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 03/06/2025

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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 3/03/25 through 3/06/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #E4A211.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 3/03/25 through 3/06/25. Event ID# E4A211. The following intakes were investigated NC00226869, NC00227159, NC00226612, NC00222475 and NC00222926. 1 of the 17 complaint allegations resulted in deficiency.	F 000		
F 550 SS=D	Resident Rights/Exercise of Rights CFR(s): 483.10(a)(1)(2)(b)(1)(2) §483.10(a) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, including those specified in this section. §483.10(a)(1) A facility must treat each resident with respect and dignity and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the resident. §483.10(a)(2) The facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility	F 550		3/27/25

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

Electronically Signed | 03/27/2025

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.

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F 550	Continued From page 1 must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the State plan for all residents regardless of payment source. §483.10(b) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States. §483.10(b)(1) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility. §483.10(b)(2) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights as required under this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and interviews, the facility failed to maintain Resident #14's dignity by failing to remove a urinal from the overbed table while the resident's meal was in front of him (Resident #14). The facility also failed to promote resident independence and dignity when staff stood over Resident #35 while assisting him to eat. These deficient practices occurred for 2 of the 2 residents reviewed for dignity and respect. The findings included: 1. Resident #14 was admitted to the facility on 9/30/20.	F 550	F550 The facility failed to maintain Resident dignity by failing to remove a urinal from the overbed table while the resident's meal was in front of him. The facility also failed to promote resident independence and dignity when staff stood over Resident while assisting to eat. These deficient practices occurred for 2 of the 2 residents reviewed for dignity and respect. 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/3/25, Nurse Aid #5 was re-educated by the Director of Nursing on maintaining	

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F 550	Continued From page 2 A review of the quarterly Minimum Data Set (MDS) dated 1/17/25 revealed the Resident #14 had severe cognitive impairment. He was able to feed himself with set up help and was totally dependent on staff for toilet use. An observation was conducted on 3/3/25 at 12:47 PM. Resident #14 was observed eating his meal with a urinal containing urine sitting on the overbed table with his meal. An interview was conducted on 3/3/25 at 12:30 PM with Nurse Aide #5. NA #5 stated she was unsure of who had placed the meal tray on the residents overbed table. An observation was conducted with the Support Nurse on 3/6/25 at 12:03 PM. Resident #14 was observed eating his meal with a urinal sitting on the overbed table with his meal. The Support Nurse removed the urinal with Resident #35's permission. An interview conducted with Resident #14 on 3/6/25 at 12:15 PM revealed he preferred to have his urinal within reach but not on the overbed table with his meal. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 2:38 PM. The DON stated she had completed education on 3/3/25 with all floor staff regarding making sure urinals were not sitting on the bedside tables while residents were eating. The DON stated the urinal should have been emptied and placed away from the table. An interview was conducted with the Administrator on 3/6/25 at 2:40 PM. The	F 550	resident dignity and remaining seated during meals when assisting residents with meals and urinals being removed from bedside tables during meals, as well as being rinsed/emptied/stored appropriately. On 3/6/25, Nurse Aid #3 was re-educated by the Director of Nursing on maintaining resident dignity and remaining seated during meals when assisting resident with meals and urinals being removed from bedside tables during meals as well as being rinsed/emptied/stored appropriately. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/26/25 an audit was conducted by the Director of Nursing to identify residents who are fed by staff and residents who use urinals for toileting. These rooms were observed for compliance with staff being seated during meals and urinals being appropriately stored during meals. Results included: All staff was seated while feeding residents and all urinals were appropriately stored during meals. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/3/25, the Director of Nursing and/or designee began education will all FT, PT, PRN staff to include agency on Residents Rights; Dignity and Respect. This education was completed on 3/27/25.	

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F 550	Continued From page 3 Administrator stated she expected staff to remove urinals from the overbed table while residents were eating their meal. 2. Resident #35 was admitted to the facility on 2/21/20. A review of the quarterly Minimum Data Set (MDS) dated 12/6/24 revealed Resident #35 was cognitively intact and required limited assistance plus one-person physical assistance for eating. An observation was conducted on 3/3/25 at 12:45 PM. Resident #35 was lying on the bed with the head of bed elevated. Nurse Aide (NA) #5 was seen standing while feeding Resident #35. There was a chair in the room at the bedside. The MDS Coordinator was observed to go in the room to speak to NA #5 about standing while feeding Resident #35. An observation was conducted on 3/5/25 at 11:54 AM. Resident #35 was lying in the bed with the head of the bed elevated. NA #3 was seen standing while feeding resident. NA #3 was observed conversing with Resident #35. There was a chair in the room at the bedside. An interview was conducted with NA #3 on 3/6/25 at 11:56 AM. NA #3 stated she knew she was supposed to be sitting while feeding Resident #35, but she was having a conversation with the resident. An interview was conducted with the Director of Nursing (DON) on 3/6/25 at 2:38 PM. The DON stated the NA should have been seated and at eye level while assisting Resident #35 with his meal.	F 550	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 Department Heads and/or designee will audit residents rooms during meal times to ensure staff are seated during meals and urinals are not on overbed tables for compliance. This monitoring will be completed weekly x 3 weeks and then monthly times 3 months or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance:3/27/25	

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F 550	Continued From page 4 An interview was conducted with the Administrator on 3/6/25 at 2:40 PM. The Administrator stated she expected that staff would be seated when assisting residents that required assistance with eating their meal.	F 550		
F 554 SS=D	Resident Self-Admin Meds-Clinically Approp CFR(s): 483.10(c)(7) §483.10(c)(7) The right to self-administer medications if the interdisciplinary team, as defined by §483.21(b)(2)(ii), has determined that this practice is clinically appropriate. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and resident and staff interviews, the facility failed to assess a resident for self-administration of medication for 1 of 5 residents reviewed for medication administration (Resident #57). The findings included: Resident #57 was admitted to the facility on 8/10/23. The resident's care plan dated 7/29/24 did not include self-administration of medication. There was not an assessment of Resident #57 in the medical record to determine if it was safe for the resident to self-administer medications. Review of the quarterly Minimum Data Set (MDS) 1/7/25 revealed Resident #57 was cognitively intact. On 03/04/25 at 09:19 AM Resident #57 was observed in the bed with two cups containing	F 554	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. F554 The facility failed to assess a resident for self-administration of medication for 1 of 5 residents reviewed for medication administration 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/4/25, the Director of Nursing provided 1:1 education to Medication aid #1 on medication administration and not leaving medication at resident□s bedside and policy for self-administration.	3/27/25

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F 554	Continued From page 5 medication on the table at the bedside. One cup had multiple pills, and the second cup contained powder. Resident #57 stated she had asked the staff to place the medications on the bedside table because she was in the middle of eating when she brought in the medication. Resident #57 stated she had forgotten to take her medication. Resident #57 stated the staff usually left her medicines at the bedside and she would go ahead and take it. Resident #57 stated powdered substance in the second cup on the bedside table was a medicated powder she placed beneath her breast when she was ready. An interview was conducted with Medication Aide (MA) #1 on 03/04/25 at 09:23 AM. MA# 1 stated she left the medications on the bedside tablet and told Resident #57 she would be right back. MA #1 stated she normally stood at the bedside and watched the residents take their medication. MA #1 stated she forgot to go back to Resident #57's room. MA #1 stated Resident #57 did not self administer her medication. An interview was conducted with the Director of Nursing on 03/04/25 at 09:25 AM. The DON stated medication should have been administered to the residents immediately. If the resident refused the medication, it should have been removed and the DON notified. The DON stated Resident #57 had not been assessed for self administration of medication. The DON further stated that all treatments should be completed by the nursing staff and not residents. An interview was conducted with the Administrator on 3/6/25 at 9:30 AM. The Administrator stated she expected that staff would make sure all medications were taken prior	F 554	On 3/20/25, resident interviewed by Administrator. Resident does not wish to self-administer medication. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. On 3/4/25, the Director of Nurse and department staff audited resident rooms for meds at bed side. Results included: No other medications noted at resident□s bedside. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/4/25, the Director of Nurses began education for all nurses & medication aids to include agency on not leaving medications at bedside and Self administration of medication. This education was completed on 3/27/25. Any staff who have not attending training will not work until training is complete. 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 Director of Nursing and/or designee will audit resident rooms during medication pass that medications are not left at bedside for compliance. This monitoring will be completed weekly x 3 weeks and then monthly times 3 months	

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F 554	Continued From page 6 to leaving the resident. The Administrator further stated she expected all treatments to be completed by staff before leaving the resident room.	F 554	or until resolved. Reports will be presented to the monthly Quality Assurance committee by the Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the monthly Quality Assurance Meeting. The monthly Quality Assurance Meeting is attended by the Administrator, Director of Nursing, Minimum Data Set Coordinator, Unit Manager, Therapy Manager, Health Information Manager, Social Service Director, and the Dietary Manager. Date of Compliance: 3/27/25	
F 565 SS=E	Resident/Family Group and Response CFR(s): 483.10(f)(5)(i)-(iv)(6)(7) §483.10(f)(5) The resident has a right to organize and participate in resident groups in the facility. (i) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner. (ii) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation. (iii) The facility must provide a designated staff person who is approved by the resident or family group and the facility and who is responsible for providing assistance and responding to written requests that result from group meetings. (iv) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such	F 565		3/27/25

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F 565	Continued From page 7 groups concerning issues of resident care and life in the facility. (A) The facility must be able to demonstrate their response and rationale for such response. (B) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group. §483.10(f)(6) The resident has a right to participate in family groups. §483.10(f)(7) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility. This REQUIREMENT is not met as evidenced by: Based on record review, and staff and resident interviews, the facility failed to provide resolution of Resident Council Meeting grievances for 4 of 11 monthly Resident Council Meetings. The Resident Council had repeated concerns regarding a wider variety of drink options and clothes/items not coming back from laundry (7/24/24, 8/28/24, 9/23/24, and 10/29/24). The findings included: a. On 7/24/24 the Resident Council Meeting Minutes noted a dietary concern that there were not enough beverage options. A housekeeping concern was also discussed about clothes/items not being returned from laundry. The follow-up/intervention section of the form was blank. b. On 8/28/24 the Resident Council Meeting Minutes noted a housekeeping concern was	F 565	F565 The facility failed to provide resolution of Resident Council Meeting grievances for 4 of 11 monthly Resident Council Meetings. 1. Corrective action for resident(s) affected by the alleged deficient practice: An additional resident council meeting was held on 3/ 25 /2025. Minutes were taken by the Activities Director. Council concerns/or grievances were addressed by the Administrator along with the appropriate department manager on 3/ 25/2025 and resolution was communicated back to Resident Council on 3/25/2025. 2. Corrective action for residents with the potential to be affected by the alleged	

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F 565	Continued From page 8 discussed about clothes/items not being returned from laundry. Previous concerns from the July 2024 Resident Council Meeting were not discussed, and the follow-up/intervention section of the form was blank. c. On 9/23/24 the Resident Council Meeting Minutes noted a housekeeping concern that clothes were not being returned from laundry, and a dietary concern that there were not enough beverage options. Previous concerns from the August 2024 Resident Council Meeting were not discussed, and the follow-up/intervention section of the form was blank. d. On 10/29/24 the Resident Council Meeting Minutes noted a housekeeping concern that clothes were not being returned from laundry, and a dietary concern that there were not enough beverage options. Previous concerns from the September 2024 Resident Council Meeting were not discussed, and the follow-up/intervention section of the form was blank. Interviews conducted with Resident #3, Resident #29, Resident #32, Resident #43, Resident #57, and Resident #68 during the Resident Council Meeting on 3/4/25 at 10:29 AM revealed no resolution with the ongoing concerns of not enough beverage options at meals and clothes/items not being returned from the laundry. The residents indicated the housekeeping issue of clothes/items not being returned was still a concern. The Activities Director (AD) was interviewed on 3/05/25 at 11:27 AM. She stated that from July through September 2024, she and the Social Worker (SW) held Resident Council Meetings	F 565	deficient practice. Beginning with the 3/ 25/2025 resident council meeting, Resident Council concerns/or grievances will be reviewed by the Administrator and applicable department manager for timely resolution and follow-up utilizing the Resident Council Communication tool. 3.Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/21/2025, the Administrator educated the facility department heads on the following: " F565 requirements " The Administrator educated department managers on the utilization of the Resident Council Communication tool and requirement for timely follow-up for all Resident Council concerns on 3/ 21/2025. " Going forward, Administrator or Director of Nurses will continue to assign responsibility for resolving concerns/or grievances from the Resident Council the morning after the meetings occur. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all department managers and will be reviewed by the Quality Assurance Committee to verify that the change has been sustained. Any managers who do not receive the scheduled in-service training on 3/27/2025 will not be allowed to work until training has been completed.	

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F 565	Continued From page 9 together. Every complaint from Resident Council was communicated with a grievance. If a concern was raised by one of the residents from July through September 2024, the SW wrote a grievance for follow-up. She could not say why the issues in the 10/29/24 Resident Council Meeting were not addressed. During an interview with the SW on 3/05/25 at 2:36 PM, she confirmed that she assisted the AD with Resident Council Meetings from July through September 2024. The issues during the July Resident Council Meeting should have been communicated via the grievance form. The SW indicated that the issues from the 7/24/24 and 8/28/24 meetings were not addressed, and she could not provide a reason why. During the September 2024 Resident Council meeting, the SW stated that the nursing issues were not addressed or communicated for an unknown reason. An interview was conducted with the Administrator on 3/06/25 at 12:52 PM. She indicated that all complaints from Resident Council should be followed by a grievance, which then was distributed to the appropriate department head and responded to in a timely manner.	F 565	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 Administrator will monitor compliance utilizing the F565 Quality Assurance Tool monthly x 3 months or until resolved. The tool will monitor to ensure that Resident Council concerns/or grievances are addressed and that follow-up is documented and provided to the Resident Council by the next scheduled council meeting. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action is initiated as appropriate. The QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 3/27/2025	
F 585 SS=B	Grievances CFR(s): 483.10(j)(1)-(4) §483.10(j) Grievances. §483.10(j)(1) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with	F 585		3/27/25

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F 585	Continued From page 10	F 585		

respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

§483.10(j)(2) The resident has the right to and the facility must make prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

§483.10(j)(3) The facility must make information on how to file a grievance or complaint available to the resident.

§483.10(j)(4) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:
(i) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent State agency, Quality Improvement Organization, State Survey Agency and State Long-Term Care Ombudsman

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F 585	Continued From page 11	F 585		

program or protection and advocacy system;
(ii) Identifying a Grievance Official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations;
(iii) As necessary, taking immediate action to prevent further potential violations of any resident right while the alleged violation is being investigated;
(iv) Consistent with §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by State law;
(v) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued;
(vi) Taking appropriate corrective action in accordance with State law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, Quality Improvement

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F 585	Continued From page 12 Organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility; and (vii) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision. This REQUIREMENT is not met as evidenced by: Based on record review, and resident and staff interviews, the facility failed to provide a written grievance summary for 2 of 6 grievances (9/23/24, 1/29/25) on behalf of Resident Council and 1 of 1 resident (Resident #57) reviewed for grievances. The findings included: Review of the facility's "Grievance Policy and Procedure" effective February 2025 read in part: "As soon as possible after the filing of a grievance report, the Grievance Officer or designee will interview the grievant, interview appropriate other parties, examine relevant records and take any other action which will enable a full understanding of the issue. The inquiry, disposition and decision will be completed within seven (7) days of receipt of grievance...A written response to the grievance will be required within 14 calendar days of the grievance being filed that should include the results of the investigation." 1a. Review of the Grievance Report Form dated 9/23/24 indicated a concern that was reported by the Social Worker (SW) on behalf of Resident Council regarding housekeeping not mopping daily. The facility response was that someone spoke to housekeeping staff about mopping	F 585	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. F585 The facility failed to provide a written grievance summary for 2 of 6 grievances on behalf of resident council and 1 of 1 resident for grievances 1. Corrective action for resident(s) affected by the alleged deficient practice: On 3/25/25, the Social Service Director provided written resolution to resident #57 written resolution to grievance on 2/7/25. On 3/25/25, the Administrator held a Resident council meeting to provide written resolution of concerns reported in the resident council meeting on 9/23/24 and 1/29/25. 2. Corrective action for residents with the	

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F 585	Continued From page 13 rooms daily after the nursing staff removed dirty linen from the floors. There was no evidence a written summary was provided to Resident Council members. The SW was interviewed on 3/05/25 at 2:36 PM. She indicated that the grievance about the daily mopping issue on 9/23/24 should have been addressed by the appropriate department head, and then she would follow up with the complainant and offer a written copy of the findings. The SW could not give a reason why a written summary of the grievance was not provided to Resident Council members. 1b. Review of the Grievance Report Form dated 1/29/25 indicated a concern that was reported by the Activity Director (AD) on behalf of Resident Council regarding missing socks, 2 sinks that were broken, and a clogged toilet. The facility response was that the missing socks were found, the sinks and toilet were repaired. There was no evidence a written summary was provided to Resident Council members. Additionally, a Grievance Report Form dated 1/29/25 indicated a concern that was reported by the AD on behalf of Resident Council regarding first and third shift nurse aides not responding to call lights, nursing staff not announcing themselves upon entry to resident rooms, medicine not given on second or third shift, snacks not given at night, and meals delivered cold. The facility response was that snacks were given on first and second shifts for residents who requested them, nursing staff were educated on customer service/communication/resident rights/abuse, nurses were reminded that they can assist with call lights, and residents should be asked about pain and medications should be given. There was	F 585	potential to be affected by the alleged deficient practice: On 3/25/25, the Administrator audited last 14 days of grievances to ensure grievances were complete and written response had been provided. The results included: All grievances were completed and a written response had been provided. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/21/25, the Administrator and/or designee began in servicing of all staff (including agency) on the Grievance Policy and Procedure. This training was completed on 3/27/25. The Director of Nursing/Administrator will ensure that any staff who does not complete the in-service training by will not be allowed to work until the training is 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: The Administrator will monitor grievances daily during stand-up meeting weekly for 2 weeks and monthly for 3 months or until resolved. Reports will be presented to the monthly QA committee by the Administrator or Director of Nursing to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at	

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F 585	Continued From page 14 no evidence a written summary was provided to Resident Council members. An interview was conducted with the AD on 3/04/25 at 12:40 PM. She stated that she submitted grievances from Resident Council Meetings in January and February 2025 to the Director of Nursing (DON) and the Assistant DON (ADON). The DON was interviewed on 3/05/25 at 2:51 PM. She stated that she was not informed of the grievance policy or the 7-day grievance resolution requirement until February 2025 during a mock survey. The DON indicated that for the January 2025 grievances filed by Resident Council, she did not provide a written response within 14 days, only had a verbal discussion with the residents. The DON acknowledged that according to the grievance policy, a written response should have been offered for all grievances within 14 days of when it was filed. During an interview with the Administrator on 3/06/25 at 12:52 PM, she stated that all grievances from Resident Council should have been addressed and offered a written response in a timely manner. 2. Resident #57 was admitted to the facility on 8/10/23. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/7/25 indicated that Resident #57 was assessed as cognitively intact. Review of the Grievance Report Form dated 2/7/25 indicated a concern that was reported by the Activities Director (AD) on behalf of Resident	F 585	the monthly QA Meeting. The monthly QA Meeting is attended by the Administrator, Maintenance Director, Support Nurse, Wound Nurse, DON, MDS Coordinator, Therapy, HIM, medical Director, and the Dietary Manager Date of Compliance: 3/27/25	

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F 585	Continued From page 15 #57 regarding a nurse aide who refused to change/assist with changing a resident on third shift. This was the second occurrence with the same nurse aide, and care from this nurse aide was no longer wanted by Resident #57. The facility response was that when Resident #57 was interviewed, she could not recall which nurse aide was the accused. The nursing team was educated on abuse and customer service. There was no evidence a written summary was provided to Resident #57. The DON was interviewed on 3/05/25 at 2:51 PM. She stated that she was not informed of the grievance policy or the 7-day grievance resolution requirement until February 2025 during a mock survey. The 2/7/25 grievance involving Resident #57 was handled by the Assistant Director of Nursing (ADON), who was involved in many tasks at the same time the grievance was filed. The DON acknowledged that according to the grievance policy, a written response should have been offered to Resident #57 within 14 days of when it was filed. The ADON was unavailable for interview during the survey. During an interview with the Administrator on 3/06/25 at 12:52 PM, she stated that the grievance from Resident #57 should have been addressed and offered a written response in a timely manner.	F 585		
F 687 SS=D	Foot Care CFR(s): 483.25(b)(2)(i)(ii) §483.25(b)(2) Foot care. To ensure that residents receive proper treatment	F 687		3/27/25

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F 687	Continued From page 16 and care to maintain mobility and good foot health, the facility must: (i) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident's medical condition(s) and (ii) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and Responsible Party (RP), staff and Nurse Practitioner interviews, the facility failed to provide foot care as ordered for 1of 1 resident reviewed for foot care (Resident #17). The findings included: Resident #17 was readmitted to the facility on 3/18/23 with diagnoses including Alzheimer's disease and dementia. Review of physician orders for Resident #17 dated 8/24/24 revealed that the application of lotion to both feet for 90 days due to dry skin was ordered. A review of Resident #17's August 2024 through current, 3/3/25 Medication Administration Records (MARs) and Treatment Administration Records (TARs) revealed no documentation for the application of lotion to Resident #17's feet. Resident #17's care plan last revised on 10/8/24 indicated that she had episodes of refusing to see the podiatrist with risk for complications. Interventions included: Allow the resident to have	F 687	F687 The facility failed to provide foot care as ordered for 1of 1 resident reviewed for foot care (Resident #17) 1. Immediate action(s) taken for the resident(s) found to have been affected include: Resident #17 was provided ordered foot care by the assigned nurse on 3/17 /2025. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. " On 3/27/2025 the administrative nurse team audited all residents with orders for foot care to assure residents were receiving foot care as ordered. This audit was completed on 3/ 27/2025. The results included: All residents with orders for foot care were receiving foot care as ordered. 3. Measures/Systemic changes to prevent	

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F 687	Continued From page 17 a choice in her care as much as possible, consult with the physician regarding refusal of care to determine if changes in prescribed care may be appropriate, encourage and allow the resident to remain in as much control over her own care as possible, explain procedures and care to the resident before care is performed, if she refuses do not argue and return at a later time to attempt again. Lastly, report all refusals of care to the nurse and document each episode. Review of the quarterly Minimum Data Set (MDS) assessment dated 1/3/25 revealed Resident #17 was severely cognitively impaired and required substantial/maximal assistance with bathing/personal hygiene. She was not coded for rejection of care behavior. Review of a health status note dated 1/30/25 at 12:12 PM and completed by Nurse #1 revealed Resident #17 was out of the facility at a doctor's appointment with her RP. Review of a Podiatry visit summary dated 1/30/25 revealed Resident #17's skin findings were severe dry/peeling/flaky skin to both feet. There was evidence of poor pedal hygiene with dry, crusty skin between 1-4 interspaces of both feet. The crusty, dead skin was removed between the toes with dry gauze. It was recommended nursing staff apply over the counter lotion twice daily to Resident #17's feet for 90 days due to dry skin. Follow-up appointment in 3 months. The RP was interviewed via telephone on 3/03/25 at 1:48 PM. He revealed that Resident #17's feet have been an issue since her admission. He stated the application of lotion to her feet would provide moisture, especially in between her toes,	F 687	reoccurrence of alleged deficient practice: Beginning on 3/ 21/25 the DON/Nurse Consultant began education for all licensed nurses, including agency nurses on: " F687 " Following physician orders " Notification of refusals process The above in-services were 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. As of 3/ 27 /2025 any of the above nursing 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: The DON or Designee will monitor compliance utilizing the F687 Quality Assurance Tool weekly x 3 weeks then monthly x 3 months or until resolved for compliance with the following foot care orders. 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,	

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F 687	Continued From page 18 to prevent further dryness, crusty, and aide in dead skin removal. An observation of Resident #17's feet was done in conjunction with an interview with Nurse #1 on 3/05/25 at 9:50 AM. Nurse #1 took off the left sock first and the foot appeared extremely dry with excess dry skin that fell onto the bed sheet. The left sock was then replaced. The right sock was then removed and appeared drier than the left foot as evidenced by more flaking skin and cracks observed on the skin of the foot. Excessively dried and dead skin fell from her foot and remained on the bed sheet. Nurse #1 stated she was not sure if there was an order for lotion to be applied to Resident #17's feet. She further stated Resident #17 sometimes refused for her socks to be taken off or to receive care related to her feet. The resident was not observed to be resistant to having her socks removed at the time of the observation. The Nurse Practitioner (NP) was interviewed on 3/05/25 at 9:59 AM. She stated she had just assessed Resident #17's feet, and they appeared to be extremely dry with excessive skin that fell from the feet when the socks were removed. The NP indicated she could not say if lotion had been applied to Resident #17's feet regularly. She stated if lotion was applied, and then her socks were replaced, the lotion would most likely rub off. During a follow-up interview with Nurse #1 on 3/05/25 at 10:06 AM, she stated that there was not a current order to apply lotion twice daily to Resident #17's feet. Nurse #1 indicated that she was unaware of the podiatry appointment on 1/30/25 or the recommendations that resulted from that visit to apply lotion twice daily to	F 687	Minimum Data Set Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: DOC: 3/27/2025	

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F 687	Continued From page 19 Resident #17's feet. Nurse Aide (NA) #1 was interviewed on 3/05/25 at 10:05 AM. She stated application of lotion to Resident #17's feet was not included in the care plan; however, she normally applied lotion to Resident #17's feet when she gave the resident a bed bath. NA #1 stated she was a part-time employee, and the last time she applied lotion to Resident #17's feet was 6 days ago. She stated Resident #17 often refused care (including a bath), and it was normally a "hit or miss" when it came to refusal of bathing. During a follow-up interview with NA #1 on 3/05/25 at 10:07 AM, she stated Resident #17 refused a bed bath that morning. Resident #17 told NA #1 she would get sick if water touched her. NA #1 stated she was going to ask if Resident #17 would allow lotion to be applied to her feet. The NA returned at 10:10 AM, and she stated that Resident #17 accepted for lotion to be applied to her feet. The Director of Nursing (DON) was interviewed on 3/05/25 at 3:01 PM. She revealed after a resident returns from an outside appointment, the paperwork for the facility should be given to the nurse on duty, who would need to take note of recommendations or instructions and follow through as needed. The DON indicated Resident #17's feet needed more "attention" when she observed them today. Resident #17 often refused care, and with that, there may be times where she seemed to comply, but the entire task was not always fulfilled. Applying lotion should be a daily routine/task as well as needed. The DON stated the application of lotion should not need to be entered as an order, even though it could not	F 687		

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F 687	Continued From page 20 be monitored without an order. The application of lotion twice daily to her feet should have been included in the care plan and activities of daily living (ADL) activity for nurse aides. During an interview with the Administrator on 3/06/25 at 12:31 PM, she revealed all outside consultations should be reviewed by the nurse on duty. If a summary did not come back with the resident, the nurse on duty should call the appropriate doctor's office. All residents assisted with personal hygiene and bathing should have lotion applied on every shift and as needed. The information from the 1/30/25 podiatry appointment should have been communicated to nursing, and lotion should have been administered to Resident #17's feet twice daily as recommended.	F 687		
F 727 SS=D	RN 8 Hrs/7 days/Wk, Full Time DON CFR(s): 483.35(b)(1)-(3) §483.35(b) Registered nurse §483.35(b)(1) Except when waived under paragraph (e) or (f) of this section, the facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week. §483.35(b)(2) Except when waived under paragraph (e) or (f) of this section, the facility must designate a registered nurse to serve as the director of nursing on a full time basis. §483.35(b)(3) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the	F 727	To remain in compliance with all federal	3/27/25

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F 727	Continued From page 21 facility failed to provide Registered Nurse (RN) coverage for 8 consecutive hours for 2 of 181 days reviewed for staffing (9/15/24 (Sunday) and 12/07/24 (Saturday). The findings included: A review of the Payroll Based Journal (PBJ) staffing data report for the first quarter of 2024 (October, November, and December) reported excessively low weekend staffing. Review of the facility's daily staff posting and staffing schedules from 9/01/24 through 2/28/25. revealed the following: a. On 9/15/24 the daily staff posting indicated a daily census of 69 on all three shifts. Review of the staffing schedule revealed there was no RN working on any shift that day. b. On 12/07/24 the daily staff posting indicated a daily census of 82 on all three shifts. Review of the staffing schedule revealed there was no RN working on any shift that day. In an interview on 3/06/25 at 11:57 AM the Director of Nursing (DON) indicated that if there was a hole in the staff schedule, they would call other staff in to fill the position. The DON reported 9/15/24 was a Sunday and 12/07/24 was a Saturday and the Minimum Data Set (MDS) nurse, who was an RN, would come in and fill the open position. She indicated she would look for timecard evidence of RN coverage for 9/15/24 and 12/07/24. In an interview on 3/06/25 at 1:58 PM the	F 727	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. F727 1. Corrective action for resident(s) affected by the alleged deficient practice: Nursing Admin and Scheduler will Review schedules and staffing sheets daily to maintain 8 consecutive registered nurse hours daily. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 3/24/25, the Administrator and Director of Nursing audited daily assignment sheets for 3/6/25-3/20/25 to ensure there was 8 consecutive registered nurse hours daily. Results included: All days had 8 hours of consecutive registered nurse hours. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/24/25, the Nurse Consultant educated the Scheduler, Director of Nursing, and the Administrator on the regulation of having a Registered Nurse in the facility 8 hours per day 7 days a week. The Director of Nursing can not be used to meet the 8 hour registered nurse hours.	

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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 727	Continued From page 22 Administrator revealed she had looked for timecards to support RN coverage and there was no documentation for RN coverage for 8 consecutive hours in the facility on 9/15/24 or 12/07/24.	F 727	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: Director of Nursing or designee will monitor compliance by auditing the nursing schedule, daily staffing sheets and actual hours worked to validate 8 consecutive registered nurse hours daily. This audit will be conducted weekly x 3 weeks then monthly x 3 months. Audits will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Support Nurses, Health Information Manager, Medical Director, and the Dietary Manager. Date of Compliance: 03/27/25	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly	F 812		3/27/25

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F 812	Continued From page 23 from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to keep food service equipment clean, free from debris, grease buildup, and/or dried spills by failing to clean the convection oven during two kitchen observations. This practice had the potential to affect food served to the residents who resided in the facility. The findings included: During a kitchen tour on 03/03/25 at 10:27 AM, the following observations were made with the Dietary Manager: The convection oven had a large volume of grease buildup inside of the oven, inside the door and on the seals. The grease buildup was encrusted on doors and on shelves where food would be cooked. A second observation of the convection oven on 3/06/25 at 11:03 AM revealed a large volume of grease buildup inside of the oven, on the door and gasket seals. The grease buildup was encrusted on doors and on shelves where food would be cooked.	F 812	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. F812 1. For dietary services, a corrective action was obtained on 3/03/2025 and 3/06/2025. During initial walk through of the kitchen, it was noted dietary services had failed to keep equipment clean, free of debris, or free of grease build-up. The oven noted with large build-up of grease on seals,	

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F 812	Continued From page 24 In an interview on 3/06/25 the Certified Dietary Manager revealed they cleaned the convection oven once a month and it was last cleaned on 2/06/25. In an interview on 3/06/25 at 11:06 AM Cook #1 stated they cleaned the convection oven once a month and the charred food was apples that spilled over two weeks ago. In an interview on 3/06/25 at 11:25 AM the Administrator stated they would clean the convection oven and create a cleaning schedule.	F 812	racks, doors, and gaskets. The Dietary Service Director and staff deep cleaned the oven 3/06/2025. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice: On 3/19/2025, the Dietary Service Director posted the cleaning schedule reviewing and highlighting oven cleaning with staff. 3. Measures/Systemic changes to prevent reoccurrence of alleged deficient practice: On 3/19/25 Dietary Service director educated all full time, part time, and as needed staff. Topics included: " Sanitation and cleaning equipment policy. " Inspections on shifts to observe oven to ensure inside and outside parts are without grease debris or food particles. " At least weekly cleaning of the oven (and as needed cleaning) per cleaning schedule. This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. 4. Quality Assurance monitoring procedure.	

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F 812	Continued From page 25	F 812	The Dietary Service Director or assignee will monitor procedures for proper cleaning and sanitation weekly x 2 weeks then monthly x 3 months using the Dietary QA Audit which will include inspections on both AM and PM shifts to observe that equipment is in proper condition. Reports will be presented to the weekly Quality Assurance committee by the Dietary Service Director to ensure corrective action initiated as appropriate. Compliance will be monitored and 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, Health Information Manager, and the Dietary Manager Compliance Date: 03/27/2025	