

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 000	INITIAL COMMENTS A complaint investigation survey was conducted from 07/09/24 through 07/10/24. Event ID #BS9U11. The following intakes were investigated NC00219015, NC00217936, and NC00217491. One (1) of the 6 complaint allegations resulted in deficiency. Intake NC00219015 resulted in immediate jeopardy. Immediate Jeopardy was identified at: CFR 483.90 at tag F925 at a scope and severity K Immediate Jeopardy began on 06/23/24 and was removed on 07/10/24.	F 000			
F 925 SS=K	Maintains Effective Pest Control Program CFR(s): 483.90(i)(4) §483.90(i)(4) Maintain an effective pest control program so that the facility is free of pests and rodents. This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and resident interviews, pest control technician interviews, and Nurse Practitioner interviews, the facility failed to maintain an effective pest control program to protect vulnerable residents from ants. On 6/23/24 Resident #1 was observed in bed with small black ants all over the floor, bedside table, bed linens, her gown, inside her incontinence brief, and on her body. Resident #1 complained of itching everywhere and had numerous small, reddened areas spread across the back and sides of her body. On 6/26/24 Resident #2 was observed in bed with small black ants all over the floor, furniture, bed linens, and clothing of Resident #2. Fire ants inject venom	F 925	The statements made on this plan of correction are not an admission to and do not constitute an agreement with the alleged deficiencies. To remain in compliance with all federal and state regulations the facility has taken or will take the actions set forth in this plan of correction. The plan of correction constitutes the facility's allegation of compliance such that all alleged deficiencies cited have been or will be corrected by the dates indicated. F925 Failed to maintain an effective pest control program to protect vulnerable residents	7/26/24	

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

TITLE

(X6) DATE

Electronically Signed

07/26/2024

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 1</p> <p>when they bite that causes a burning sensation and can cause localized sterile blisters, whole body allergic reactions such as anaphylactic shock, and, occasionally, death. Individual ants can bite and sting several times and because large numbers of ants are often together, incidents usually involve multiple stings. High numbers of stings can lead to severe medical reactions even in people with normal immune systems. The elderly and immobile individuals are at a higher risk of multiple stinging incidents. A reasonable person would experience serious adverse psychosocial outcomes that would include feeling helpless, intense anxiety, humiliation, and panic during the incident and fear of recurrence after the incident from being covered with ants on their body and clothing while in bed and being unable to leave the bed without assistance. This deficient practice was for 2 of 3 residents reviewed for pest control (Resident #1 and Resident #2).</p> <p>Immediate jeopardy began on 6/23/24 when the facility failed to maintain an effective pest control program. The immediate jeopardy was removed on 7/10/24 when the facility implemented an acceptable credible allegation of immediate jeopardy removal. The facility remains out of compliance at a lower level and severity of "E" (no harm with the potential for more than minimal harm that is not immediate jeopardy) to ensure education is completed and monitoring systems put in place are effective.</p> <p>The findings included:</p> <p>Review of fire ant information titled "Medical Problems and Treatment Considerations for the Red Imported Fire Ant", which was provided by</p>	F 925	<p>from ants.</p> <p>1. Corrective action for resident affected by the alleged deficient practice. On 6/23/24 Resident #1's skin assessment by Nurse #1 revealed several small reddened areas on her back and sides, resident complained of itching and was observed scratching. Nurse #1 removed the ants from the resident and the resident was moved to another room. On 6/23/24 Nurse #1 called the Medical provider, orders were given for Benadryl 25 mg 1 tab by mouth every six hours PRN x three days and Calamine lotion to red areas three times a day as needed for 7 days. Resident #1 is her own responsible party. On 6/23/24 the Maintenance Supervisor cleaned and sanitized the room. He checked the adjoining rooms with no observed pests on 6/23/24. On 6/24/24 Resident #1 was seen by the Nurse Practitioner and resident had no reports of pruritis during her visit and resident currently is not experiencing any skin irritation, itching or discomfort per nursing assessment on 7/9/24. On 6/26/24 Resident #2 was observed in bed by Nurse #2. Nurse #2 observed small black ants all over the floor, furniture, bed linens, and clothing of Resident #2. Nurse #2 did not observe any signs of physical injury from the ants on Resident #2 and resident was immediately moved into another room.</p> <p>2. Corrective action for residents with the potential to be affected by the alleged deficient practice.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	Continued From page 2 the Entomological (scientific study of insects) Program Manager with the North Carolina Department of Agriculture and Consumer Services and the State Public Health Entomologist (a scientist who studies insects and related animals) with the North Carolina Division of Public Health, Communicable Disease Branch revealed the following: When a fire ant bites it injects venom that can cause localized sterile blisters, whole body allergic reactions such as anaphylactic shock, and, occasionally, death. The intense burning sensation that occurs from the injected venom accounts for the popular name of "fire ant". Individual worker ants can bite and sting several times and the site of the sting hurts for a few minutes and then reddens. The bite will then swell into a bump or hive within 20 minutes and within several hours to a day after being stung, most people will develop a white fluid-filled sterile pustule (small, inflamed, pus-filled sores that look like blisters) which are a characteristic of the fire ant sting. Because large numbers of worker ants are often together stinging incidents usually involve multiple stings and the ants can crawl rapidly (1.6 centimeters per second) and within seconds, they begin stinging almost simultaneously. People vary greatly in their sensitivity to fire ant stings with some people being hypersensitive to it may have other medical conditions (such as a heart condition or diabetes) that can result in serious medical problems or even death from a single sting. High numbers of stings can lead to severe medical reactions even in people with normal immune systems. The elderly, infants, neurologically compromised people, and otherwise immobile or unaware individuals are at a higher risk of multiple stinging incidents and should be supervised carefully. The information further stated fire ant workers can	F 925	All residents are potentially at risk for the deficient practice. On 6/24/24 the Maintenance Supervisor initiated daily inspection of 100% of all rooms on 400 hall for any signs of pest. On 6/26/24 the Maintenance Supervisor called Pest control to come to the facility as his daily inspection did identify ants observed in a vacant room which he cleaned and sanitized. Pest control came to the facility on 6/26/24 and sprayed rooms 405,407,409. There were some dead ants but there were no live pests noted by pest control. Pest control proactively treated 100% of the exterior perimeter of 400 hall. Pest Control identified and treated fire ant mounds on the exterior of the facility on 6/26. The Maintenance Supervisor has completed ongoing pest control monitoring of 100% of 400 hall 5x weekly since 6/26/24 without additional identification of pests. On 7/9/24 licensed nurses did skin checks on 100% of the residents and there were no identified skin concerns associated with pest/insect bites. On 7/9/24 Admissions Coordinator, Therapy Director, Nurse Secretary, Human Resources, Maintenance Supervisor, Activity Coordinator, and the Business Office Manager did 100% room checks and did not identify any pests in the facility. 3. Measures /Systemic changes to prevent reoccurrence of alleged deficient practice: On 7/9/24 the Maintenance Supervisor		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 3</p> <p>easily enter structures through even tiny cracks and crevices. Occasionally, entire colonies will migrate into structures and nest in wall voids or other locations. This is particularly common when outdoor conditions become very hot and dry or when flooding occurs in the immediate landscape.</p> <p>Review of the facility's pest control logs revealed the facility had a contract which was dated 6/23/22 for monthly inspection of all exterior and interior areas of the facility for pest activity and emergency calls were available 24 hours a day 7 days a week.</p> <p>The pest control log with a service date of 6/17/24 revealed that all interior and exterior areas were inspected and serviced by Pest Control Technician #1 with no ant activity noted in the report.</p> <p>An observation of the 400 Hall was conducted on 7/09/24 at 10:05 am which revealed Resident #1's and Resident #2's rooms were located on the same side of the hall (400 Hall) and were the immediate next door to each other on the hall.</p> <p>a. Resident #1 was admitted to the facility on 6/18/24 and resided on the 400 Hall on the side of the hall located on the back exterior of the facility.</p> <p>The weekly skin assessment completed on 6/18/24 revealed Resident #1 had no skin issues noted.</p> <p>The Minimum Data Set (MDS) admission assessment dated 6/25/24 revealed Resident #1 had moderate cognitive impairment, adequate</p>	F 925	<p>was educated to notify pest control immediately upon identifying any pests by the Administrator.</p> <p>On 7/9/24 the Administrator began in servicing all staff (full time, part time, and prn including agency) on the need to provide effective Pest management to ensure residents are safe from ants and pests. This education will be provided to new hires during the orientation process by Human Resources. No staff shall work without this education effective 7/10/24. The Administrator, Director of Nursing, and Human Resources will monitor to ensure no staff works without completing the education. This education included:</p> <ul style="list-style-type: none"> The Maintenance Supervisor weekly inspects and repairs (as needed) any structural issues, such as cracks, holes, or gaps that could allow pests to enter the building. The Maintenance Supervisor and the Department Heads conduct regular inspections of all areas of the facility, including resident rooms, common areas, kitchens, and storage areas to identify any signs of pest activity. The Maintenance Supervisor will maintain detailed records of all pest control activities, including inspection reports, treatment records, and any actions taken to address identified issues. Staff will need to recognize signs of pest activity, they were educated on what pests are, and understand the importance of maintaining a pest free-free 		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 4</p> <p>vision without corrective lenses, and required staff assistance to get out of bed during the 7-day lookback period.</p> <p>The nursing progress note dated 6/23/24 at 6:25 am by Nurse #1 revealed there was an ant infestation in Resident #1's bed and room. Resident #1 was observed to have several small, reddened areas on the skin across the back and sides of the body and Resident #1 reported itching all over. Resident #1 was observed by Nurse #1 to be scratching the skin a lot. The nursing progress note further noted Resident #1 was moved to a new room and the provider was notified.</p> <p>A telephone interview was conducted on 7/09/24 at 11:32 am with Nurse #1 who revealed she had entered Resident #1's room during rounds and found Resident #1 to be "covered in ants." Nurse #1 stated she was unable to say exactly how many ants were on Resident #1 but stated there were "a lot of ants and that they were everywhere." Nurse #1 stated the ants were small, black ants and they were on the bed linens, the floor, tables, and on Resident #1's body including inside the incontinence brief. She stated Resident #1 was removed from the bed by staff because she was not able to get out of bed by herself. Nurse #1 stated Resident #1's gown was removed, her skin was wiped with the personal care wipes, and her body and scalp were checked to make sure there were no more ants. Nurse #1 stated they attempted to move Resident #1 to the empty room on the same side of the hall, which was along the back of the building, but she stated when they checked the room the small black ants were in that room as well, so they moved Resident #1 across the hall.</p>	F 925	<p>environment. Staff should know how to report any pest sightings or concerns immediately. Any pest sightings should be reported immediately to the Maintenance Supervisor or the on call Administration.</p> <ul style="list-style-type: none"> • Always address any concerns or complaints from residents or their families regarding pest control promptly and effectively. • The facility maintains high standards of cleanliness and sanitation throughout the facility to eliminate food and water sources that attract pests. The facility will ensure proper storage and disposal of waste to prevent attracting pests. Educate staff to ensure food is stored properly, waste is disposed of properly, and we maintain cleanliness to reduce the risk of pest infestations. <p>On 7/9/24 the Maintenance Supervisor called pest control to come to the facility on 7/10/24 and do a thorough inspection and provide treatments as needed.</p> <p>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.</p> <p>The Director of Nurses, or designee will monitor compliance utilizing the F 925 QA Tool weekly x 3 weeks then monthly x 2 months or until resolved. This tool will monitor 8 random rooms, on various halls, various days, to observe for any pests. Any observation of pests will be reported</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 5</p> <p>Nurse #1 reported that she completed a thorough skin assessment of Resident #1 and noted there were "so many" tiny red marks on the back, sides, and buttock area of the body and Resident #1 reported she was "so itchy and was scratching herself all over." Nurse #1 stated she had never seen ants like this in the resident rooms prior but had reported that at times would see one or two ants here or there. Nurse #1 stated she notified the Administrator, Director of Nursing (DON), the on-call medical provider, and the Maintenance Supervisor of the ants.</p> <p>A physician order dated 6/23/24 for diphenhydramine 25 milligram (mg) tablet every 6 hours as needed for itching for 3 days.</p> <p>A physician order dated 6/23/24 for calamine lotion to apply to red areas topically every 8 hours as needed for red areas for 7 days.</p> <p>Review of the Maintenance Log dated 6/23/24 Nurse #1 noted ant infestation in Resident #1's room.</p> <p>The Nurse Practitioner (NP) progress note dated 6/24/24 revealed Resident #1 recently complained of itching everywhere, was noted to have numerous small, reddened areas spread across the back and sides. The NP progress note further stated Resident #1's room was noted to have an ant infestation and was moved to another room. The NP noted that Resident #1 did not report pruritis (itching) during the visit.</p> <p>A telephone interview was conducted on 7/09/24 at 3:45 pm with the NP who revealed she saw Resident #1 on 6/24/24 as a follow-up to the on-call provider notification of the ant infestation</p>	F 925	<p>to Maintenance or designee immediately. QA reports will be presented to the monthly 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 monthly Quality Assurance Meeting. The monthly QA Meeting is attended by the Administrator, Director of Nursing, MDS Coordinator, Therapy Manager, Unit Manager, Health Information Manager, and the Dietary Manager.</p> <p>Date of Compliance: 07/11/2024</p>		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 6</p> <p>and reported itching. The NP reported that Resident #1 was unable to get out of bed without staff assistance based on her observations and knowledge of the resident. The NP stated Resident #1 was alert and oriented and had never reported itching prior to the ant infestation. She reported that based on the time frame of the ant infestation, Resident #1's noted reddened marks, and reported itching, the reddened marks and itching were due to the ant bites.</p> <p>An interview was conducted on 7/09/24 at 10:02 am with Resident #1 who was identified as alert and oriented by the Administrator, revealed that about two weeks ago, unable to recall exact date, she thought she saw ants on the floor and on the furniture in her room and told someone who came in and killed the ants. Resident #1 stated sometime later that night the nurse woke her and told her she had ants all over her and she needed to get out of the bed quickly. Resident #1 stated the staff got her out of bed and into her wheelchair then moved her to another room. Resident #1 stated she did see a lot of ants on her bed, the floor, and on the furniture when she got out of the bed. Resident #1 stated she could not tell that she was bitten but she stated the nurse told her she had bites from the ants. Resident #1 reported her body and arms were itchy for a few days from the bites. Resident #1 stated she had difficulty repositioning in the bed to get comfortable that night, but she was unable to get out of bed without help and she didn't realize the ants were in the bed or she would have called staff for help. Resident #1 stated she had not seen ants in her room prior to that night.</p> <p>A telephone interview was conducted on 7/09/24 at 2:37 pm with Nurse Aide (NA) #1 who revealed</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 7</p> <p>she was assigned to Resident #1 on 6/22/23 from 3:00 pm until 6/23/24 at 7:00 am. NA #1 stated Resident #1 had told her about the ants in her room during the 3:00 pm shift and she killed and cleaned up the ants. NA #1 stated she saw a few ants on the floor around some crumbs and did not see any more ants at that time, so she did not report the ants to anyone. NA #1 stated she provided incontinence care to Resident #1 throughout both of her shifts and did not observe ants in her room until she was called to the room by Nurse #1 in the morning. NA #1 reported when she entered Resident #1's room there were "a lot of ants, not sure how many, just a lot of ants" and they were all around the room. She stated they were small black ants and they were on Resident #1's body, bed, floor, and tables in Resident #1's room. NA #1 stated when they tried to find another room for Resident #1 to go to since her room had so many ants she stated the empty rooms on the same side of the hall, along the back of the building, also had ants in them so they moved Resident #1 across the hall. NA #1 stated Resident #1 required assistance to get out of bed. She indicated Resident #1 was able to turn a "little bit" in bed but needed help to fully turn in bed. NA #1 stated she had not seen that many ants before, but she stated she had seen small amounts of ants in the facility around food crumbs on the floor.</p> <p>A telephone interview was conducted on 7/10/24 at 9:44 am with Nurse #3 who revealed she was new to the facility and was on orientation with Nurse #1 on the morning of 6/23/24 when Resident #1's room was infested with ants. Nurse #3 stated she and Nurse #1 entered Resident #1's room in the morning for rounds and first noticed ants on top of the blanket but when the</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 8</p> <p>blanket was lifted, "oh my goodness they were all over." Nurse #3 reported small black ants were all over the room, floor, tables, bed, and Resident #1. Nurse #3 stated they got Resident #1 out of the bed and cleaned her up to make sure no more ants were on her. She stated she did not do the actual skin assessment, so she was unable to state if any bites were present. Nurse #3 stated Resident #1 was alert and oriented and reported that her whole body itched, and she was scratching herself. Nurse #3 reported when they tried to move Resident #1 to another room on the same side of the hall, she saw ants in two empty rooms, so they had to move her across the hall. Nurse #3 stated there were just so many ants, that she felt itchy herself just seeing how many ants were on Resident #1.</p> <p>During an interview with the Maintenance Supervisor on 7/9/24 at 3:30 pm he revealed he was called by a Nurse from the facility about the ants in Resident #1's room on 6/23/24 and he came in the same day and sprayed the ant spray he had used at the facility in Resident #1's room and thoroughly cleaned and sanitized the room. The Maintenance Supervisor stated he did not see any other areas on the hall that Resident #1 was located on when he came in on 6/23/24, but he sprayed the entire hall as a precaution with the same spray. The Maintenance Supervisor stated he did not call for the Pest Control Company to come because he treated the room and did not observe any further ant activity in any other rooms on Hall 400. The Maintenance Supervisor stated the ants that were in Resident #1's room were small black ants.</p> <p>During an interview on 7/09/24 at 3:19 pm the Administrator revealed she did not recall being</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 9</p> <p>notified by Nurse #1, but she recalled the progress note about the ants and discussed it with the Maintenance Supervisor on 6/24/24. The Administrator stated Resident #1 was moved to a new room and the room was cleaned and sprayed. The Administrator stated she believed the Maintenance Supervisor called for the Pest Control Company to treat the facility, but she would have to speak to the Maintenance Supervisor to confirm.</p> <p>b. Resident #2 was admitted to the facility on 6/06/24 and resided on the 400 Hall on the side of the hall located on the back exterior of the facility.</p> <p>The care plan initiated on 6/07/24 revealed Resident #2 required extensive staff assistance to turn and reposition in bed and for transfers from bed to chair.</p> <p>The Minimum Data Set (MDS) admission assessment dated 6/13/24 revealed Resident #2 was cognitively intact, had adequate vision without corrective lenses, and required staff assistance to get out of bed.</p> <p>The nursing progress note dated 6/26/24 at 6:01 am by Nurse #2 revealed Resident #2 was moved from her room due to an ant infestation. Nurse #2 noted that multiple ants were swept from Resident #2's room at the beginning of the shift but Resident #2 refused to change rooms. Nurse #2 further noted that by the end of the shift there were even more ants in the room and Resident #2 was moved to another room. Nurse #2 noted that Resident #2 did not have any areas of concern noted on the skin at this time.</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 10</p> <p>A telephone interview was conducted on 7/09/24 at 11:29 am with Nurse #2 who revealed she was notified by Nurse Aide (NA) #2 around 6:00 am on the morning of 6/26/24 that ants were all over Resident #2's room. She stated when she entered Resident #2's room she observed small black ants "everywhere." She explained they were on the bed, floor, tables, sheets, bed pad, clothes, and few on the outside of the incontinence brief. She stated she brushed the ants from Resident #2's body with her hands. Nurse #2 stated the ants were all over everything and it was unsafe for Resident #2 to remain in the room. She stated Resident #2 did not want to change rooms, but she did agree at that time to move to another room since there were so many ants. Nurse #2 clarified that Nurse #5 had observed the ants, cleaned up the ants, and attempted to have Resident #2 change rooms prior to her shift and that was reported to her at shift change. Nurse #2 stated she had not observed ants in Resident #2's room during her shift until notified by NA #2 at approximately 6:00 am. She reported she completed a skin check of Resident #2 and did not observe any bites and Resident #2 did not report any complaints of itching. Nurse #2 stated she had seen a few ants in the facility in the past but never had seen that many ants before.</p> <p>An attempt to conduct a telephone interview with Nurse #5 on 7/10/24 at 11:28 am and 1:05 pm was unsuccessful.</p> <p>An attempt to conduct a telephone interview with NA #2 on 7/10/24 at 9:30 am was unsuccessful.</p> <p>An interview was conducted on 7/09/24 at 9:44 am with Resident #2 who revealed about one</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 11</p> <p>week ago her room was infested with small black ants, and she needed to change her room. Resident #2 stated she saw the black ants on her hands, gown, floor, and bed linens. Resident #2 stated she saw ants in her room earlier that day, but she didn't want to move to another room and the nurse had cleaned the ants up. Resident #2 stated she didn't think the ants would have been on the bed later, so once that happened she was okay being moved. Resident #2 stated the staff helped her get out of bed and they moved her to another room. Resident #2 stated she did not have any bites or itchiness from the ants being on her and she stated she had not seen ants in her room since that day.</p> <p>An interview was conducted on 7/09/24 at 1:56 with the Maintenance Supervisor who revealed he was notified of the ants in Resident #2's room on the morning of 6/26/24 and notified the Pest Control Company that an emergency visit was needed. He stated he sprayed Resident #2's room prior to the Pest Control Company's arrival and observed "quite a few small black ants" in the room around the baseboards and air conditioning unit. The Maintenance Supervisor reported the ants entered the facility from the outside normally around the air conditioning units, and he stated the ants were worse at this time of the year. The Maintenance Supervisor stated when the Pest Control Company arrived on 6/26/24 he was told that the small black ants in Resident #2's room were "sweet ants" the kind that were normally in homes and were attracted by food.</p> <p>Review of the pest control visit log dated 6/26/24 revealed a visit was conducted for ants. Pest Control Technician #2 observed dead ants in the resident care area reported for ants. Pest Control</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 12</p> <p>Technician #2 also reported live fire ant mounds on the exterior building perimeter were identified, and they were treated at that time.</p> <p>A telephone interview was conducted on 7/09/24 at 3:00 pm with Pest Control Technician #2 who reported he was notified on 6/26/24 that two resident rooms were reported to have ants prior to his arrival. He stated he did not see any live ants in the two resident rooms, but it was reported that the Maintenance Supervisor had sprayed the ants prior to his arrival. Pest Control Technician #2 stated that he believed the dead ants he saw in Resident #2's room were odorous house ants (also known as sweet or sugar ants) which were small ants that were black in color. He stated the odorous house ants were very small and were not normally known to bite or be aggressive. Pest Control Technician #2 stated he walked the perimeter of the building and observed several active live fire ant mounds around the back of the building on the side of the hall where the two resident rooms were located. He stated he treated all the live fire ant mounds he observed at that time. Pest Control Technician #2 stated fire ants were aggressive in nature and did bite. He stated fire ants were able to access a building through gaps in doors, around windows, or air conditioner units.</p> <p>An interview was conducted on 7/09/24 at 1:27 pm with the Rehabilitation Director who revealed that she observed approximately 10-12 small black ants on the floor in the rehabilitation office on either 6/29/24 or 6/30/24. She stated she first saw one on the desk which was why she looked on the floor and observed the other ants. She stated she killed the ants and then swept to make sure no more ants were present. The</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 13</p> <p>Rehabilitation Director stated she had not seen ants in the rehabilitation office prior and had not observed any ants in the rehabilitation gym.</p> <p>Review of the pest control visit log dated 7/01/24 revealed Pest Control Technician #1 completed a routine visit and inspected the Physical Therapy room for ants and live ants were observed and treated.</p> <p>A telephone interview was conducted on 7/09/24 at 2:33 pm with Pest Control Technician #1 who revealed he received the call from the facility on 6/26/24 for a visit due to ants but he was unavailable that day, so Pest Control Technician #2 went to the facility. He stated he received the report from Pest Control Technician #2 that fire ant mounds were identified and treated on the exterior back of the facility. He stated he returned to the facility on 7/01/24 for the routine visit and he observed one active fire ant mound located at the exterior rear of the facility near the rehabilitation office and the previously reported resident hall, which he treated. He stated he also observed dead ants in the rehabilitation office on this visit, which he identified as fire ants. Pest Control Technician #1 stated fire ants were small (not tiny) dark reddish to black in color, they were aggressive in nature, and more prone to biting and stinging than odorous house ants.</p> <p>A walking tour and interview was conducted on 7/10/24 at 10:50 am with Pest Control Technician #1 and the Maintenance Supervisor of the perimeter of the facility. Pest Control Technician #1 identified the previous fire ant mounds that were treated on 6/26/24 to this surveyor. The area was observed as a hard, dry area of dirt with multiple ant holes along the side/rear exterior wall</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 14</p> <p>which was identified by the Maintenance Supervisor as the rehabilitation gym. No live fire ants were noted at this location. The tour continued around the rehabilitation gym where Pest Control Technician #1 identified the fire ant mound that was treated on 7/01/24 which was located approximately four feet from the back exterior wall of the resident hall where Resident #1 and Resident #2 were located. The area was observed as a hard, dry area of dirt with no live fire ants observed. An additional active fire ant mound was identified by the Pest Control Technician #1 at this time which was approximately eight feet from the back exterior of the resident hall. He agitated the fire ant mound with his foot, and live fire ants were observed to be small, dark reddish brown to black in color. Pest Control Technician #1 treated the active fire ant mound. Pest Control Technician #1 stated fire ants were known to move long distances for food sources and were capable of entering the facility from the locations of the mounds that were treated.</p> <p>An interview was conducted with the Administrator on 7/10/24 at 2:46 pm who revealed resident room rounds were completed daily by the Administrative team and the ant infestation was not identified during the rounds prior to the incident.</p> <p>The Administrator was notified of immediate jeopardy on 7/09/24 at 4:33 pm.</p> <p>The facility provided the following credible allegation of immediate jeopardy removal:</p> <p>1. Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome as</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 15 a result of the noncompliance:</p> <p>On 6/23/24 Resident #1 was observed in bed by Nurse #1 with small black ants all over the floor, bedside table, bed linens, gown, inside the incontinent brief, and on her body. Resident #1 was unable to get out of bed without staff assistance.</p> <p>On 6/23/24 Resident #1's skin assessment by Nurse #1 revealed several small, reddened areas across her back and sides, resident complained of itching and was observed scratching. Nurse #1 removed the ants from the resident and the resident was moved to another room.</p> <p>On 6/23/24 Nurse #1 called the Medical provider; orders were given for Benadryl 25 mg 1 tab by mouth every six hours PRN x three days and Calamine lotion to red areas three times a day as needed for 7 days. Resident #1 is her own responsible party.</p> <p>On 6/24/24 the resident was seen by the Nurse Practitioner and resident had no reports of pruritis during her visit and resident currently is not experiencing any skin irritation, itching or discomfort per nursing assessment on 7/9/24.</p> <p>On 6/23/24 the Maintenance Supervisor cleaned and sanitized the room. He checked the adjoining rooms with no observed pests on 6/23/24.</p> <p>On 6/24/24 the Maintenance Supervisor initiated daily inspection of 100% of all rooms on 400 hall for any signs of pests.</p> <p>On 6/26/24 the Maintenance Supervisor called</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 16</p> <p>Pest control to come to the facility as his daily inspection did identify ants observed in a vacant room which he cleaned and sanitized.</p> <p>On 6/26/24 Resident #2 was observed in bed by Nurse #2. Nurse #2 observed small black ants all over the floor, furniture, bed linens, and clothing of Resident #2. Resident #2 was unable to get out of bed without staff assistance.</p> <p>Nurse #2 did not observe any signs of physical injury from the ants on Resident #2 and resident was immediately moved into another room.</p> <p>Pest control came to the facility on 6/26/24 and sprayed rooms 405,407,409. There were some dead ants but there were no live pests noted by pest control. Pest control proactively treated 100% of the exterior perimeter of 400 hall. Pest Control identified and treated fire ant mounds on the exterior of the facility on 6/26/24.</p> <p>The Maintenance Supervisor has completed ongoing pest control monitoring of 100% of 400 hall 5x weekly since 6/26/24 without additional identification of pests.</p> <p>All residents are at risk of harm due to this deficient practice.</p> <p>On 7/9/24 licensed nurses did skin checks on 100% of the residents and there were no identified skin concerns associated with pest/insect bites.</p> <p>On 7/9/24 the Admissions Coordinator, Therapy Director, Nurse Secretary, Human Resources, Maintenance Supervisor, Activity Coordinator, and the Business Office Manager did 100% room</p>	F 925			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 17</p> <p>checks and did not identify any pests in the facility.</p> <p>On 7/9/24 the Maintenance Supervisor was educated to notify pest control immediately upon identifying any pests by the Administrator.</p> <p>On 7/9/24 the Maintenance Supervisor called pest control to come to the facility on 7/10/24 and do a thorough inspection and provide treatments as needed.</p> <p>2. Specify the actions the entity will take to alter the process or system failure to prevent a serious adverse outcome from occurring or reoccurring and when the action will be completed.</p> <p>On 7/9/24 the Administrator began in servicing all staff (full time, part time, and prn including agency) on the need to provide effective Pest management to ensure residents are safe from ants and pests. This education will be provided to new hires during the orientation process by Human Resources. No staff shall work without this education effective 7/10/24. The Administrator, Director of Nursing, and Human Resources will monitor to ensure no staff works without completing the education. This education included:</p> <p>The facility maintains high standards of cleanliness and sanitation throughout the facility to eliminate food and water sources that attract pests. The facility will ensure proper storage and disposal of waste to prevent attracting pests. Educate staff to ensure food is stored properly, waste is disposed of properly, and we maintain cleanliness to reduce the risk of pest infestations.</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 18</p> <p>The Maintenance Supervisor weekly inspects and repairs (as needed) any structural issues, such as cracks, holes, or gaps that could allow pests to enter the building.</p> <p>The Maintenance Supervisor and the Department Heads conduct regular inspections of all areas of the facility, including resident rooms, common areas, kitchens, and storage areas to identify any signs of pest activity.</p> <p>The Maintenance Supervisor will maintain detailed records of all pest control activities, including inspection reports, treatment records, and any actions taken to address identified issues.</p> <p>Staff will need to recognize signs of pest activity, they were educated on what pests are, and understand the importance of maintaining a pest free-free environment. Staff should know how to report any pest sightings or concerns immediately. Any pest sightings should be reported immediately to the Maintenance Supervisor or the on-call Administration.</p> <p>Always address any concerns or complaints from residents or their families regarding pest control promptly and effectively.</p> <p>The alleged date of immediate jeopardy removal is 7/10/24.</p> <p>The credible allegation of immediate jeopardy removal was validated by onsite verification on 7/10/24 as evidence by staff interviews, alert and oriented resident interviews, record review, and observations.</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	<p>Continued From page 19</p> <p>Interviews were conducted with those residents identified as alert and oriented by the facility with no additional concerns regarding ants.</p> <p>The Maintenance Supervisor's education dated 7/09/24 presented by the Administrator and signed by the Maintenance Supervisor was reviewed.</p> <p>Interviews were conducted with staff which included nursing, housekeeping, laundry, dietary, and administration to confirm education had been completed regarding identification and notification when ants or other pests were identified, ensuring the area was clean, proper waste disposal, and food storage.</p> <p>Staff education logs dated 7/09/24 and 7/10/24 were reviewed for all departments including dietary, rehabilitation, housekeeping, administrative, and nursing. Those staff that have not received education in person or via telephone on 7/09/24 will be educated prior to the beginning of their next scheduled shift by the Administrator, Director of Nursing, or Human Services.</p> <p>Administrative room round logs dated 7/09/24 were reviewed with no newly identified concerns.</p> <p>Skin assessment sheets dated 7/09/24 were reviewed with no newly identified concerns.</p> <p>Observations were conducted on 7/09/24 and 7/10/24 with no identified active ants or pests in the resident rooms, common areas, or bathrooms.</p> <p>The facility's Immediate Jeopardy removal date of</p>	F 925			

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/14/2024
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345358	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 07/10/2024
NAME OF PROVIDER OR SUPPLIER LOUISBURG HEALTHCARE & REHABILITATION CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 202 SMOKETREE WAY LOUISBURG, NC 27549		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE	
F 925	Continued From page 20 7/10/24 was validated.	F 925			