

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>345358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                         | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/03/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Louisburg Healthcare & Rehabilitation Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>202 Smoketree Way<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   |                                                                                       |                                                 |
| F 0554<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | <p>Allow residents to self-administer drugs if determined clinically appropriate.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review, resident and staff interviews, the facility failed to assess a resident's ability to keep a rescue albuterol inhaler (a medication used to rapidly open airways and relief breathing difficulties) at bedside for self-administration for 1 of 2 residents reviewed for self-administration of medications (Resident #25). The findings included: Resident # 25 was admitted to the facility 4/2/26 with diagnoses that included chronic obstructive pulmonary disease (COPD) (a progressive lung disease that blocks airflow and makes it difficult to breathe) and dependence on supplemental oxygen. The admission Minimum Data Set (MDS) dated [DATE] revealed Resident # 25 was cognitively intact. Resident #25 was readmitted to the facility on [DATE]. A physician's order dated 5/28/26 revealed an order ProAir (Albuterol Sulfate) HFA Aerosol Solution - one (1) inhalation orally every 4 hours as needed for shortness of breath. An observation was conducted of Resident #25 on 6/1/2026 at 9:18 AM. Resident #25 was lying in the bed with the head of bed elevated. An albuterol sulfate inhaler was observed in the box of tissues sitting on the resident's bedside table. Resident #25's care plan dated 4/4/26 did not include any goals or interventions for self-administering medications. Review of Resident #25's medical record did not show an assessment for self-administration of medications. During an interview and observation with Resident #25 on 6/1/26 at 12:30 PM, the albuterol inhaler was sitting in a box of tissues box that was on the bedside table. Resident #25 stated he has always kept the rescue inhaler with him for shortness of breath (SOB). Resident #25 stated he had been keeping the rescue inhaler at the bedside since he was admitted to the facility back in April of 2026. Resident #25 stated the rescue inhaler was his personal inhaler from home. He denied that he had informed the staff that he had the inhaler. Resident #25 verbalized that he was to use the inhaler every 4 hours as needed for SOB. Nurse #2 was interviewed on 06/01/2026 12:49 PM and she confirmed she was assigned to Resident #25 on 6/1/26 during the 7:00 AM to 3:00 PM shift. Nurse #2 discussed she was not sure what the process was for a resident to self-administer medication because she had been working at the facility for short period of time. Nurse #2 stated she did not know that Resident #25 had the inhaler at his bedside. Nurse #2 stated she had administered Resident #25's morning medications and did not see an inhaler in the box of tissues on the bedside table. Nurse #2 stated if she saw any medication left in a resident's room, she would remove it immediately. During an interview with the Director of Nursing (DON) on 6/3/26 at 4:10pm, the DON stated she was not aware Resident #25 had the inhaler at bedside. She explained if a resident wanted to self-administer their medication, the facility would need to do an assessment to ensure the resident was safe to self-administer their medication. The DON stated once a resident was able to self-administer their medication the resident would have a plan of care to self-administer their medication. She explained Resident #25 had the potential to self-administer his own medication due to the resident's cognition. The DON stated if a nurse saw medication at a resident's bedside, she would (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<br>REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--------------------------------------------------------------------------|-------|-----------|

Department of Health & Human Services  
Centers for Medicare & Medicaid Services

Printed: 10/09/2026  
Form Approved OMB  
No. 0938-0391

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>345358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                   | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/03/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Louisburg Healthcare & Rehabilitation Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                       | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>202 Smoketree Way<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                             |                                                                                       |                                                 |
| F 0554<br><br>Level of Harm - Minimal harm<br>or potential for actual harm<br><br>Residents Affected - Few                         | expect that the nurse would remove the medication. The DON further stated she expected a conversation to be held with the resident about self-administering, an assessment to be completed, and an order obtained. The Administrator was interviewed on 6/3/26 at 4:12 pm. The Administrator stated she was not sure if there were any residents in the facility who self-administered their own medication. She explained if a resident wanted to self-administer their medication, the nurse would need to complete an evaluation. The Administrator stated if a nurse saw medication at a resident's bedside, she expected the nurse to remove the medication and then an evaluation completed to see if the resident was safe to self-administer. |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>345358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/03/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Louisburg Healthcare & Rehabilitation Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                    | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>202 Smoketree Way<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                          |                                                                                       |                                                 |
| <p>F 0658</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review, and staff interviews, the nurse failed to provide care according to professional standards when she borrowed and administered Resident #35's Potassium Chloride Extended Release (ER) tablets to Resident #8 and left the room without ensuring the resident had taken the medication for 1 of 5 residents reviewed for medications (Resident #8). Findings: Resident #8 was admitted on [DATE] with diagnoses including kidney disease, peptic ulcer, and constipation. A review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] revealed that the resident was cognitively intact. A review of Resident #8's current physician's orders revealed an order for Potassium Chloride ER Tablet 20 mEq (milliequivalents) to be given one (1) tablet by mouth one time a day for supplement and to take with food and a full glass of water. An observation was conducted on 6/2/26 at 1:22 PM as Resident #8 was lying in bed holding a candy wrapper that contained a yellow pill. The Director of Nursing (DON), who was in Resident #8's room at the time of the observation stated that the medication was Potassium Chloride Extended Release (ER) Tablet 10 mEq. An interview conducted on 6/2/26 at 1:22 PM with Resident #8 revealed that he had a pill in his hand because he felt Nurse #1 gave him too many pills. Resident #8 stated that he only takes one white pill, but Nurse #1 gave him two yellow pills today, and he decided to save one. Resident #8 stated that Nurse #8 handed him two pills in a cup and a cup of water and she walked out before he could take his medication. The resident revealed he took one pill and saved the other because he always took one pill for supplement and did not understand why the nurse gave him two yellow tablets this time. An interview was conducted on 6/2/26 at 1:39 PM with Nurse #1. Nurse #1 revealed that Resident #8's prescribed Potassium Chloride ER Tablet Extended Release 20 mEq had run out that morning, and she borrowed Resident #35's Potassium Chloride ER Tablet Extended Release 10 mEq and administered them to Resident #8. Nurse #1 stated that she was aware the facility has back up medication, but she did not have the time to go fetch the medication or to call the pharmacy. Nurse #1 revealed that she committed a mistake and was apologetic for borrowing Resident #35's medications to give to Resident #8. Nurse #1 stated that she borrowed two 10 mEq tablets and gave them to Resident #8. Nurse #1 stated that she did not stay in the room until Resident #8 took his medication because she was behind in passing medications and was rushing through. During an interview with the Physician Assistant (PA) on 6/03/26 at 3:09 PM she stated that Resident #8 taking half of the dosage of the prescribed Potassium Chloride ER 20 MEQ tablet had no adverse effect on him and that the error was not a significant issue. An interview was conducted on 6/2/26 at 1:43 PM with the DON. The DON stated that nurses are not allowed to borrow other residents' medications to administer on another resident. The DON stated that Nurse #1 was supposed to retrieve the Potassium Chloride ER Tablet 20 mEq from the emergency medications in the facility or call the pharmacy immediately she noted Resident #8 had run out of his medications. The DON revealed that nurses are required to observe the residents taking their medications before leaving the room. In an interview with the Administrator on 6/2/26 at 2:12 PM she revealed that the facility has back up emergency medications in the facility for nurses to use in the event a resident runs out of their medications.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>345358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                           | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/03/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Louisburg Healthcare & Rehabilitation Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                               | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>202 Smoketree Way<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                     |                                                                                       |                                                 |
| <p>F 0761</p> <p>Level of Harm - Minimal harm<br/>or potential for actual harm</p> <p>Residents Affected - Few</p>                 | <p>Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on observation, record review and staff interviews, the facility failed to store an unknown white cream in a locked cart. A white cream was observed on top of an empty barrier dressing package on the resident's bedside table. This occurred for 1 of 1 resident reviewed for medication storage. (Resident #52) The findings included: Resident #52 was readmitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] revealed the resident was cognitively intact. Review of active physician's orders dated 4/23/26 revealed an order for Calcium alginate with silver dressing to right buttocks daily. Review of active physician's orders dated 4/23/26 revealed an order for ammonium lactate lotion 12% apply to both legs daily. An observation and interview were conducted with Resident #25 on 5/31/26 at 12:18 PM. Resident #25 was sitting up in bed and there was an empty barrier dressing package sitting on the bedside table. A glob of cream that was the size of a silver dollar, white in color and had a thick creamy consistency was sitting on top of the packaging. Resident #25 denied that he knew what the cream was. Resident #25 reported that the cream had been sitting on the bedside table since the previous day. Resident #25 stated the nurse had been in earlier and completed his dressing change. The resident reported that the cream was on the bedside table then. Resident #25 could not give an approximate time of when the cream was placed on the table the previous day. An observation was conducted on 05/31/2026 at 12:49 PM with the Director of Nursing (DON). The DON confirmed that the glob of white cream sitting on an empty barrier dressing on Resident #52's bedside table should not have been left in the room. The DON inspected the cream and removed both the empty barrier dressing package and cream from the resident's bedside and discarded it. An interview was conducted with Nurse #2 on 05/31/2026 at 1:20 PM. Nurse #2 confirmed that she was the nurse responsible for caring for Resident #25 on the 7:00 AM to 3:00 PM shift. Nurse #2 stated she had cared for Resident 25 on the 7:00 AM to 3:00 PM on 5/30/2026 also. Nurse #2 stated she had changed Resident #25's dressing that morning but she did not recall there being an empty barrier dressing package with white cream on the bedside table. Nurse #2 stated the nurse assigned to the resident was responsible for dressing changes when the wound care nurse was not present. The nurse stated the wound nurse was not there that day, but she did work and complete Resident #25's dressing change on 5/30/26. Nurse #2 stated she had applied the ammonium lactate lotion to Resident #25's legs but denied placing the cream on the empty dressing and placing it on the bedside table. During an interview with the Wound Nurse on 6/2/26 at 1:15 PM she stated that she had completed Resident #25's dressing to his right buttocks on 5/30/26. The Wound Nurse stated she did not apply any creams on Resident #25's body. She further stated that the application of cream to Resident #25's leg was the day shift nurse caring for the resident's responsibility. An interview was conducted with the DON on 6/3/26 at 4:15 PM. The DON stated all medications and creams were to be removed when the nurse exited the resident's room. An interview was conducted with the Administrator on 6/3/26 at 4:17 PM. The Administrator stated that she expected that leftover medications would be discarded prior to leaving the resident's room.</p> |                                                                                       |                                                 |

|                                                                                                                                    |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      |                                                                                       |                                                 |
|------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------|-------------------------------------------------|
| STATEMENT OF DEFICIENCIES<br>AND PLAN OF CORRECTION                                                                                | (X1) PROVIDER/SUPPLIER/CLIA<br>IDENTIFICATION NUMBER:<br><br>345358                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                  | (X2) MULTIPLE CONSTRUCTION<br><br>A. Building<br>B. Wing                              | (X3) DATE SURVEY<br>COMPLETED<br><br>06/03/2026 |
| NAME OF PROVIDER OR SUPPLIER<br><br>Louisburg Healthcare & Rehabilitation Center                                                   |                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                      | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>202 Smoketree Way<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                                            |                                                                                       |                                                 |
| F 0842<br><br>Level of Harm - Potential for<br>minimal harm<br><br>Residents Affected - Some                                       | <p>Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> Based on record review and interviews with staff, the facility failed to ensure the medical record was complete regarding documentation of wound care for 1 of 3 residents reviewed for pressure ulcers (Resident # 17).The findings included:Resident #17 was admitted to the facility on [DATE] with diagnoses that included Stage IV pressure ulcer of the sacral region.A physician's order initiated 4/23/2026 revealed an order for Sodium Hypochlorite External Solution 0.25 % (Dakins Solution). Apply to sacrum topically every day shift for wound care. Cleanse with Dakins. Apply Dakins wet to moist dressing. Apply dry dressing. Apply to sacrum topically as needed for wound care. Change dressing if soiled, or dressing comes off.Review of Resident #17's Treatment Administration Record (TAR) revealed in May 2026, nurse initials were missing for the dressing change for the sacral pressure ulcer on 5/10/26, 5/18/26, 5/23/26, and 5/28/26. An interview was conducted with Nurse #1 on 6/3/26 at 2:48 PM. Nurse #1 confirmed she had worked with Resident #17 on 5/10/26 and 5/23/26 during the 7:00 AM to 3:00 PM shift. Nurse #3 stated she completed the dressing change for Resident #17 both days. Nurse #3 stated she was not sure why she did not document the dressing changes since she usually documented the treatment as soon as the dressing was complete.Nurse #4 who worked with Resident #17 on 5/18/26 and did not document completion of the treatment was not available by phone for interview. A telephone interview was conducted with Nurse #3 on 6/3/26 at 2:45 PM. Nurse #3 confirmed she had worked with Resident #17 on 5/28/26 during the 7:00 AM to 3:00 PM shift. Nurse #3 stated she completed the dressing change for Resident #17 on 5/28/26. Nurse #3 further stated the laptop she was using to document her treatments cutoff before she had an opportunity to chart so she plugged the laptop in for it to charge. Nurse #2 reported she did not realize she had not gone back and documented the dressing change.An interview was conducted with the Director of Nursing (DON) on 6/3/26 at 4:18 PM. The DON stated she expected the nurses would have completed dressing change documentation as soon as the dressing was completed. An interview with the Administrator on 6/3/26 at 4:19 PM revealed she expected staff to complete wound care documentation as soon as they completed the dressing change or treatment.</p> |                                                                                       |                                                 |