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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisburg Healthcare & Rehabilitation Center	202 Smoketree Way Louisburg, NC 27549

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review and staff interviews, the facility failed to refer residents with serious mental health diagnoses for a Preadmission Screening and Resident Review (PASRR) level II screening for 1 of 3 residents reviewed for PASRR (Resident #38). The findings included: Review of Resident #38's Hospital Discharge Summary dated 2/02/23 revealed no diagnosis of schizophrenia. Resident #38 was admitted to the facility on [DATE] with diagnoses which included major depressive disorder and anxiety. Review of Resident #38's Preadmission Screening and Resident Review (PASRR) Level I Determination Notification dated 3/24/23 revealed Resident #38 required no further screening unless a significant change occurred which suggested a diagnosis of mental illness. Review of the Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #38 was cognitively intact and was coded for anxiety, depression, and schizophrenia. Resident #38 was not coded for behaviors. Review of Resident #38's active diagnosis list on 3/03/24 revealed Resident #38 had a diagnosis of schizophrenia which was created on 10/20/23 with an active date of 6/23/23. An interview was conducted on 3/05/24 at 9:10 am with the Social Worker who revealed she was responsible to submit notification for PASRR review for Resident #38, but she stated she was unable to recall being notified of Resident #38's schizophrenia diagnosis. The Social Worker stated she would have submitted a review of Resident #38's PASRR Level I based on the new diagnosis of schizophrenia. An interview was conducted with the Administrator on 3/06/24 at 10:37 am who revealed the Social Worker was responsible for Resident #38's PASRR review.

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

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F 0655 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Create and put into place a plan for meeting the resident's most immediate needs within 48 hours of being admitted **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 20710 Based on interviews with staff and record review the facility failed to ensure a baseline care was completed within 48 hours after admission and failed to complete all sections of the baseline care plan for a new admission for 1 of 3 residents (Resident #63) reviewed. The findings included: Resident #63 was admitted into the facility on [DATE] with diagnoses of cancer, dialysis, and diabetes. A review of Resident #63's medical record showed that the baseline care plan was started on 2/1/24 and had only one section completed, which was medication regimen section. The general information section was completed on 2/3/24. Resident #63's health conditions, dietary, therapy and social services were not completed. A review of Resident #63's admission Minimum Data Set, dated dated dated [DATE] noted he was severely cognitively impaired, was dependent on staff for his activities of daily living, was incontinent of bowel and was receiving dialysis. In an interview on 3/5/24 at 8:20 AM the Director of Nursing (DON) indicated the Social Worker (SW) was responsible for the care plans, as the MDS Nurse was part time. In an interview on 3/5/24 at 9:24 AM the Administrator indicated that the base line care plan begins with the Social Worker. In an interview on 3/5/24 at 11:15 AM the Minimum Data Set (MDS) Nurse stated that she works part time to help out. She indicated for a new admission; she checks the care plan to see if the nursing team has entered the resident care details. The MDS nurse indicated the Social Worker handled the baseline care plans.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on observations, record review, resident and staff interviews, and Medical Director interview, the facility failed to obtain and implement physician orders for the care and monitoring of a resident on hemodialysis for 1 of 2 residents for dialysis (Resident #15). The findings included: Resident #15 was admitted to the facility on [DATE] with diagnoses which included end stage renal disease (ESRD) with dependence on dialysis. Review of the care plan last revised on 8/31/23 revealed Resident #15 received hemodialysis (a machine filters waste from the body when the kidneys no longer work adequately) three times a week due to renal disease. The interventions included applying firm and direct pressure using two fingers to bleeding shunt or port site, and do not draw blood or take blood pressure on the arm with shunt or graft (catheter access area for delivery of hemodialysis). Resident #15 had an active physician order dated 10/19/23 for dialysis on Tuesday, Thursday, and Saturday. Review of the arteriovenous graft (AVG) surgery discharge summary dated 1/15/24 revealed Resident #15 had an arteriovenous (AV) fistula (an artery and vein joined surgically to administer dialysis) placed in the right upper arm. An attempt to interview Nurse #3, who was assigned to Resident #15 on 1/15/24, via telephone on 3/04/24 at 2:04 pm was unsuccessful. Review of the dialysis communication note to nurse dated 1/16/24 revealed the dialysis center requested the facility to note on resident chart for no intravenous (IV) or blood pressure (BP) in the right arm. A review of Resident #15's active physician orders revealed no orders for monitoring of the right arm AV fistula, no IV in the right arm, and no blood pressure check on the right arm. Review of the Minimum Data Set (MDS) quarterly assessment dated [DATE] revealed Resident #15 was cognitively intact and was coded for dialysis. An interview and observation was conducted on 3/04/24 at 12:40 pm with Resident #15 who revealed she received her dialysis through the right arm AV fistula. Resident #15 stated the nursing staff did not check her right arm AV fistula site every shift. Resident #15's AV fistula site was observed to be in the upper right arm and there was no documentation observed in the resident medical record about no blood pressures or IV from the right arm. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted on 3/04/24 at 12:53 pm with Nurse #2 who revealed when a resident returned from dialysis the access site was checked for bleeding, vital signs were obtained, and the post-dialysis weight from the dialysis communication binder was entered into the medical record. Nurse #2 reported she did not see a physician order to check the AV fistula site for Resident #15. Nurse #2 stated she believed an AV fistula site was assessed once a shift for bruit (a whooshing sound heard at the fistula site with a stethoscope) and thrill (vibration caused by blood flow felt with fingers) but stated she would have to check to be sure since there was not a physician order. During an interview on 3/04/24 at 1:20 pm the Registered Nurse (RN) Supervisor stated when Resident #15 returned from the surgical procedure for the AV fistula the nurse that received the discharge information should have entered physician orders for the fistula site care which would include shunt procedures for bleeding, monitoring for bruit and thrill, and no BP or IV in the arm that the fistula was in. She further stated the dialysis communication book was to be reviewed upon Resident #15's return from dialysis and the nurse should have completed the recommendations as requested by dialysis regarding no BP or IV in the right arm. The RN Supervisor stated the dialysis communication books were reviewed during the morning clinical meeting, but she was unable to state how the communication from dialysis regarding no blood pressure or IV in the right arm was missed for Resident #15. Interviews were conducted on 3/05/24 at 9:41 am and 3/06/24 at 8:53 am with the Support Nurse who revealed the nurse that received the dialysis communication book was responsible for the review and completion of the recommendations for no BP or IV for Resident #15's right arm. The Support Nurse further reported when Resident #15 returned from the AV fistula procedure the instruction sheet should have been reviewed by the receiving nurse and if any orders were needed the nurse should have contacted the physician. The Support Nurse was unable to state how the orders for Resident #15's AV fistula site monitoring and no BP or IV in the right arm were missed. An interview with the Medical Director was conducted on 3/05/24 at 10:24 am. The Medical Director stated she was not aware there were no orders for monitoring of the AV fistula site and did not know how the orders to monitor the site were overlooked. The Medical Director stated Resident #15's AV fistula should have had orders in place which included monitoring for bruit and thrill. An interview was conducted on 3/05/24 at 3:20 pm with Nurse #5 who revealed she was aware of Resident #15's right arm AV fistula but did not realize there were not physician orders to monitor the fistula, and for no BP or IV in right arm. Nurse #5 stated when Resident #15 returned from dialysis she often left her room right away to go visit with other residents or go outside so she was not always able to check her fistula, but she would try. Nurse #5 stated she was aware the fistula site had to be checked every day, and that no BP or IV was to be done in the right arm but she did not check to see if the physician orders were entered for Resident #15. (continued on next page)

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with the Director of Nursing (DON) on 3/06/24 at 10:34 am who revealed the nurse assigned to Resident #15 was responsible to review the surgical discharge summary upon the residents return and leave the summary to be reviewed by the DON for follow-up to make sure all necessary orders were entered. The DON stated she believed Resident #15's AV fistula surgical discharge summary was received by the nurse but was not left for her to review. The DON further stated the nurses were to monitor the AV fistula site for bleeding, and the bruit and thrill were to be checked every shift. The DON stated the nurse who was assigned to Resident #15 should have reviewed the dialysis communication binder when she returned from treatment and completed the recommendations sent for no BP or IV in the right arm in the resident record and in the room. The DON was unable to state how the physician orders for the AV fistula site monitoring and the dialysis communication recommendations were missed for Resident #15. During an interview on 3/06/24 at 10:34 am the Administrator stated Resident #15's AV fistula surgical discharge summary was to be reviewed by the nurse that was assigned when the resident returned and if any orders were needed, they were expected to obtain the orders. The Administrator stated the discharge summary was to be left for the DON to review and follow-up as needed during the daily clinical meeting.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, Nurse Practitioner, Consultant Pharmacist, and Medical Director interviews the facility failed to attempt a gradual dose reduction (GDR) per Consultant Pharmacist recommendations of psychotropic medications for 1 of 5 residents reviewed for unnecessary medications (Resident #38). The findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses which included anxiety, insomnia, and major depressive disorder. Resident #38 did not have a diagnosis of schizophrenia upon admission to the facility. The Minimum Data Set (MDS) annual assessment dated [DATE] revealed Resident #38 was cognitively intact and was not coded for behaviors. Resident #38 was coded for anxiety, depression, and schizophrenia and they received antipsychotic, hypnotic, and antidepressant medications. The MDS annual assessment noted Resident #38 had not had a gradual dose reduction (GDR) of the antipsychotic medication and there was no documentation of clinical contraindications (inadvisable because of harm to person) related to a GDR attempt. A review of Resident #38's hospital discharge summary dated 2/02/23 revealed Resident #38 was discharged from the hospital with the following medications: paliperidone (an antipsychotic medication used to treat schizophrenia and schizoaffective disorder) 1.5 milligrams (mg) 3 tablets every morning, bupropion extended release (an antidepressant medication) 300 mg daily, and zolpidem (hypnotic, sedative medication used for insomnia) 5 mg at night. Review of Resident #38's active physician orders on 3/06/24 revealed the following: An active physician order with a start date of 2/03/23 for paliperidone 1.5 mg tablet give 3 tablets daily. An active physician order with a start date of 2/03/23 for bupropion extended release 300 mg daily. An active physician order with a start date of 2/03/23 for zolpidem 5 mg tablet at bedtime. An active physician order dated 2/21/24 for outpatient psychiatric appointment for routine follow-up. Review of the Note to Attending Physician/Prescriber dated 8/23/23 revealed the Consultant Pharmacist notified the attending physician that it was time to evaluate psychoactive medications for a GDR. The following medications were listed for possible GDR: zolpidem 5 mg at night, bupropion extended release (ER) 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The Nurse Practitioner (NP) response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Review of the Note to Attending Physician/Prescriber dated 11/15/23 revealed the Consultant Pharmacist sent a follow-up to the 8/23/23 notification regarding GDR recommendation for Resident #38. The Consultant Pharmacist notified the attending physician that it was time to evaluate psychoactive medications for a GDR for the following medications: zolpidem 5 mg at night, bupropion extended release (ER) 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The NP response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. Review of the Note to Attending Physician/Prescriber dated 12/13/23revealed the Consultant Pharmacist notified the provider that a signed note in Resident #38's medical record in November 2023 regarding GDR review for psychoactive medications, that the resident was seen by outside psychiatric provider. Please send the GDR request to their office for review and return to the facility. The Consultant Pharmacist reported it was time to evaluate Resident #38's psychoactive medications for a GDR. The following medications were listed for possible GDR: zolpidem 5 mg at night, bupropion extended release 300 mg daily for depression, and paliperidone 4.5 mg daily for depression. The NP response to the GDR recommendation was that Resident #38 was followed by outpatient psychiatry. Review of the Medication Regimen Review dated 1/16/24 revealed the Consultant Pharmacist notified the provider that according to documentation in the medical record, Resident #38 received outpatient psychiatric services. The Consultant Pharmacist requested the provider follow-up on obtaining the most recent consultations for review. The Consultant Pharmacist further noted they needed the documentation to ensure GDRs were monitored for hypnotic and antidepressant medication. Review of the Medical Director Progress Note dated 2/02/24 revealed Resident #38 was seen for a regulatory visit with chronic health problems being addressed which included schizophrenia. The Medical Director noted Resident #38 was under the care of an outpatient psychiatrist with no new symptoms or exacerbations reported during the visit. Review of the care plan revised on 2/24/24 revealed Resident #38 received antipsychotic medication related to diagnosis (no diagnosis noted) and received an antidepressant medication related to depression. Resident #38 was at risk for adverse side effects with interventions for the Consultant Pharmacist to review my psychotropic medication quarterly and as needed for possible changes or reductions. Review of Resident #38's electronic medical record revealed no documentation of outpatient psychiatric appointments or supporting clinical documentation regarding contraindications for GDR attempts from the outpatient psychiatric provider. Interviews were conducted on 3/06/24 at 8:45 am and 10:15 am with the Support Nurse who revealed Resident #38 was followed by an outpatient psychiatrist, but the facility had not received any documentation regarding his care. The Support Nurse stated she had tried to call the outpatient psychiatrist and was unable to make contact. The Support Nurse stated Resident #38 was reportedly seen by the outpatient psychiatrist via telehealth in July of 2023, but the facility was unable to locate any information regarding the visit and was unable to determine who assisted Resident #38 with the telehealth call. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	A telephone interview was conducted on 3/06/24 at 10:09 am with the Consultant Pharmacist who revealed the facility was notified that the notation that Resident #38 was followed by outpatient psychiatry was not a sufficient response to the GDR recommendation. The Consultant Pharmacist stated they were unable to locate any outpatient psychiatric documentation on Resident #38's medical record to state a GDR was clinically contraindicated and had asked the facility on multiple occasions to obtain documentation to ensure Resident #38's psychotropic medications were being monitored. An interview was conducted on 3/06/24 at 11:35 am with the Nurse Practitioner (NP) who revealed she was told Resident #38 was followed by outpatient psychiatrist. The NP stated she had asked the facility many times to obtain the outpatient psychiatrist visit records so she could review the information, but she had not received any documentation. An attempt to interview the Medical Director via telephone was unsuccessful on 3/06/24 at 11:53 am. The Medical Director returned the call on 3/07/24 2:31 pm and reported she had requested Resident #38's outpatient psychiatrist documentation but the facility had not received the information. The Medical Director stated the normal process for residents that were prescribed psychotropic medication was to be followed by the in-house psychiatric provider, but she was told Resident #38 was followed by outpatient provider. During an interview on 3/06/24 at 12:30 pm the Administrator stated the Support Nurse worked with the NP regarding Resident #38's outpatient psychiatric visits. The Administrator stated she would have to speak to the Support Nurse regarding the issue of obtaining Resident #38's outpatient psychiatric information.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	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. 45045 Based on observation and staff interviews the facility failed to label and date an open bottle of eye drops for one of two medication carts observed for medication storage (Hall 400). The findings included: During an observation of the 400 Hall medication cart on 3/04/24 at 8:59 am in the presence of Nurse #1 a squeeze bottle of prednisolone acetate ophthalmic suspension 1% (steroid medication used to treat inflammation of the eyes caused by certain conditions) was in the top drawer, opened, with no open date noted on bottle, and there were no resident identifiers on the bottle. At the time of the observation, an interview was conducted with Nurse #1 who confirmed the squeeze bottle of the prednisolone acetate ophthalmic suspension 1% medication was opened, did not have the date the bottle was opened, and had no resident identifiers. Nurse #1 stated she did not know when the medication was opened or where the bag that had the resident name on it went. She stated the medication was for a resident on the hall and she confirmed she had already administered the medication. Nurse #1stated she knew which resident the medication belonged to because there was only resident prescribed the medication on her cart. Nurse #1 removed the prednisolone acetate ophthalmic suspension 1% from the medication cart. An interview was conducted on 3/06/24 at 9:20 am with the Director of Nursing (DON) who revealed Nurse #1 should not have used the eye drops without resident identification on the bottle. The DON stated Nurse #1 should have reordered the medication from the pharmacy. During an interview on 3/06/24 at 10:57 am the Administrator stated Nurse #1 should have discarded the medication without the resident information available.

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F 0842 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Safeguard resident-identifiable information and/or maintain medical records on each resident that are in accordance with accepted professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45045 Based on record review, staff interviews, Consultant Pharmacist, Nurse Practitioner, and Medical Director interviews, the facility failed to obtain outpatient psychiatrist visit notes for a resident prescribed psychotropic medication for 1 of 5 residents reviewed for unnecessary medications (Resident #38) The findings included: Resident #38 was admitted to the facility on [DATE] with diagnoses which included anxiety, insomnia, and major depressive disorder. Review of the Medication Regimen Review dated 1/16/24 revealed the Consultant Pharmacist notified the provider that according to documentation in the medical record, Resident #38 received outpatient psychiatric services. The Consultant Pharmacist requested the provider follow-up on obtaining the most recent consultations for review. Review of Resident #38's medical record revealed no documentation of outpatient psychiatric appointments or supporting clinical documentation from the outpatient psychiatric provider. An interview was conducted on 3/06/24 at 8:45 am with the Support Nurse who revealed Resident #38 was followed by an outpatient psychiatrist, but the facility did not have any documentation regarding his outpatient psychiatric appointments. She stated Resident #38 was reportedly seen by the outpatient psychiatrist via telehealth in July of 2023, but the facility was unable to locate any information regarding the visit and was unable to determine who assisted Resident #38 with the telehealth call. The Support Nurse stated she was unable to contact the outpatient psychiatric provider to obtain the records for Resident #38 because the office does not answer the phone. A telephone interview was conducted on 3/06/24 at 10:09 am with the Consultant Pharmacist reported they were unable to locate any outpatient psychiatric documentation on Resident #38's medical record and had asked the facility on multiple occasions to obtain documentation to ensure Resident #38's psychotropic medications were being monitored. An attempt to contact the outpatient psychiatrist provider on 3/06/24 at 10:21 am was unsuccessful. An interview was conducted on 3/06/24 at 11:35 am with the Nurse Practitioner (NP) who revealed she was told Resident #38 was followed by outpatient psychiatrist, but the facility did not have any of the records from the outpatient psychiatrist. The NP stated she had asked the facility many times to obtain the outpatient psychiatrist visit records so she could review the information, but she stated she had not received any documentation.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 43222 Based on observations, record review, and staff interviews, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor the interventions that the committee put into place following the 7/28/21 recertification and complaint investigation, the 10/1/21 revisit survey, and the 10/5/23 complaint investigation. This was for two deficiencies cited in the area of Label/Store Drugs and Biologicals and Influenza/Pneumococcal Vaccines. The continued failure of the facility during two or more federal surveys of record shows a pattern of the facility's inability to sustain an effective QAA program. Findings Included: This tag was cross-referenced to: F761: Based on observation and staff interviews the facility failed to label and date an open bottle of eye drops for one of two medication carts observed for medication storage (Hall 400). During the recertification and complaint investigation survey of 7/8/21, the facility failed to keep an unattended medication cart locked, an unattended treatment cart locked, medication cart drawers free of loose medications, and to discarded expired medications. During the revisit survey of 10/1/21, the facility failed to keep an unattended treatment cart, containing medicated treatments locked. During the complaint investigation survey of 10/5/23, the facility failed to: discard 2 vials of an expired controlled substance (Ativan) stored in a locked box in the medication room refrigerator, and date an opened vial of insulin stored in the medication cart. The Administrator was interviewed on 3/06/24 at 12:01 PM. She revealed that medication cart audits were performed daily, and ongoing education was provided during audits and if issues arose. The cart in question had an audit performed on 3/2/24. The Administrator stated that the medication cart audit was not performed on 3/3/24 due to the entrance of the state survey team. If any medication (or eye drops) were not labeled and dated, they should be discarded, and a replacement would be retrieved from the backup pharmacy. F883: Based on record review and staff interviews, the facility failed to administer the pneumococcal vaccine to eligible residents for 2 of 5 residents reviewed for immunizations (Resident #19 and Resident #43). During the recertification and complaint investigation survey of 7/28/21, the facility failed to offer the Pneumococcal Polysaccharide Vaccine (PPSV23) a year following the Pneumococcal Conjugate Vaccine (PCV13) for a resident who had consented to Pneumococcal bacteria vaccination.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement policies and procedures for flu and pneumonia vaccinations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 43222 Based on record review and staff interviews, the facility failed to offer the pneumococcal vaccine for 1 of 5 residents (Resident #19) and administer the pneumococcal vaccine to eligible residents for 1 of 5 residents reviewed for immunizations (Resident #43). The findings included: 1. Resident #19 was admitted to the facility on [DATE] with a diagnosis of intracranial injury with loss of consciousness. Review of Resident #19's admission packet dated 1/26/24 revealed Resident #19's responsible party (RP) gave authorization for the pneumococcal vaccine to be administered. The Minimum Data Set (MDS) admission assessment dated [DATE] revealed Resident #19 was severely cognitively impaired and was not offered the pneumococcal vaccine. As of 3/4/24 there was no documentation of the pneumococcal vaccine being provided to Resident #19. Review of Resident #19's immunization record on 3/5/24 revealed that the pneumococcal vaccine was labeled as consent refused. An interview was conducted with the Infection Preventionist/Support Nurse on 03/05/24 at 8:57 AM. She revealed that vaccinations were offered to residents upon admission. If consent was given, then an order would be entered on the resident's medication administration record. Then the vaccine would be ordered from the pharmacy, and all vaccine activity would be documented under the immunization tab in the medical record. Resident #19 consented for the pneumococcal vaccine. She stated she was unsure why the immunization record showed consent refused. The Infection Preventionist indicated Resident #19 was supposed to receive the pneumococcal vaccine based on the consent records. Review of a health status note dated 3/5/24 at 12:32 PM and written by the Infection Preventionist revealed that Resident #19 was offered the pneumococcal vaccine, and he declined. Resident #19 was adamant that he did not want any further vaccines. The RP was notified and said it was fine if Resident #19 did not accept the pneumococcal vaccine. Resident #19's RP was interviewed on 3/05/24 at 1:37 PM. He revealed that the pneumococcal vaccine was important for Resident #19 to remain healthy. The RP stated that he was not sure if Resident #19 received the pneumococcal vaccine at his previous facility. During a follow-up interview with Resident #19's RP on 3/05/24 at 1:50 PM, he stated that he called the previous facility and there was no record of the pneumococcal vaccine provided to Resident #19. The RP indicated that it was important for Resident #19 to receive the vaccine and would like them administered to stay healthy. (continued on next page)

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	03/06/2024

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Louisburg Healthcare & Rehabilitation Center	202 Smoketree Way Louisburg, NC 27549

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview with the Administrator on 03/05/24 at 2:01 PM, she revealed that all vaccines must be consented or declined upon admission. The pneumococcal vaccine needed to be ordered from the pharmacy. If the resident or RP gave consent, they would receive the vaccine when available. The Administrator stated that the Treatment Nurse should have documented the refusal in Resident #19's medical record. 2. Resident #43 was initially admitted to the facility on [DATE] with a diagnosis of encephalopathy. Review of Resident #43's admission packet dated 3/14/23 revealed Resident #43's RP gave authorization for the pneumococcal vaccine to be administered. The Minimum Data Set (MDS) significant change assessment dated [DATE] revealed Resident #43 was severely cognitively impaired and was not offered the pneumococcal vaccine. Review of Resident #43's immunization record on 3/5/24 revealed that the pneumococcal vaccine was labeled as immunization required and not given. An interview was conducted with the Infection Preventionist/Support Nurse on 3/05/24 at 8:57 AM. She revealed that vaccinations were offered to residents upon admission. If consent was given, then an order would be entered on the resident's medication administration record. Then the vaccine would be ordered from the pharmacy, and all vaccine activity would be documented under the immunization tab in the medical record. Resident #43's RP consented for the pneumococcal vaccine to be administered dated 3/14/23. The immunization record showed that the immunization was required, which meant that Resident #43 should have received the pneumococcal vaccine. During an interview with the Administrator on 3/05/24 2:01 PM, she revealed that all vaccines must be consented or declined upon admission. The pneumococcal vaccine needed to be ordered from the pharmacy. If the resident or RP gave consent, they would receive the vaccine when available. The Administrator indicated that nursing staff should have contacted the provider to notify them that Resident #43 wanted the pneumococcal vaccine, but its arrival was pending. She stated that Resident #43 should have received the pneumococcal vaccine soon after admission.