STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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
E 000	Initial Comments An unannounced Recertification survey was conducted on 02/14/2023 through 02/17/2023. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JXLG11.	E 000		
F 000	INITIAL COMMENTS A recertification survey was conducted from 02/14/2023 through 02/17/2023. Event ID# JXLG11	F 000		
F 578 SS=E	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still	F 578		3/1/23

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

Electronically Signed | 03/01/2023

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 1 legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on records reviews and staff interviews, The facility failed to have advance directives in the residents records for 4 of 7 sampled residents. (Resident #9, Resident #13, Resident #27 and Resident #133). Findings included: 1. Resident #9 was admitted to the facility on 02/12/2021. Quarterly Minimum Data Set (MDS) dated 11/16/2022 indicated Resident#9's cognition was severely impaired. Review of the computerized clinical record for Resident #9 revealed no advanced directive noted in the resident's medical record. A review of the form "An Advance directive For North Carolina A practical Form for all Adults" reviewed in Resident#9's clinical record was left	F 578	Using Lean rapid A3 problem solving methodology, new standard work was created for the Admission Coordinator (AC) or designee to execute advanced directive (AD) verification upon admission. If the resident has a POA or living will, the AC will ask the resident/family to provide documents and will notify unit nursing leadership to be expecting the outstanding documents. Unit nursing leadership will follow-up with the family to obtain the documents. If the resident/family does not wish to pursue naming a POA or living will, Part A and B on the form entitled "An Advanced Directive for North Carolina: A Practical Form for All Adults" will be signed and dated with a line marked through the sections they don't wish to complete. This document will be scanned into the EMR. The DON will audit charts of all new admissions x30 days to ensure the new standard work is being	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 2 blank with no indication if the resident wanted to formulate an advance directive or refused. During the interview with Director of Nursing (DON) on 02/15/2023 at 01:04 PM, she stated that the Admission's Coordinator (AC) reviewed the advance directive forms with the residents or responsible party during the admission to the facility. She also indicated, the AC have them sign and acknowledge they had received education. DON indicated they offered resources from the spiritual care department if they did not have an advance directive already formulated. They gave the residents or the responsible party a form to complete. The DON further indicated she did not find the advance directive in Resident #9's medical record and there was no documentation found that stated the resident refused. She added that the advanced directive should have been scanned in Resident #9's computerized clinical record or a note indicating the resident's refusal to formulate an advance directive. During the interview with Social Worker (SW) on 02/15/23 at 02:42 PM, she stated after the residents were admitted and they need to implement an advance directive, she would give a form from the admission packet and provide information on where to find a notary and the resident or responsible party will bring the completed advanced directive back. It will then be entered into the residents electronic record. During the interview with Administrator on 02/17/2023 at 10:30 AM, she stated the advanced directives should have been in Resident #9's clinical record or a note indicating refusal. The Administrator further stated the AC should have ensured the residents' advanced	F 578	implemented as written.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 3	F 578		

directives were placed in the medical records if a resident had formulated one.

The Admission Coordinator was unavailable for the interview.

2. Resident #13 was admitted to the facility on 04/17/2020.

Quarterly Minimum Data Set (MDS) dated 10/20/2022 indicated Resident#13 cognition was severely impaired.

Review of the computerized clinical record for Resident #13 revealed no advanced directive noted in the resident's medical record.

A review of the form "An Advance directive For North Carolina A practical Form for all Adults" reviewed in Resident#13's clinical record was left blank with no indication if the resident wanted to formulate an advance directive or refused.

During the interview with Director of Nursing (DON) on 02/15/2023 at 01:04 PM, she stated that the Admission's Coordinator (AC) reviewed the advance directive forms with the residents or responsible party during the admission to the facility. She also indicated the AC had them sign and acknowledge they had received the education. The DON indicated they offered resources from the spiritual care department if they do not have an advance directive already formulated. They gave the residents or the responsible party a form to complete. The DON further indicated she did not find the advance directive in Resident #13's medical record and there was no documentation found that stated the resident refused. She added that the advanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 4	F 578		

directive should have been scanned in the Resident#13's computerized clinical record or a note indicating the resident's refusal to formulate an advance directive.

During the interview with the Social Worker (SW) on 02/15/23 at 02:42 PM, she stated after the residents are admitted to the facility and they need to implement an advance directive, she gives them a form from the admission packet and provide information on where to find a notary and the resident or responsible party will bring the completed advanced directive back. It will then be entered into the residents electronic record.

During the interview with Administrator on 02/27/2023 at 10:30 AM, she stated the advanced directives should have been in the Resident #13's clinical record or a note indicating refusal. The Administrator further stated the AC should ensure the residents' advanced directives were placed in the medical records if a resident had formulated one.

Admission Coordinator was unavailable for the interview.

3. Resident #27 was admitted to the facility on 01/15/2023.

The quarterly Minimum Data Set (MDS) dated 12/09/2022 had Resident #27 coded as cognitively intact.

The care plan dated 12/09/2023 had focus of ADL selfcare performance deficit due to paraplegia.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 5	F 578		

A review of the Electronic Medical Record (EMR) for Resident #27 revealed an advanced directive was not received.

A review of the code status revealed the resident was a full code without advanced care planning.

An interview with the Director of Nursing (DON) was conducted on 02/15/2023 at 01:04 PM. The DON stated the process they use for completion of advanced directives are completed by the Admission Coordinator (AC). The residents receive and they go over the forms with them. The resident or representative will sign the form to acknowledge they had received education. If the resident does not want the advanced directive, then they will sign the form and the document will be placed in the residents' EMR, if they want to pursue an advanced directive, then they are referred to the Spiritual Care department to get the forms and instructions on completing the advance directive. The DON also stated she could not find the advance directive in the medical records and there was no documentation found that stated the resident refused and expected to see documentation in the EMR to reflect the residents preference.

An interview with the Social Worker (SW) was conducted on 02/15/23 at 2:42 PM. The SW stated if a resident or family wants an advanced directive then she can also give a form from the admission packet and provide information to find a notary and bring the completed advanced directive back to the facility and it will be entered into the resident's record. The SW also stated she did not recall any residents that had given her a completed advanced directive.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 6	F 578		

An interview with the Administrator was conducted on 02/17/2023 at 10:30 AM. The Administrator stated the advanced directives should have been in Resident #27's EMR or a note indicating refusal. The Administrator further stated the AC should ensure the residents' advanced directives were placed in the medical records if a resident had formulated one.

The AC was not available for interview.

.4 Resident #133 was admitted to the facility on 01/07/2023.

The admission Minimum Data Set (MDS) dated 01/16/2023 had the Resident #133 coded as severely cognitively impaired.

The care plan dated 02/14/2023 had focus of the resident has, a communication problem.

A review of the Electronic Medical Record (EMR) for Resident #133 revealed an advanced directive was not received.

A review of the code status revealed the resident is a full code without advanced care planning.

An interview with the Director of Nursing (DON) was conducted on 02/15/2023 at 01:04 PM. The DON stated the process they use for completion of advanced directives are completed by the Admission Coordinator (AC). The residents receive and they go over the forms with them. The resident or representative will sign the form to acknowledge they had received education. If the resident does not want the advanced

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 578	Continued From page 7 directive, then they will sign the form and the document will be placed in the residents' EMR, if they want to pursue an advanced directive, then they are referred to the Spiritual Care department to get the forms and instructions on completing the advance directive. The DON also stated she could not find the advance directive in the medical records and there was no documentation found that stated the resident refused and expected to see documentation in the EMR to reflect the residents preference. An interview with the Social Worker (SW) was conducted on 02/15/23 at 2:42 PM. The SW stated if a resident or family wants an advanced directive then she can also give a form from the admission packet and provide information to find a notary and bring the completed advanced directive back to the facility and it will be entered into the resident's record. The SW also stated she did not recall any residents that had given her a completed advanced directive. An interview with the Administrator was conducted on 02/17/2023 at 10:30 AM. The Administrator stated the advanced directives should have been in Resident #27's EMR or a note indicating refusal. The Administrator further stated the AC should ensure the residents' advanced directives were placed in the medical records if a resident had formulated one. The AC was not available for interview.	F 578		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1)(3) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and	F 656		3/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 656	Continued From page 8	F 656		

implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following -
(i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and
(ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6).
(iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record.
(iv)In consultation with the resident and the resident's representative(s)-
(A) The resident's goals for admission and desired outcomes.
(B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.
(C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 656	Continued From page 9 §483.21(b)(3) The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (iii) Be culturally-competent and trauma-informed. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to develop a plan of care to address psychotropic medication of antidepressant for 1 of 5 sampled residents (Resident #26). Findings included: Resident #26 was admitted to the facility on 05/17/2022 with the diagnoses including dementia and depression. The quarterly Minimum Data Set (MDS) quarterly assessment dated 11/21/2022 revealed the resident was severely cognitively impaired and was receiving antidepressant medication. A record review of Resident #26's care plan dated 12/08/2022 revealed there was no plan of care in place related to antidepressant medication. Review of the February 2023 Medication Administration Record (MAR) revealed Resident#26 was receiving Lexapro (antidepressant)10 milligram (mg) daily. An interview was conducted with the MDS/Care Plan nurse on 02/16/2023 at 10:30 am. The MDS nurse stated the facility develops a care plan for every psychotropic medications that the residents were receiving at the facility. The MDS nurse confirmed there was no care plan in place for antidepressant medication for Resident #26 and there should be one. The MDS nurse stated it	F 656	A quality report in the facility's EMR system (EPIC) has been created to monitor the prescription of new medications. The MDS coordinator or designee will run the report weekly to identify any new medications that have been prescribed over the past week that need to be care planned. Then, the care plan will be updated accordingly. The DON will monitor a secure spreadsheet maintained by the unit's nursing leadership x1 month to ensure new medications requiring care planning have been captured and a care plan is created/updated.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 656	Continued From page 10 was an oversight that a care plan was not implemented for antidepressant medication for Resident #26. An interview with the Director of Nursing (DON) on 02/16/2023 at 2:05 pm revealed the care plan should reflect the resident's care that was being provided. She added that Resident #26's care plan should have reflected the antidepressant medication.	F 656		
F 657 SS=D	Care Plan Timing and Revision CFR(s): 483.21(b)(2)(i)-(iii) §483.21(b) Comprehensive Care Plans §483.21(b)(2) A comprehensive care plan must be- (i) Developed within 7 days after completion of the comprehensive assessment. (ii) Prepared by an interdisciplinary team, that includes but is not limited to-- (A) The attending physician. (B) A registered nurse with responsibility for the resident. (C) A nurse aide with responsibility for the resident. (D) A member of food and nutrition services staff. (E) To the extent practicable, the participation of the resident and the resident's representative(s). An explanation must be included in a resident's medical record if the participation of the resident and their resident representative is determined not practicable for the development of the resident's care plan. (F) Other appropriate staff or professionals in disciplines as determined by the resident's needs or as requested by the resident. (iii)Reviewed and revised by the interdisciplinary team after each assessment, including both the	F 657		3/1/23

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 657	Continued From page 11 comprehensive and quarterly review assessments. This REQUIREMENT is not met as evidenced by: Based on record review and resident and staff interviews, the facility failed to invite 1 of 12 sampled residents to attend a quarterly care plan meetings (Resident #5). Findings included: Resident #5 was admitted to the facility on 07/19/16 with diagnoses that included anemia, arthritis, and depression. Resident #5's quarterly Minimum Data Set (MDS) dated 12/09/2022 revealed Resident #5's cognition was intact. During an interview on 02/14/2023 at 1:25 PM Resident #5 stated she did not recall being invited to attend care plan meetings. During an interview on 02/16/2023 at 10:26 AM, the Social Worker (SW) revealed she had either mailed a letter to the resident's Responsible Party or hand-delivered a letter to alert and oriented residents, inviting them to schedule a care plan meeting. The SW was unable to find any documentation Resident #5 ,or his family member were notified or invited to attend care plan meetings for December 2022 care plan meeting. During an interview on 02/16/2023 at 10:30 AM the MDS Coordinator confirmed Resident #5 should have had care plan meetings scheduled for December 2022 care plan meetings. The MDS Coordinator stated after each care plan meeting a note was entered into the resident's	F 657	The MDS coordinator maintains a calendar of residents' quarterly care plan meeting deadlines. The MDS coordinator will share this calendar with the DON. Additionally, the DON created a documentation dot phrase (a standard documentation template) for the MDS coordinator or designee to use to document the standard elements of the care plan meetings including those who attended. At the end of the month x1 month, the DON will audit 5 charts to ensure the care plan meeting was executed and the documentation template was used to capture all necessary elements of the care plan meeting including those who attended.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345245	A. BUILDING _____ B. WING _____	02/17/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
PENDER MEMORIAL HOSP SNF	507 E FREMONT STREET BURGAW, NC 28425

(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 657	Continued From page 12 medical record indicating what was discussed. The MDS Coordinator was unable to find any documentation Resident #5 or his family member were invited to attend the care plan meetings or the meetings were conducted for December 2022 care plan. During an interview on 02/17/18 at 12:03 PM the Administrator stated it was her expectation every resident was notified of care plan meetings and documentation of the care plan meeting was placed in their medical record.	F 657		