 11/21/22, 11/27/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 11/28/122, 12/18/122			345358	B. WING _			1	
Coursing Healthcare & Rehabilitation center	NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	1 12/	17/2022
Coursing Healthcare & Rehabilitation center					20	2 SMOKETREE WAY		
F 732 Continued From page 8 11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/22/22, 11/28/22, 11/29/22, 11/29/22, 11/29/22, 11/29/22, 12/10/2	LOUISBU	RG HEALTHCARE & REI	HABILITATION CENTER					
11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/23/22, 11/28/22, 11/29/22, 11/26/22, 11/27/22, 11/28/22, 12/4/22, 12/5/22, 12/6/22, 12/1/22, 12/8/22, 12/9/22, 12/10/22, 12/11/22, and 12/12/22). The QA support nurse was interviewed on 12/13/22 at 1:55 PM. She reviewed all the Nurse Staffing Information from 11/11/22 through 12/12/22. She confirmed the nurse staffing information was incorrect. During an interview on 12/14/22 at 9:13 AM, the DON revealed the reason why all the daily Nurse Staffing Information sheets were inaccurate was because she was never trained to adjust the daily	PRÉFIX	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	PREFIX	x	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA		COMPLETION
the day. The Administrator was interviewed on 12/14/22 at 9:34 AM. She revealed her expectation was that the daily Nurse Staffing Information be accurate and posted daily. The Administrator or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings. This monitor will be completed weekly x 5 weeks reviewing daily nursing staff posting from the previous week to ensure the form is being completed and reviewing for accuracy of the daily nursing staff posting. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses 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	F 732	11/18/22, 11/19/22, 1 11/23/22, 11/24/22, 1 11/28/22, 11/29/22, 1 12/3/22, 12/4/22, 12/1 12/8/22, 12/9/22, 12/1 12/12/22). The QA support nurse 12/13/22 at 1:55 PM. Staffing Information for 12/12/22. She confininformation was incorporated the reastaffing Information shecause she was new staffing sheet as the staffing sheet staffing she	1/20/22, 11/21/22, 11/22/22, 1/25/22, 11/26/22, 11/27/22, 1/30/22, 12/1/22, 12/2/22, 5/22, 12/6/22, 12/7/22, 10/22, 12/11/22, and e was interviewed on She reviewed all the Nurse rom 11/1/22 through med the nurse staffing rect. In 12/14/22 at 9:13 AM, the ason why all the daily Nurse heets were inaccurate was ver trained to adjust the daily staffing changed throughout s interviewed on 12/14/22 at ed her expectation was that	F7	732	education on Daily Nursing Staff Postir Requirements for the following staff, the Administrator, DON, ADON, MDS Nursiand the Support Nurses. Objectives: To identify the regulatory requirement of F 732 for Posted Nursing Staff Information To monitor that the requirement for F732 is met daily and includes the data requirements, posting requirements, Public access to posted nurse staffing data, and Facility data retention requirements. Monitoring Procedure to ensure the the plan of correction is effective and the specific deficiency cited remains correct and/or in compliance with regulatory/requirements. The Administrator or designee will mone compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings. This monitor will be completed weekly x 5 weeks reviewing daily nursing staff posting from the previous week to ensure the form is be completed and reviewing for accuracy the daily nursing staff posting. Reports will be presented to the weekly Quality Assurance committee by the Administrator Director of Nurses to ensure correction is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the	e ent ent at hat beted hitor g hing of s ator ive	

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	ROVIDER OR SUPPLIER	HABILITATION CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549	· '	1211-112022
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F 732	Continued From pag	e 9	F 73	weekly QA Meeting is attended Administrator, Director of Nursin Coordinator, Therapy Manager, Manager, Health Information Mand the Dietary Manager.	ng, MDS Unit anager,	
F 812 SS=D	CFR(s): 483.60(i)(1)(§483.60(i) Food safe		F 8	Date of Compliance: 12/16/2022	<u>'</u>	12/16/22
	state or local authorit (i) This may include of from local producers, and local laws or reg (ii) This provision doe facilities from using p gardens, subject to o safe growing and foo (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accorda standards for food se This REQUIREMENT by: Based on observatio interviews with facility date opened food ite the nourishment refri past their use by date	red satisfactory by federal, ies. ood items obtained directly subject to applicable State ulations. es not prohibit or prevent produce grown in facility ompliance with applicable d-handling practices. es not preclude residents is not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced ons, record review and y staff, the facility failed to ms stored for resident use in gerator and to discard foods of for 1 of 1 nourishment incicice had the potential to		 For dietary services, a correaction was obtained on 12/14/20 On 12/14/2022, the Support Nur discarded any non-labeled/dated items in the kitchen and nourish fridges. 	022. rse d food	

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	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345358	B. WING			l	14/2022
NAME OF PR	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
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F 812	Continued From page	÷ 10	F	812			
	_	n on 12/12/22 at 8:35 AM an			Corrective action for residents with the potential to be affected by the alleg deficient practice.		
	conducted. The obserpaper plates sandwice (name of resident) "D 11/24/22. There was a what looked like pasta 12/12/22 with no name bottle dated 11/24/22 open bottle of soda, who brown bag with unide no label, dated 12/12/22 open bottle d	e. There was a 16oz Sprite with name of resident, 1 with no date/label and a ntified foil wrapped item with 1/22. PM an observation of the of gerator was conducted with Nurse. There was also a nat looked like pasta, beans with no name. There was a ed 11/24/22 with name of			All residents have the potential to be affected by the alleged deficient practic On 12/14/2022, the Administrator, EVS Director, & Support Nurse completed a observation of the nourishment refrigerators to ensure all food items we labeled/dated properly. Results: 4 items thrown out. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff Topics included: (See Education) "Food storage and dating information has been integrated in	n ere s	
	and a brown bag with item with no label, da On 12/13/22 at 3:36 F Nurse stated if food it dated they would be t On 12/13/22 at 3:39 F the housekeeping statchecking and cleaning refrigerator. She indices	PM the Infection Control ems were not labeled or hrown out. PM the Administrator stated ff were responsible for g out the nourishment lated all unlabeled and ere to be thrown out and ily.			This information has been integrated in the standard orientation training and in required in-service refresher courses for all staff and will be reviewed by the Quarkssurance process to verify that the change has been sustained. All residents and families are made award of the food policy on admission. The Since re-educated all residents with a BIMs of 14 or higher on 12/14/2022 to the food policy. 4. Quality Assurance monitoring procedure.	the or ality are W	
		ted his staff checked the			The EVS Director, MOD or designee w	ill	

	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE S AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING						
						(С
		345358	B. WING _			12/	14/2022
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE		
LOUISBUI	RG HEALTHCARE & REF	ABILITATION CENTER			2 SMOKETREE WAY		
				LC	DUISBURG, NC 27549		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
	REGULATORY OR LE	e 11 tor first thing each day and purishment refrigerator. He ust have put the items in	TAG	3312	CROSS-REFERENCED TO THE APPROPRIA	od es. / on II	