

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Louisburg Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Smoketree Way Louisburg, NC 27549	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772</p> <p>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.</p> <p>The findings included:</p> <p>1. Resident #14 was admitted to the facility on [DATE].</p> <p>A review of the quarterly Minimum Data Set (MDS) dated [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>An interview was conducted with the Administrator on 3/6/25 at 2:40 PM. The Administrator stated she expected staff to remove urinals from the overbed table while residents were eating their meal.</p> <p>(continued on next page)</p>		

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0550</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>2. Resident #35 was admitted to the facility on [DATE].</p> <p>A review of the quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #35 was cognitively intact and required limited assistance plus one-person physical assistance for eating.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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.</p>

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<p>F 0554</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41772</p> <p>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).</p> <p>The findings included:</p> <p>Resident #57 was admitted to the facility on [DATE].</p> <p>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.</p> <p>Review of the quarterly Minimum Data Set (MDS) 1/7/25 revealed Resident #57 was cognitively intact.</p> <p>On 03/04/25 at 09:19 AM Resident #57 was observed in the bed with two cups containing 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.</p> <p>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.</p> <p>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.</p> <p>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 to leaving the resident. The Administrator further stated she expected all treatments to be completed by staff before leaving the resident room.</p>		

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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>43222</p> <p>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).</p> <p>The findings included:</p> <p>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.</p> <p>b. On 8/28/24 the Resident Council Meeting Minutes noted a housekeeping concern was 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.</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>(continued on next page)</p>		

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F 0565 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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.		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Honor the resident's right to voice grievances without discrimination or reprisal and the facility must establish a grievance policy and make prompt efforts to resolve grievances.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222</p> <p>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.</p> <p>The findings included:</p> <p>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.</p> <p>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 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.</p> <p>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.</p> <p>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 no evidence a written summary was provided to Resident Council members.</p> <p>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).</p> <p>(continued on next page)</p>		

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<p>F 0585</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>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.</p> <p>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.</p> <p>2. Resident #57 was admitted to the facility on [DATE].</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated that Resident #57 was assessed as cognitively intact.</p> <p>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 #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.</p> <p>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.</p> <p>The ADON was unavailable for interview during the survey.</p> <p>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.</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Provide appropriate foot care.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222</p> <p>Based on observation, record review, and Responsible Party (RP), staff and Nurse Practitioner interviews, the facility failed to provide foot care as ordered for 1 of 1 resident reviewed for foot care (Resident #17).</p> <p>The findings included:</p> <p>Resident #17 was readmitted to the facility on [DATE] with diagnoses including Alzheimer's disease and dementia.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>Review of the quarterly Minimum Data Set (MDS) assessment dated [DATE] 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.</p> <p>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.</p> <p>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.</p> <p>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, to prevent further dryness, crusty, and aide in dead skin removal.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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 on to 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.</p> <p>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.</p> <p>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 Resident #17's feet.</p> <p>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.</p> <p>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.</p> <p>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 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.</p> <p>(continued on next page)</p>		

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<p>F 0687</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p>		

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<p>F 0727</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis.</p> <p>20710</p> <p>Based on record review and staff interviews, the 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)).</p> <p>The findings included:</p> <p>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.</p> <p>Review of the facility's daily staff posting and staffing schedules from 9/01/24 through 2/28/25. revealed the following:</p> <p>a. On 9/15/24 the daily staff posting indicated a daily census of 69 on all three shifts.</p> <p>Review of the staffing schedule revealed there was no RN working on any shift that day.</p> <p>b. On 12/07/24 the daily staff posting indicated a daily census of 82 on all three shifts.</p> <p>Review of the staffing schedule revealed there was no RN working on any shift that day.</p> <p>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.</p> <p>In an interview on 3/06/25 at 1:58 PM the 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.</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/06/2025
NAME OF PROVIDER OR SUPPLIER Louisburg Healthcare & Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 202 Smoketree Way Louisburg, NC 27549	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>20710</p> <p>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.</p> <p>The findings included:</p> <p>During a kitchen tour on 03/03/25 at 10:27 AM, the following observations were made with the Dietary Manager:</p> <p>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.</p> <p>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.</p> <p>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.</p> <p>In an interview on 3/06/25 at 11:06 AM [NAME] #1 stated they cleaned the convection oven once a month and the charred food was apples that spilled over two weeks ago.</p> <p>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.</p>		