STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345298	A. BUILDING _____ B. WING _____	C 05/04/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF PENDER	311 S CAMPBELL 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 and complaint investigation survey was conducted on 05/01/23 through 05/04/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #M7BU11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/01/23 through 05/04/23. Event ID# M7BU11. The following intake was investigated NC00201331. 3 of the 3 complaint allegations did not result in deficiency.	F 000		
F 578 SS=D	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	F 578		5/19/23

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

Electronically Signed | 05/18/2023

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F 578	Continued From page 1 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 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 resident's records for 1 of 7 sampled residents. (Resident #52). Findings included: Resident #52 was admitted to the facility on 12/15/2022. A review of Resident #52's admission's "Notice of Acknowledgments" dated 01/04/2023 revealed no note that the resident wanted to formulate an advance directive or refused. Significant change Minimum Data Set (MDS) dated 02/27/2023 indicated Resident #52's cognition was severely impaired.	F 578	F578: The facility will continue to allow residents the right to formulate an advance directive. Resident # 52 was interviewed regarding their right to formulate an advance directive and results were documented in the electronic medical record by the Social Worker as of 5.12.23. No negative outcome was identified relating to these observations. Current residents have the potential to be affected. Current resident medical records were audited by the Social Worker as of 5.12.23 to ensure that each resident had been provided the right to	

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F 578	Continued From page 2 Review of the computerized clinical record for Resident #52 revealed no advanced directive noted in the resident's medical record. During the interview with Social Worker (SW) on 05/02/23 at 10:42 AM, she acknowledged there was no indication in the medical record if Resident #52's representative wanted to formulate an advance directive or refused to formulate one. During the interview with Director of Nursing (DON) on 05/03/2023 at 01:04 PM, she stated that the Admission's Coordinator or SW was responsible for reviewing the advance directive forms with the residents or responsible party during the admission to the facility. The DON further indicated she did not find the advance directive in Resident #52's medical record and there was no documentation found that stated the resident or responsible party refused. She added that the expectation was that the advanced directive should have been completed and scanned in Resident #52's computerized clinical record or a note indicating the refusal to formulate an advance directive. During the interview with the Administrator on 05/04/2023 at 10:30 AM, He stated the advanced directives should have been completed and scanned in Resident #52's clinical record or a note indicating refusal. The Administrator further stated he would ensure the residents' advanced directives were placed in the medical records if a resident had formulated one.	F 578	formulate an advance directive and wishes documented in the electronic medical record. No negative outcome was identified relating to this audit. The Social Worker was inserviced by the Corporate Social Services Liaison on the facility policy for ensuring that each resident is provided the right to formulate an advance directive and wishes documented in the electronic medical record as of 5.12.23. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 5.15.23. The DON/designee will randomly audit 5 resident electronic medical records weekly x 4 weeks then every other week x 4 weeks then randomly x 4 weeks. Variances will be corrected at the time of observation and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months beginning on 5.19.23 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random electronic medical record audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified.	

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