STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345358	A. BUILDING _____ B. WING _____	C 12/14/2022

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LOUISBURG HEALTHCARE & REHABILITATION CENTER	202 SMOKETREE WAY LOUISBURG, NC 27549

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E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 12/11/22 through 12/14/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #UYDL11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey were conducted from 12/11/22 through 12/14/22. Event ID# UYDL11. The following intakes were investigated NC00195685. 4 of the 4 complaint allegations were not substantiated.	F 000		
F 695 SS=D	Respiratory/Tracheostomy Care and Suctioning CFR(s): 483.25(i) § 483.25(i) Respiratory care, including tracheostomy care and tracheal suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents' goals and preferences, and 483.65 of this subpart. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews and staff and Physician interviews, the facility failed to obtain a Physician order for the use of supplemental oxygen for 1 of 2 residents (Resident #14) reviewed for oxygen. The findings included: Resident #14 was admitted to the facility on	F 695	1The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility□s allegation of	12/16/22

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

Electronically Signed | 12/30/2022

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F 695	Continued From page 1 10/21/22 with diagnoses that included a history of acute respiratory failure, pulmonary hypertension, and pleural effusion (fluid buildup between the tissues lining the lungs and chest). Resident #14's hospital discharge summary dated 10/21/22 revealed no orders for oxygen use. Resident #14's Nursing Admission Assessment dated 10/21/22 revealed the Resident required oxygen at 2 liters per minute (lpm) via nasal cannula. An admission Minimum Data Set (MDS) assessment dated 10/28/22 revealed the Resident was severely cognitively impaired. The MDS further revealed Resident #14 received oxygen therapy during the assessment period. A care plan initiated 11/2/22 indicated Resident #14 required oxygen therapy. Interventions included observe for signs and symptoms of respiratory distress (restlessness, increased heart rate, confusion) and provide oxygen therapy per Physician's order. A review of the December 2022 Physician orders revealed Resident #14 did not have a current order for supplemental oxygen. A review of the facility standing orders for Resident #14 signed by the facility Physician upon admission, did not reveal an order for supplemental oxygen. During observations on 12/11/22 at 3:54 pm and 12/12/22 at 8:20 am the Resident was receiving	F 695	compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F695 1. Corrective action for resident(s) affected by the alleged deficient practice: On 12/12/2022 a corrective action was obtained for Resident #14 when an order as entered for oxygen use. 2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/12/2022, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) began identification of residents that were potentially impacted by this practice. This audit consisted of a walking round to identify 100% of current residents who were identified as receiving oxygen therapy and ensuring that orders for oxygen were present in the resident□s record. This audit was completed on 12/12/2022. Results included: 8 out of 8 residents who receive oxygen therapy have orders for oxygen. On 12/12/2022 the Director of Nursing and Staff Development Coordinator implemented corrective action for those residents which included: entering orders for oxygen. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice:	

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F 695	Continued From page 2 oxygen at 2 liter per minute via nasal cannula. An interview was conducted on 12/12/22 at 3:15 pm with Nurse #1. The Nurse indicated he input Resident #14's Physician orders per the hospital discharge summary. Nurse #1 stated he was unable to recall if he received a phone report from the discharging hospital indicating the Resident required supplemental oxygen. An interview was completed with the Director of Nursing (DON) on 12/12/22 at 3:28 pm. The DON indicated she completed Resident #14's admission assessment. She stated she was unable to recall if the Resident had a Physician order for supplement oxygen. The DON indicated the oxygen order must have not been confirmed in the group orders, so it was not added to Resident #14's Physician orders. The DON stated new resident admission orders are reviewed for accuracy during the facility's daily clinical meeting and was unaware why the oxygen order was missed. An interview was completed with the Family Nurse Practitioner (FNP) on 12/13/22 at 11:00 am. The FNP indicated supplemental oxygen required a Physician order. She stated nurses were to contact the on-call healthcare provider to obtain an order for oxygen. An interview was completed with the Administrator on 12/14/22 at 9:27 am. She stated it was her expectation a Physician order be obtained for supplemental oxygen.	F 695	On 12/14/22, the Staff Development Coordinator began reeducating Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency licensed nurses on oxygen use education. (See Education). All new hires will receive the in-service training during orientation. " policy and procedures related Oxygen use " The need for orders for any resident receiving oxygen therapy Additionally, on 12/13/22, the Nurse Consultant educated the DON and the ADON on the admission order review process. This education included: Admission order process Admission checklist 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consists of monitoring 5 random residents who are currently receiving oxygen therapy to ensure that orders for oxygen are present	

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F 695	Continued From page 3	F 695		

to assure compliance. The Director on Nursing will audit new and readmissions for accuracy of oxygen orders utilizing a Admission/Readmission Audit tool Monitoring will be completed weekly x 5 weeks on various days and various shifts. Reports will be presented to the weekly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.

Date of Compliance: 12/16/2022

. Corrective action for resident(s) affected by the alleged deficient practice:

On 12/12/2022 a corrective action was obtained for Resident #14 when an order as entered for oxygen use.

2. Corrective action for residents with the potential to be affected by the alleged deficient practice.

All residents have the potential to be affected by the alleged deficient practice.

On 12/12/2022, the Director of Nurses (DON) and Assistant Director of Nurses (ADON) began identification of residents

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F 695	Continued From page 4	F 695	that were potentially impacted by this practice. This audit consisted of a walking round to identify 100% of current residents who were identified as receiving oxygen therapy and ensuring that orders for oxygen were present in the resident□s record. This audit was completed on 12/12/2022. Results included: 8 out of 8 residents who receive oxygen therapy have orders for oxygen. On 12/12/2022 the Director of Nursing and Staff Development Coordinator implemented corrective action for those residents which included: entering orders for oxygen. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 12/14/22, the Staff Development Coordinator began reeducating Licensed Nurses, Registered Nurses (RN□s) and Licensed Practical Nurses (LPN□s) including agency licensed nurses on oxygen use education. (See Education). All new hires will receive the in-service training during orientation. " policy and procedures related Oxygen use " The need for orders for any resident receiving oxygen therapy Additionally, on 12/13/22, the Nurse Consultant educated the DON and the	

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F 695	Continued From page 5	F 695	ADON on the admission order review process. This education included: Admission order process Admission checklist 4. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory requirements. Quality assurance monitoring will be completed by the Director of Nurses or designee using the F695 Quality Assurance Tool. This monitoring consists of monitoring 5 random residents who are currently receiving oxygen therapy to ensure that orders for oxygen are present to assure compliance. The Director on Nursing will audit new and readmissions for accuracy of oxygen orders utilizing a Admission/Readmission Audit tool Monitoring will be completed weekly x 5 weeks on various days and various shifts. Reports will be presented to the weekly QA committee by the DON or designee to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly QA Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Health Information Manager, and the Dietary Manager. Deficiencies that are identified during the monitoring process will be addressed through the facility Quality Assurance process.	

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F 695	Continued From page 6	F 695	Date of Compliance: 12/16/2022	
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of	F 732		12/16/22

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F 732	Continued From page 7 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on staff interviews and record review, the facility failed to post readily accessible Nurse Staffing Information at the beginning of each shift for 1 of 4 days during the survey (12/11/22) and failed to post accurate Nurse Staffing Information for 42 of 42 days of Nurse Staffing Information reviewed from 11/1/22 through 12/12/22. The findings included: 1. An observation and interview with the Director of Nursing (DON) on 12/11/22 at 10:32 AM revealed Nurse Staffing Information was not readily displayed within the facility. The DON indicated daily Nurse Staffing Information was not posted on the weekends because there was not any administrative staff in the building to post it. An interview was conducted with the Quality Assurance (QA) support nurse on 12/13/22 at 1:39 PM, and she stated Nurse Staffing Information should be posted every day including weekends. 2. A review of the posted Nurse Staffing Information sheets was compared with the Daily Staffing Hours assignment sheets which included both nurse and nurse aide actual assignments and shifts worked. The comparison revealed licensed and unlicensed nursing staff were not recorded accurately for all shifts and days from 11/1/22 through 12/12/22 (11/1/22, 11/2/22, 11/3/22, 11/4/22, 11/5/22, 11/6/22, 11/7/22, 11/8/22, 11/9/22, 11/10/22, 11/11/22, 11/12/22, 11/13/22, 11/14/22, 11/15/22, 11/16/22, 11/17/22,	F 732	1. Corrective action for resident(s) affected by the alleged deficient practice: The Daily Nurse Staff Posting for December 11, 2002 was posted on 12/11/22 by the Director of Nurses. On 12/13/2022 □ 12/14/2022, The Assistant Director of Nurses (ADON) and the Support through December 13, 2022 to reflect the assigned staff who worked each day. This was completed on 12/14/2022. On 12/14/2022, the Administrator reviewed the daily nurse staff postings from November 2022 through December 13, 2022 to ensure a daily nurse staff posting was completed and that it was accurate to reflect the assigned staff who worked each day. 2. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: There were no resident affected by this deficient practice. The Administrator or designee will be responsible for ensuring a daily nurse staff posting was completed and that it was accurate to reflect the assigned staff who worked each day. The daily posting will be reviewed weekly for accuracy. On 12/13/2022, the Quality Assurance	

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F 732	Continued From page 8 11/18/22, 11/19/22, 11/20/22, 11/21/22, 11/22/22, 11/23/22, 11/24/22, 11/25/22, 11/26/22, 11/27/22, 11/28/22, 11/29/22, 11/30/22, 12/1/22, 12/2/22, 12/3/22, 12/4/22, 12/5/22, 12/6/22, 12/7/22, 12/8/22, 12/9/22, 12/10/22, 12/11/22, and 12/12/22). The QA support nurse was interviewed on 12/13/22 at 1:55 PM. She reviewed all the Nurse Staffing Information from 11/1/22 through 12/12/22. She confirmed the nurse staffing information was incorrect. During an interview on 12/14/22 at 9:13 AM, the DON revealed the reason why all the daily Nurse Staffing Information sheets were inaccurate was because she was never trained to adjust the daily staffing sheet as the staffing changed throughout the day. The Administrator was interviewed on 12/14/22 at 9:34 AM. She revealed her expectation was that the daily Nurse Staffing Information be accurate and posted daily.	F 732	Clinical Nurse Consultant completed education on Daily Nursing Staff Posting Requirements for the following staff, the Administrator, DON, ADON, MDS Nurse and the Support Nurses. Objectives: " To identify the regulatory requirement of F 732 for Posted Nursing Staff Information " To monitor that the requirement for F732 is met daily and includes the data requirements, posting requirements, Public access to posted nurse staffing data, and Facility data retention requirements. 3. Monitoring Procedure to ensure that the plan of correction is effective and that specific deficiency cited remains corrected and/or in compliance with regulatory/requirements. The Administrator or designee will monitor compliance utilizing the F732 Quality Assurance Tool weekly for daily nursing staff postings. This monitor will be completed weekly x 5 weeks reviewing daily nursing staff posting from the previous week to ensure the form is being completed and reviewing for accuracy of the daily nursing staff posting. Reports will be presented to the weekly Quality Assurance committee by the Administrator or Director of Nurses to ensure corrective action is initiated as appropriate. Compliance will be monitored and the ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The	

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F 732	Continued From page 9	F 732	weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager. Date of Compliance: 12/16/2022	
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations, record review and interviews with facility staff, the facility failed to date opened food items stored for resident use in the nourishment refrigerator and to discard foods past their use by date for 1 of 1 nourishment refrigerator. This practice had the potential to affect foods served to the residents.	F 812	1. For dietary services, a corrective action was obtained on 12/14/2022. On 12/14/2022, the Support Nurse discarded any non-labeled/dated food items in the kitchen and nourishment fridges.	12/16/22

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F 812	Continued From page 10 The findings included: During an observation on 12/12/22 at 8:35 AM an observation of the nourishment refrigerator was conducted. The observation revealed 2 large oval paper plates sandwiched together labeled with (name of resident) "Do not throw away." dated 11/24/22. There was also a plastic container of what looked like pasta, beans beef dated 12/12/22 with no name. There was a 16oz Sprite bottle dated 11/24/22 with name of resident, 1 open bottle of soda, with no date/label and a brown bag with unidentified foil wrapped item with no label, dated 12/12/22. On 12/13/22 at 3:34 PM an observation of the of the nourishment refrigerator was conducted with the Infection Control Nurse. There was also a plastic container of what looked like pasta, beans beef dated 12/12/22 with no name. There was a 16oz Sprite bottle dated 11/24/22 with name of resident, 1 open bottle of soda, with no date/label and a brown bag with unidentified foil wrapped item with no label, dated 12/12/22. On 12/13/22 at 3:36 PM the Infection Control Nurse stated if food items were not labeled or dated they would be thrown out. On 12/13/22 at 3:39 PM the Administrator stated the housekeeping staff were responsible for checking and cleaning out the nourishment refrigerator. She indicated all unlabeled and undated food items were to be thrown out and staff should check daily. On 12/14/22 at 9:09 AM the environmental services manager stated his staff checked the	F 812	2. Corrective action for residents with the potential to be affected by the alleged deficient practice. All residents have the potential to be affected by the alleged deficient practice. On 12/14/2022, the Administrator, EVS Director, & Support Nurse completed an observation of the nourishment refrigerators to ensure all food items were labeled/dated properly. Results: 4 items thrown out. 3. Systemic changes In-service education was provided to all full time, part time, and as needed staff. Topics included: (See Education) " Food storage and dating information This information has been integrated into the standard orientation training and in the required in-service refresher courses for all staff and will be reviewed by the Quality Assurance process to verify that the change has been sustained. All residents and families are made aware of the food policy on admission. The SW re-educated all residents with a BIMs of 14 or higher on 12/14/2022 to the food policy. 4. Quality Assurance monitoring procedure. The EVS Director, MOD or designee will	

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F 812	Continued From page 11 nourishment refrigerator first thing each day and throw did clean the nourishment refrigerator. He indicated someone must have put the items in after staff had cleaned.	F 812	monitor compliance for proper food storage weekly x 5 weeks which will include inspections to ensure that all food is labeled, dated, and within proper dates. Reports will be presented to the weekly Quality Assurance committee by the Administrator to ensure corrective action initiated as appropriate. Compliance will be monitored and ongoing auditing program reviewed at the weekly Quality Assurance Meeting. The weekly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy, Health Information Manager, and the Dietary Manager Compliance date: 12/16/2022	