PRINTED: 06/10/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345245	B. WING _	B. WING		C 05/06/2024	
	ROVIDER OR SUPPLIER MEMORIAL HOSP SNF			STREET ADDRESS, CITY, STATE, 507 E FREMONT STREET BURGAW, NC 28425	ZIP CODE	, , ,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	((EACH CORRECTIVE CROSS-REFERENCEE	IN OF CORRECTION E ACTION SHOULD B D TO THE APPROPRIA CIENCY)		(X5) COMPLETION DATE
E 004 SS=F	S403.748(a), §416.54 §441.184(a), §460.84 §483.475(a), §484.10 §485.542(a), §485.62 §485.920(a), §486.36 §494.62(a). The [facility] must correderal, State and loopreparedness requiredevelop establish and emergency prepared requirements of this spreparedness progral limited to, the following: * [For hospitals at §48 §485.625(a):] Emerge CAH] must comply wistate, and local emerrequirements. The pfollowing: * [For hospitals at §48 §485.625(a):] Emerge CAH] must comply wistate, and local emerrequirements. The [hdevelop and maintain emergency prepared requirements of this sall-hazards approach * [For LTC Facilities and Plan. The LTC facility an emergency prepared reviewed, and updates.)	(a), §482.15(a), §483.73(a), 2(a), §485.68(a), 5(a), §485.727(a), 0(a), §491.12(a), Inply with all applicable cal emergency ments. The [facility] must designed maintain a comprehensive ness program that meets the ection. The emergency must include, but not be g elements: The [facility] must develop regency preparedness plan d], and updated at least lan must do all of the designed preparedness ospital or CAHs at ency Plan. The [hospital or th all applicable Federal, gency preparedness ospital or CAH] must a comprehensive ness program that meets the ection, utilizing an the section of the election of the section o		TITLE			5/30/24

Electronically Signed

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.

05/31/2024

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '		(X3) DATE SURVEY COMPLETED C	
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* [For ESRD Facilities Plan. The ESRD facina maintain an emerger must be [evaluated], years. . This REQUIREMEN' by: Based on record revensure the Emergen was reviewed and up The findings included Review of the EP pla 3/2023. The skilled reviewed EP plan cohospital Chief Nursir manager of Hospital Emergency Manage dated 3/2023. The process of the plan and the second floor of the seco	ility must develop and not preparedness plan that and updated at least every 2 T is not met as evidenced view, the facility failed to cy Preparedness (EP) plan odated at least annually. d: an read it was last updated on nursing facility is housed on ne local hospital. The intained signatures of the neg Officer, the hospital ment Coordinator which were policy stated the next review	E 004	The annual effectiveness review of the Physical Environment plans (Emergen Preparedness, Hazardous Materials, Security, Utilities, Fire and Life Safety, Safety Management, and Medical Equipment) was reviewed and approve by the Physical Environment Committe on 3/13/24 and by the Board of Truste (BOT) at their 4/17/24 meeting. The Hazard Vulnerability Analysis which includes an analysis of hazardous materials, human events, technological events, and natural events was review and approved by the Physical Environment Committee which is chair by the President/Administrator and includes the skilled nursing unit (SNU) Director of Nursing (DON) as a commit member at the 1/29/24 meeting. On 5/1/24, on or about 2:15pm, the DO reviewed the emergency operations por (EOP) and determined no changes we needed. On 5/17/24 the EOP was reviewed at the SNU Quality Assurance Process Improvement (QAPI) meeting On 5/27/24, the EOP was reviewed and	ed ee ees Il red ttee DN blicy ere ee	
	ROVIDER OR SUPPLIER MEMORIAL HOSP SNF SUMMARY S' (EACH DEFICIENT REGULATORY OR Continued From page * [For ESRD Facilities Plan. The ESRD facimaintain an emerger must be [evaluated], years. This REQUIREMEN' by: Based on record revenue the Emergen was reviewed and up The findings included Review of the EP pla 3/2023. The skilled reviewed EP plan cohospital Chief Nursir manager of Hospital Emergency Manage dated 3/2023. The public summan supplemental strength of the second floor o	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. . This REQUIREMENT is not met as evidenced	ROVIDER OR SUPPLIER MEMORIAL HOSP SNF SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 1 * [For ESRD Facilities at §494.62(a):] Emergency Plan. The ESRD facility must develop and maintain an emergency preparedness plan that must be [evaluated], and updated at least every 2 years. This REQUIREMENT is not met as evidenced by: Based on record review, the facility failed to ensure the Emergency Preparedness (EP) plan was reviewed and updated at least annually. The findings included: Review of the EP plan read it was last updated on 3/2023. The skilled nursing facility is housed on the second floor of the local hospital. The reviewed EP plan contained signatures of the hospital Chief Nursing Officer, the hospital manager of Hospitality Services and the hospital Emergency Management Coordinator which were dated 3/2023. The policy stated the next review	ROVIDER OR SUPPLIER SUMMARY STATEMENT OF DEFICIENCIES BURGAW, NC 28425	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED		
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E 004	Continued From page	e 2	E	The EOP applies to the there is a plan to kee during emergency sit review of this policy of needed) ensures it rethat any changes in the community, healthcar might impact residented into consideration and as possible. The SNU mandatory annual edecate EOP to ensure their of understanding of the to implement it when Furthermore, on 5/1/2 SNU staff annual edecate validate staff received confirmed it was community of the quarter on the individual cale leadership (DON, clir Minimum Data Set (Nand President/Adminautomatic reminder is The DON will ensure agenda and reviewed meeting on an annual quarter each year. At has been set on each calendars to ensure the completed. To ensure the EOP residual to the total pool of the completed. To ensure the EOP residual the EOP residented to the total pool of the completed.	ep all residents safetuations. An annual with revisions (as emains current and the facility, re industry, etc. that it safety are taken d mitigated as much staff complete ducation regarding ongoing policy and how/who necessary. 24, the DON audited ducation transcripts of the education and the first QAPI er has been placed endars of SNU nical coordinator, MDS) coordinator, wistrator). The set never to expire the EOP is on the dat the SNU QAPI all basis in the first nannual reminder the first nannual reminder the first nannual reminder the sNU QAPI all basis in the first nannual reminder the first nannual reminder the sNU leaded the review is	e i i i i i i i i i i i i i i i i i i i		

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E 004	Continued From page	e 3 Policies and Procedures		004	and will have a "required read" as a required writer to ensure the policy med SNU requirements. This required input be completed in January each year pricto the plan update. A "required read" who be scheduled for the DON annually after the document was approved (in April) to validate EOP policy was updated. This annual review of the EOP policy who be reported at the SNU QAPI meeting a documented in the minutes.	will or ill er o	5/30/24
SS=L	CFR(s): 483.73(b) §403.748(b), §416.54 §441.184(b), §460.84 §483.475(b), §484.10 §485.542(b), §485.62 §485.920(b), §486.36 §494.62(b). (b) Policies and procedure policies and procedure policies and procedure plan set forth in paragrand the communication that is section. The policies reviewed and update the procedures. The LTC implement emergency procedures, based or forth in paragraph (a)	A(b), §418.113(b), A(b), §482.15(b), §483.73(b), A(c), §485.68(b), A(c), §485.727(b), B(c), §491.12(b), A(c), §483.73(b):] of this section, and a the least every 2 years. A(c), §483.73(b):] Policies and a facility must develop and a the emergency plan set of this section, risk					
	plan set forth in paragassessment at paragassessment at paragand the communication this section. The polities are reviewed and updates. The LTC facilities at procedures. The LTC implement emergency procedures, based or forth in paragraph (a) assessment at paragassessment at para	graph (a) of this section, risk raph (a)(1) of this section, on plan at paragraph (c) of cies and procedures must ated at least every 2 years. §483.73(b):] Policies and facility must develop and y preparedness policies and in the emergency plan set					

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E 013	this section. The poli be reviewed and upd: *Additional Requirem Facilities: *[For PACE at §460.8 procedures. The PAC develop and impleme policies and procedur plan set forth in paragasessment at paraging and the communication this section. The poli address management emergencies, includir equipment, power, or emergencies; and nathreaten the health or staff, or the public. The must be reviewed and years. *[For ESRD Facilities procedures. The dial and implement emergand procedures, bases set forth in paragraph assessment at paraging and the communication this section. The poli be reviewed and upd. These emergencies in to, fire, equipment or emergencies, water is natural disasters likelingeographic area.	cies and procedures must ated at least annually. ents for PACE and ESRD 34(b):] Policies and	EO	13		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 013	Continued From page Based on staff intervresident interviews, a failed to implement the on 4/9/24 when Nurse Resident #2 with a kr (4/9/24), in the present threatened Resident gonna get you with it. feared for her life, put and "prayed he wasn and NA #2 did not dis administration and did administration was not 4/11/24 when Reside Nurse #1 and who the The knife remained in until police were cont confiscate the knife. The police as having a "flip blade" (a blade with blade was automa a button). This failure emergency procedure residents) at high like harm perpetrated by Immediate Jeopardy facility failed to imples procedures to protect observed Resident #2 jeopardy was remove implemented a credit jeopardy removal. The	iews, police interview, and record review the facility heir emergency procedures to Aide (NA) #2 witnessed hife. Later that same day ance of NA #1, Resident #2 #1 with the knife stating, "I'm are Resident #1 stated she ther head under the covers, are going to kill [her]." NA #1 sclose the information to do not contact 911. The but aware of the incident until ant #1 reported the incident to the informed administration. In Resident #2's possession acted on 4/11/24 to The knife was described by a 4 inch handle with a 4 inch which was spring loaded and attically engaged by pressing the to immediately implement the sput all residents (34 selihood of suffering serious		013		DP) y 24. 24 reen res n s lth s d ned the d ne, a the	
	"F" (no actual harm w than minimal harm th jeopardy) to ensure e	vith the potential for more			Emergency Operations Policy including how to call for help. This education was complete with this new hire on 5/20/24	S	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I ` ′		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	-	
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E 013	titled "Security Alert Freviewed 3/2023 revesituation is "an individination having made threats, harm or act out in violany firearm, knife, or bodily harm, injury or stated "Any staff persuspects an active the [911] or designate son the Patient Care Supedesignated by the Paresident #2 was adm 4/28/23 with diagnose antisocial personality. Resident #2's quarter assessment, dated 3/ assessed as cognitive symptoms or behavior ambulating independent wheelchair. During an interview wheelchair. During an interview wheelchair. During an interview wheelchair. During an interview wheelchair.	ency preparedness policy Response Policy" last saled an active threat lual displaying a weapon, and shown intent to cause dence". A weapon is defined other object that can cause death. The policy further on who encounters or reat situation will: call 9-911 meone to call 9-911, notify ervisor and help with tasks tient Care supervisor. We will be a stroke and disorder. Ity Minimum Data Set (MDS) 18/24 revealed he was ely intact, with no mood rs. He was assessed as ently and utilized a manual with NA #2 on 4/30/24 at on 4/9/24 Resident #2 the hallway on 4/9/24. She e black knife with a blue I he was waving the knife en it. She reported he did the knife but was "showing it e did not report the knife to se it wasn't any of her	EO	113	education regarding the EOP to ensure their ongoing understanding of the policiand how/when to implement it when necessary. On 5/1/24, the DON audited SNU staff annual education transcripts validate staff received the education. Of 5/28/24, the President/Administrator reviewed the education was completed planned. She confirmed 100% completion. Team members are empowered and required to activate the EOP at the immediate onset of an actual or perceivent threat. Residents have the right to be find femotional or physical abuse. Reside are instructed, empowered, and require to report actual or perceived abuse or security threats to any team member. Drills and actual events involving the E activation were conducted on May 3, 121, 29, and 30, 2024. The DON will document the effectiveness of the EOF activations. Effective 5/3/24, the DON began monitoring adherence to the corrective action measures. A spreadsheet is maintained to track confirmation that residents received the personal belongings (contraband) policy upon admission; new hires understand unit policies and	cy d to on re as ved ree nts ed OP 4,	
	#2 stated Resident #2 criminal history. She	one of her business." NA 2 often bragged about his further stated he was aff at times and would get			procedures pertaining to abuse and emergencies; - new hires received the emergency operations badge buddy; and		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345245	B. WING		C 05/06/2024		
NAME OF PI	ROVIDER OR SUPPLIER	040240		STREET ADDRESS, CITY, STATE, ZIP CODE	0	5/06/2024	
				507 E FREMONT STREET			
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E 013	submitted to the state report indicated the faincident on 4/11/24 at included a timeline of #2 entered the room [waved] a knife" and indicated that Nurse Aroom when Resident and she (NA #1) "turn away." An interview was con 4/30/24 at 11:28 AM. 4/9/24 Resident #2 ca wheelchair and stood was in bed. She revelorandished a knife an "I'm gonna get you will Resident #2 "popped waved the 4-inch black indicated she put her "prayed he wasn't going Resident #2 left the recovers over her head roommate at the time could not recall where the incident occurred (Resident #1's) was to She reported that NA Resident #2 came in her (NA #1's) exact to Resident #2 brandish stated she remained incident because she She stated she normal	the investigation report was agency on 4/18/24. The acility became aware of the 3:00 PM. The investigation events. On 4/9/24 Resident of Resident #1, "brandished threatened her. Resident #1 Aide (NA) #1 was in the #2 threatened Resident #1 and her head and walked ducted with Resident #1 on Resident #1 on Resident #1 on and in her room in a at her bedside while she healed Resident #2 and threatened her stating, the it." Resident #1 stated the switchblade open" and the in front of her face. She head under the covers and ing to kill me." She stated from while she had the she indicated she had a of the incident, but she in the roommate was at when the she added that her bed he one closest to the door. #1 was in the room when on 4/9/24 but was unsure of the cation within the room when ed the knife. Resident #1	E 013	- SNU staff completed mandato abuse/neglect education. Drills/actual events involving the activation will be conducted twic for four months and logged. In comonitor our performance and er solutions are sustained, effective the DON documents the effective the EOP activations. The denone be the emergency plan activation numerator will be the number of was implemented according to poon will monitor compliance with implementing the corrective action measure listed above for 4 monongoing monitoring data will be at the SNU Quality Assurance Followement (QAPI) meetings a documented in the minutes.	e EOP ce a month order to nsure e 5/3/24, veness of ninator will ons and the fitimes it coolicy. The oth ion ths. The reported Process		

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		ATE SURVEY OMPLETED
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E 013	was scared, "He was she feared for her life powerless to stop him was his plan. Reside member of the incided member told her (Reincident to the facility would report it. Resimember she reported #1 on 4/11/24. She sroom on 4/11/24 afte incident to Nurse #1. An interview was con 4/30/24 on 3:35 PM. called her into her rook Resident #2 had three Nurse #1 stated Resisharing this with her something happened knife. Nurse #1 state and reported this to to During an interview was and reported this to to Resident #1 on 4/5 while she was in Resistated she heard Resitalking about a knife. Resident #1's room. recall what specifical trying to get her work stated she was in and and explained the cooccurred while she was in and and explained the cooccurred while she wistated she thought the Resident #2) were jo	Resident #1 stated that she gonna get me," and that a. She stated she felt in from harming her if that ent #1 informed her family int on the phone. The family sident #1) to report the or she (her family member) dent #1 stated the first staff if the incident to was Nurse stated the DON visited her in she initially disclosed the inducted with Nurse #1 on She stated Resident #1 on She stated Resident #1 on She stated her with a knife. Inducted with a knife. Inducted she was (Nurse #1) in case with Resident #2 and the ed she went immediately he DON. With Nurse Aide #1 on the stated she provided care inducted she provided care inducted in the stated she provided care in the stated she could not be saident #1 and Resident #2 Resident #2 was in NA #1 stated she could not be was allowed as the time. She dout of Resident #1's room inversation about the knife in the hallway. She ey (Resident #1 and	EO	13		

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E 013	criminal history. NA did not look for the k not want to be involved. A second interview with the DON preser #1 reported she nev knife on 4/9/24. NA #2 in the doorway of and heard him say sknife. NA #1 indicated. During this interview she was afraid of Refrequently bragged as She further stated shave reported to the had a knife. NA #1 sknife was considered which in its own entitias illegal drugs, drug switchblades, gun et An interview was con 4/30/24 at 10:53 AM Resident #1 on 4/11. Resident #2 had threwith a knife on 4/9/2	a great deal about his past a #1 stated she "intentionally" nife. She indicated she did red. vas conducted with NA #1 not on 5/1/24 at 11:00 AM. NA er saw Resident #2 with the #1 stated she saw Resident Fesident #1's room (4/9/24) omething about having a red she did not hear a threat. NA #1 acknowledged that resident #2 because he about his criminal history. The was not aware she should administration Resident #2 stated she was not aware a di contraband (property by thy is a crime to possess such graraphernalia,	EO			
	face. The DON star police department (the second floor of a hose She reported she was police department for the knife. She report police on 4/11/24 whethe knife from Resid	ted she called the hospital he facility was located on the spital) immediately for advice. as advised to contact the local or assistance with confiscating ted she contacted the local no responded and confiscated ent #2. The DON did not e local police department.				

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EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG EQUATORY OR LSC IDENTIFYING INFORMATION) E 013 Continued From page 10 She stated she implemented the facility's emergency plan at that time. She indicated residents were escorted to their rooms and room doors were shut. The DON stated she had staff members relocated to their rooms and room doors were shut. The DON stated she had staff members relocated to the dayroom while she waited for the police and manned the nurse's station and call light system. She indicated at the time Resident #2 was secured in a locked nursing supervisor closet. She stated she saw the knife while was secured in a locked nursing supervisor closet. She stated she saw the knife when it was confiscated on 4/11/24. She reported the blade was 4 inches long and the handle was 4 inches long. She stated she understood from when she talked to Resident #2 on 4/11/24 that he ordered the knife and had it delivered after he was admitted to the facility. She stated the police made her aware of two outstanding warrants for Resident #2 on 4/11/24. He was not arrested due to Resident #1 not wanting to press charges and he was receiving care in the facility. She stated afterwards, during a meeting with her staff, she discovered NA #1 had overhead Resident #1 and Resident #2 discussing the knife on 4/9/24. The DON further stated NA #2 had been shown the knife by Resident #2 on 4/9/24. The DON stated after the incident Resident #2 began threatening residents and staff. He was discharged on 4/18/24 to the local police due to him having two outstanding				5	07 E FREMONT STREET		
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Review of the police report completed by Police Officer #1 dated 4/11/24 revealed a warrant check was conducted and Resident #2 was found to have two felony warrants. During a phone interview conducted with Police	E 013	She stated she imple emergency plan at the residents were escondoors were shut. The members relocated to waited for the police station and call light stime Resident #2 was door shut. The DON officers came, Reside charges and the knife nursing supervisor clock hife when it was concepted the blade was handle was 4 inches understood from when on 4/11/24 that he ondelivered after he was She stated the police outstanding warrants. He was not arrested wanting to press charcare in the facility. Shad overhead Resided discussing the knife of stated NA #2 had been Resident #2 on 4/9/2 incident Resident #2 and staff. He was dilocal police due to him warrants. Review of the police of the conficer #1 dated 4/11 check was conducted to have two felony was desident was a conducted to have two felony was desident was was d	emented the facility's part time. She indicated ted to their rooms and room the DON stated she had staff to the dayroom while she and manned the nurse's system. She indicated at the sin his private room with the stated when the police tent #1 did not want to press to was secured in a locked coset. She stated she saw the entire stated on 4/11/24. She has 4 inches long and the long. She stated she ten she talked to Resident #2 dered the knife and had it is admitted to the facility. It is made her aware of two her for Resident #2 on 4/11/24. It is due to Resident #1 not the resident #2 on 4/11/24. It is and he was receiving the stated afterwards, during aff, she discovered NA #1 tent #1 and Resident #2 on 4/9/24. The DON further ten shown the knife by 4. The DON stated after the began threatening residents is scharged on 4/18/24 to the michael having two outstanding the report completed by Police 1/24 revealed a warrant to dand Resident #2 was found the arrants.	E 013			

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COM	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED		
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prosecution. He further explained Resident #2 was receiving medical care from the facility so he was not taken into custody for the outstanding warrants on 4/11/24. Review of a notice of discharge for Resident #2 dated 4/18/24 revealed Resident #2 was discharged from the facility on 4/18/24 due to the safety of individuals in the facility being endangered. The notice of discharge revealed his discharge location was the local jail. The Administrator was notified of immediate jeopardy on 5/1/24 at 1:15 PM. The facility provided the following immediate jeopardy removal plan: " Identify those recipients who have suffered, or are likely to suffer, a serious adverse outcome	E 013	Officer #2 on 5/6/24 came to the facility of the knife. She explains facility had elected indicated the knife's the handle of the knistated the handle of the knistated the handle work officer #2 stated the A phone interview work officer #1 on 5/2/24 spoke with Residen incident was disclost threatening behavior not be tolerated. Por Resident #2 stated Resident #2 was not Resident #1 was not prosecution. He fur was receiving media was not taken into a warrants on 4/11/24. Review of a notice of dated 4/18/24 reveal discharged from the safety of individuals endangered. The nhis discharge location. The Administrator with jeopardy on 5/1/24 and the facility provided jeopardy removal plain.	at 2:16 PM she stated she on 4/11/24 solely to confiscate ained the resident, staff, and not to press charges. She blade was 4 inches long and ife was blue and black. She as 4 inches long. Police is knife had a flip blade. As conducted with Police is at 10:42 AM. He stated he at #2 on 4/12/24 after the sed and informed him that it to residents and staff would blice Officer #1 reported the would comply. He stated it arrested on 4/11/24 because it willing to cooperate with their explained Resident #2 cal care from the facility so he custody for the outstanding of discharge for Resident #2 aled Resident #2 was a facility on 4/18/24 due to the in the facility being otice of discharge revealed on was the local jail. As notified of immediate at 1:15 PM. If the following immediate an:	EC				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULT A. BUILDIN	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	'	00/00/2024	
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E 013	Continued From pag	e 12	E	013			
	procedures when stawho was in possessing residents admitted to suffering from harm Incident On 04/09/2024, NA Resident #2 was in pwasn't until 04/11/20 to a nurse that Resident #1 with a knife that Nath knowing about Resident growing about Resident of retaliation from forward with the came forward that the "da 04/09/2024) Resident from the came forward with compresident (Resident #2 with confident for the came of the c	mplement emergency aff failed to report a resident ion of a knife. The 34 o the facility were at risk of perpetrated by Resident #2. #1 and NA #2 knew that possession of a knife. It 24 after Resident #1 reported ient #2 threatened Resident NA #1 and NA #2 admitted to dent #2's knife for ays. NA #1 and NA #2 were from Resident #2 if they ne information. Bopm a nurse notified the DON) that Resident #1 y before yesterday" (on int #2 entered her room,					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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		345245	B. WING	B. WING		05/	06/2024
NAME OF PR	ROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		
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PENDER	MEMORIAL HOSP SNF				BURGAW, NC 28425		
(X4) ID	SUMMARY STA	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
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E 013	Continued From page	e 13	E	013	3		
	remaining vigilant in t	heir surroundings.					
		Opm, in addition to moving					
		oms, the remaining staff					
		day room. The DON stayed					
		monitoring the patient call					
	•	al police arrived, they					
		2 that having a weapon on					
		SNU was located within a					
	hospital) is not allowe						
	confiscated. The DON	N and local police asked					
	Resident #2 if he had	any concerns about his					
	safety and he respond	ded no. The DON instructed					
	them to search Resid	ent #2's room for any					
	additional contraband	and there was nothing					
	additional found.						
		ty minutes of calling the					
		nt and after the knife was					
		and the situation was under					
		ounced via a unit overhead					
	page that staff and re	sidents were free to move					
	about the unit.						
		residents and completed					
		and determined no other					
	residents had been ha						
		idenced by no complaints or					
		r residents at the time.					
	Cognitively impaired in						
		physical harm (i.e. no					
	_	rigin) or emotional anguish					
		uscle tension, restlessness,					
		The residents (other than freported no additional					
		ng behavior or abuse.					
	On 04/16/2024 on our						
		or interviewed NA #1 and					
		to knowing Resident #2 was					
		ife on 04/9/2024. During					
		view, both indicated they					
		ion because Resident #2					
	Silared lear of retaliat	ion because resident #2					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345245	B. WING		C 05/06/2024		
	ROVIDER OR SUPPLIER	1	5	TREET ADDRESS, CITY, STATE, ZIP CODE 07 E FREMONT STREET BURGAW, NC 28425	1 03/00/2024		
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E 013	labeled them as a "#1 and NA #2 refrai knowledge and ther were not activated." "Specify the act the process or syste adverse outcome from the action will On 05/01/2024, the completed: 1. On or about 2: Emergency Operation changes to policy we will be action of the action of the annual training transmembers to ensure emergency operation revealed 100% completed: 3. At 4:00pm, the provided education members (Licensed Assistants, Activity via on-site in-person emergency operation to do when staff and potential or actual han abuse situation), activate the emergency operation activate the e	snitch." Due to this fear, NA ned from reporting their refore, emergency procedures ion the entity will take to alter em failure to prevent a serious om occurring or recurring, and be complete: following actions were 15pm, the DON reviewed the ons Policy and determined no rere needed. DON reviewed the 2023 scripts for of all SNU team they completed required ons plan education. Results appliance of all SNU staff grassistants, activity SNU Clinical Coordinator to SNU clinical team I Nurses, Certified Nursing Coordinator) present on-site in training regarding ons activation (including what addorr patients experience for the staff are empowered to ency operations plan starting Nursing leadership should also	E 013				
	educated team mer	00pm, the Nursing Supervisor nbers in the following g emergency operations					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		' '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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E 013	activation via in-person huddle is a fixed time members to focus on immediate face-to-face discuss important top designed to improve and teamwork within is typically held at shithe daily action plan, which improves efficite teamwork by anticipagoal of huddles is to member accountabilithelp foster a culture of collaboration) on the a. SNU licensed nub. SNU certified nuc. Therapy services d. Environmental Sec. Dietary f. Facilities g. Clinical outcome An emphasis was plathe serious nature an residents by not implipated and the serious filter of staff did to a resident or staff mestabbed or severely in the following actions 05/02/2024: 1. To continue educate members that had not 6:50am, the DON face and in-service and coregarding emergency	en, face-to-face huddles (A for gathering of team acare coordination, facilitate ce clarification of issues and pics. This process is productivity, communication, clinical practice settings and ift changes. It focuses on and adjustments needed ency and enhances atting needs for the day. The increase individual team ty for patient safety and to of empowerment and following units: urses raing assistants is ervices. Is aced on the understanding of ad threat to the safety of ementing emergency scenarios were discussed to understand that in this case, ember could have been injured. Is were completed on cation efforts of team of yet received education, at calilitated a SNU team meeting	E 01	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIF	PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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E 013	2. At 8:00am, the E activating the emerge was discussed in the SNU nurse's station information is readily emergency. 3. At 8:15am, the N created a badge bud and steps to activate plan. A badge buddy document that is atta badge. The purpose immediate access to high-risk, low-volume distributed to SNU st distributed to SNU st distributed to Social Management, Therap Services, Environme Engineering, and Nu Supervision will roun receive the badge bufloor. 4. At 8:30 AM, the Outcomes facilitated face-to-face in-service operations activation staff and/or patients actual harm which costuation) in the faciliti Social Workers, Adm Therapy Services, Dienvironmental Services.	or actual harm which could be situation). OON posted the process of ency operations plan that huddle/in-service at the desk phones so that available for staff in an Manager of Clinical Outcomes dy outlining the criteria for the emergency operations is an employee badge-sized ched to a staff member's of a badge buddy is to have information related to a processes. These were aff and will continue to be Workers, Admissions, Case by Services, Dietary Intal Services Plant rising Supervision. Nursing d and track to ensure staff ddy prior to working on the Manager of Clinical another in person, e on the emergency (including what to do when experience potential or buld be related to an abuse by's education room for inssions, Case Management,	E 01	3		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
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E 013	regarding emergency (including what to do experience potential of the provided an abuse by unit leaders until 1 and prior to staff work informed the leaders of Case Management, The Services, Environment Engineering, and Nurrand all the staff must education on the emergineering, and Nurrand all the staff must education on the emergineering of the SNU. 6. At 2:50pm, during police provided an inin-service to SNU staff that were present abortion of the security management leaders, team member potential security risks response if situations and 911 notifications. Clinical Outcomes will were not present education of SNU starteturning to work.	Admissions, Case y Services, Dietary ntal Services, Plant sing Supervision, education operations activation when staff and/or patients or actual harm which could e situation) will be ongoing 00% compliance is achieved ing on the floor. The DON of Social Work, Admissions, therapy Services, Dietary ntal Services, Plant sing Supervision that they attend the outlined orgency operations plan until achieved and prior to staff g shift change, company person, face-to-face off (nurses, nurse assistants) out abuse. The in-service of workplace violence., the organic plan, responsibilities of ors duty to report, actual and os, activation of emergency of abuse/potential harm The DON or Manager of of provide SNU staff that cation via daily huddles and This information will be who will ensure 100%	EO	13			
	•	n facilitated by the Human					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ` ′	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED		
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(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
E 013	regarding the Emergine reasonable suspicion computer-based lear facility's Professional about resident abuse of the SNU staff's an Additionally, the DON ensuring completion checklist that include of understanding of the policy including how completion of the SN checklist will be kept DON updated the SN ensure new staff record orientation. Alleged Date of Immo 05/03/2024 Onsite validation of the tremoval plan was contreviews confirmed were educated on accomplete or a contreview confirmed were educated on accomplete or and the criteria for and stemergency operation document that is attained badge. The DON version for ensuring new staft training that includes understanding of the	ency Operations Plan and of a crime examples. A ning module created by the Development Department and neglect remains a part nual education requirements. It will be responsible for of a unit-specific orientation is each new hire's verification the emergency operations to call for help. Proof of U-specific orientation in the employee's file. The IU orientation checklist to eive a badge buddy as part ediate Jeopardy Removal: The immediate jeopardy mpleted on 5/6/24. The all staff from all departments to trivating the emergency ctivation including what to do rience potential or actual eat of harm situation. Seed on 5/6/24 revealed all badge buddy which outlines eps to activate the is plan and is a badge-sized ched to a staff member's rified she was responsible of complete unit specific verification of staff's emergency operations policy for help. The facility's date	E 01				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1 ' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WING		C 05/06/2024
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F 000	INITIAL COMMENTS		F 00	00	
	from 4/30/24 through information was obtain validation of the imme	ned remotely 5/3/24. Onsite ediate jeopardy removal on 5/6/24. Therefore, the were investigated: 0216218. esulted in immediate			
	Immediate Jeopardy v	was identified at:			
	(L) CFR 483.12 at tag F6 (J)	0013 at a scope and severity 00 at a scope and severity 07 at a scope and severity			
	The tags F600 and F6	607 constituted Substandard			
F 600 SS=J	E0013 and F600 and A partial extended sur	was removed on 5/3/24 for on 5/4/24 for F607. vey was conducted.	F 60	00	5/28/24
	Exploitation The resident has the	m Abuse, Neglect, and right to be free from abuse, tion of resident property,			

PRINTED: 06/10/2024 FORM APPROVED OMB NO. 0938-0391

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3	(X3) DATE SURVEY COMPLETED C	
		345245	B. WING			06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	, 30.	• • • • • • • • • • • • • • • • • • •
(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 CORRECTI (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPRO DEFICIENCY)	_D BE	(X5) COMPLETION DATE
F 600	Continued From pag and exploitation as dincludes but is not lincorporal punishment any physical or chemitreat the resident's m §483.12(a) The facilit §483.12(a)(1) Not us physical abuse, corpinvoluntary seclusion. This REQUIREMEN' by: Based on record revinterviews with police facility failed to prote from resident-to-residents. On 4/09/24 F #1's room and threat "I'm gonna get you we Resident #2 "popped waved the 4 inch bla Resident #1 stated shead under the cove going to kill [her]."	e 20 efined in this subpart. This nited to freedom from involuntary seclusion and nical restraint not required to redical symptoms. Ity must- e verbal, mental, sexual, or oral punishment, or is not met as evidenced riew, observation, and e, resident, and staff, the ct a resident's right to be free dent mental and verbal Resident #2 entered Resident ened her with a knife stating with it." Resident #1 reported I the switchblade open and de in front of [her] face." he feared for her life, put her rs, and "prayed he wasn't his deficient practice affected	F 60	In addition to the actions taken by 5 which are already reflected in this 2 document, the following actions hav been taken: On 5/3/24, the Director of Nursing (I modified the admission policy to sur comprehensive admission eligibility assessment beyond whether the faccould meet the resident's clinical ne and had a bed available. In evaluati potential candidates for skilled nursi	5/4/24 567 /e DON) pport a cility reds ing	
	facility failed to prote perpetrated by Residuals removed on 5/3, implemented a credil jeopardy removal. To compliance at a lower "D" (no actual harm than minimal harm the jeopardy) to ensure the second residuals and the second removed re	began on 4/9/24 when the ct Resident #1 from abuse lent #2. Immediate jeopardy //24 when the facility ble allegation of immediate the facility remains out of er scope and severity level of with the potential for more		unit (SNU) admission, the admission (social worker, case manager, finan counselor) will utilize available informincluding previous hospitalizations, medical records, and behaviors to determine whether the patient will be appropriate fit in the milieu. Considerations include but are not I to age, room availability, clinical conditions, personal preferences, at safety and needs of other residents unit. Upon admission, the Minimum Set (MDS) coordinator and/or Social Worker or designee will complete as	ncial mation e an imited nd the on the Data	

Facility ID: 955685

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		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	JLTIPLE CONSTRUCTION DING		(X3) DATE SURVEY COMPLETED	
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		345245	B. WING		05	5/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE			
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LINDLIN	MEMORIAL HOOF ON			BURGAW, NC 28425			
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F 600	Continued From page	e 21	F 60	0			
	Findings included:	:	' 00	admission assessment and creat	to an		
	rindings included.			individualized care plan that ensu			
	Resident #2 was adm	nitted to the facility on		safe environment for residents. T			
		es that included stroke and		interdisciplinary approach with th			
	antisocial personality			Director, MDS Coordinator, DON			
	anacona porconany	2.55. 25.1		Worker, Case Manager, and Fina			
	Resident #2's quarter	ly Minimum Data Set (MDS)		Counselor with the Medical Direct			
		/18/24 revealed he was		having the final approval. This pr			
	assessed as cognitive	ely intact, with no mood		has been updated to critically eva	aluate		
	symptoms or behavio	ors. He was assessed as		potential residents via a holistic a	ıpproach		
ambulating independently and utilized a manual			including efforts to determine if a				
	wheelchair.			resident's known history of a crim			
				endanger other residents prior to			
		care plan as of 4/9/24, last		accepting the resident for admiss	sion.		
	-	did not have a care plan ·					
	related to behavioral	issues.		The education for the social work admission department, case			
		MDS assessment dated		management, therapy services, o			
	3/17/24 indicated her	cognition was intact.		services, environmental services engineering, and nursing supervi	•		
		ucted on 4/30/24 at 10:00		complete on 5/5/24.			
		ed nursing facility was on the					
	second floor of the lo	cal hospital.		The DON reviewed the files of th			
				new hire on 5/28/24 and confirme			
		rt with a timeline of events,		new hire's file verifies understand	•		
	submitted on 4/18/24			the EOP policy including how to	call for		
		the room of Resident #1, he		help.			
	,	ished [waved] a knife" and		Additionally, the DON is year and	ible for		
		#1. Resident #1 indicated		Additionally, the DON is respons			
	` '	#1 was in the room when ed her (Resident #1) and		ensuring completion of a unit-spe orientation checklist that includes			
		ner head and walked away."		new hire's verification of understa			
	ono (itanta) tumeu i	ioi iioda diia walked away.		the abuse policy (definition of abuse	•		
	Review of an incident	t report completed by the		reportable situations, and who/ho			
		OON) dated 4/18/24 revealed		report) and the emergency opera			
		Resident #1's room and		policy including how to call for he			
	brandished a knife or			of completion of the SNU-specific	•		
				orientation checklist is kept in the			
	An interview was con	ducted with Resident #1 on		employee's file. The DON review			

Facility ID: 955685

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	I \			(X3) DATE COMF	SURVEY
			A. BOILDI				С
		345245	B. WING				06/2024
NAME OF P	ROVIDER OR SUPPLIER		•	S ⁻	TREET ADDRESS, CITY, STATE, ZIP CODE		
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FLINDLIN	WILMORIAL HOSP SIN			В	SURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 600	4/9/24 Resident #2 co wheelchair and stood was in bed. She revel brandished a knife, a "I'm gonna get you w Resident #2 "popped waved the 4-inch blace indicated she put her "prayed he wasn't go Resident #2 left the recovers over her head roommate at the time could not recall where the incident occurred (Resident #1's) was t She reported that NA Resident #2 came in her (NA #1's) exact to Resident #2 brandish stated she remained	Resident #1 stated on ame in her room in a lat her bedside while she ealed Resident #2 and threatened her stating ith it." Resident #1 stated the switchblade open" and de in front of her face. She head under the covers and ing to kill me." She stated oom while she had the late of the incident but she et the roommate was at when a she of the door. She added that her bed he one closest to the door. #1 was in the room when on 4/9/24 but was unsure of ocation within the room when need the knife. Resident #1	F	600	files of the new hires on 5/28/24 and confirmed the new hire's file verifies understanding of the emergency operations policy including how to call help. The admission policy that was reviewe and revised on 5/3/24 by the DON app to residents on the SNU and ensures a comprehensive assessment is conduct on potential residents. In order to ensue existing residents understood their right to be free abuse, neglect, misappropriation of resident property, a exploitation including freedom from corporal punishment, involuntary seclusion and any physical or chemica restraint not required to to treat the resident's medical symptoms, on 5/1/2 an ad hoc resident council meeting wa facilitated by nursing leadership to educate the residents on their rights to	d lies aced re and	
	time out of her room at throughout the day. I was scared "he was geared for her life. So to stop him from harm During an interview was 4/30/24 at 1:07 PM si to Resident #1 on 4/9 while she was in Resistated she heard Resitalking about a knife. recall what specificall trying to get her work stated she was in and	ally spent a great deal of and participated in activities Resident #1 stated that she gonna get me" and that she he stated she felt powerless ning her if that was his plan. with Nurse Aide #1 on he stated she provided care 0/24 and did not see a knife ident #1's room. NA #1 stated she could not by was said because she was a done at the time. She dout of Resident #1's room versation about the knife			free from physical and mental abuse. There was a discussion about the different types of abuse and when and how to report abuse. Residents were a educated on the personal belongings policy including the list of contraband items and that this same policy will be provided to each new resident upon admission. On 5/5/24, the SNU admission packet was updated by the DON to include the list of contraband items that include bu are not limited to weapons (firearms, knives, explosives); lighters and other smokeless tobacco, illicit substances, a drug paraphernalia which are strictly	e t	

PRINTED: 06/10/2024 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED C	
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NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	<u>:</u>		
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F 600	Continued From page	÷ 23	F 60	00			
F 600	occurred while she we stated she thought the Resident #2 were jok Resident #2 frequent history and bragged a criminal history. NA did not look for the knot want to be involved. A second interview we with the DON present #1 reported she never knife on 4/9/24. NA #2 in the doorway of and heard him say so knife. She reported she reported him for having confiscated by the postated he (Resident #1 (NA #1 and NA #2). acknowledged that she because he frequently history. She reported discovered on 4/11/24 snitch" and "snitches. An interview was con 4/30/24 at 10:53 AM. pulled her into her (Resident #1 was afra because Resident #2 knife. The DON states.	as in the hallway. She ey (Resident #1 and king around because y discussed his criminal a great deal about his past #1 stated she "intentionally" life. She indicated she did ed. as conducted with NA #1 ton 5/1/24 at 11:00 AM. NA r saw Resident #2 with the #1 stated she saw Resident Resident #1's room (4/9/24) lomething about having a he (NA #1) heard Resident he (NA #1) and NA #2 had hig the knife after it was lice on 4/11/24 and he full lice on	F 60	prohibited. On 5/5/24 the same was given to each resident and every resident's family member of attorney by the DON. A flier what constitutes contraband wat the entrances (elevators) to and in the visitor restroom on the constitutes admission evaluated that is used by the DON or deseach referral for admission to this objective tool fosters a comprehensive admission elignassessment that takes historically behaviors, personal preference milieu compatibility into consideration tool is in a spreadsheet formate monitor our performance and a solutions are sustained, the Doduction of the compatibility in the consideration of the compatibility in the compatibi	d emailed to er(s)/power outlining vas placed the unit the SNU. he ation tool signee for the SNU. gibility cal es, and deration. The transcription in es to the enber of evaluate tor is the unit. The ethe tool for months. rts of by the SNU Medical tiveness of ess, EOP		
	the blade was 4 inche inches long. She sta	nches long. She reported es long and the handle was 4 ited she understood from esident #2 on 4/11/24 he		implementation, and timeliness reporting requirements including limited to Adult Protective Serving ongoing monitoring data will be	ng but not vices. The		

Facility ID: 955685

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		L IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345245	B. WING			C 05/06/2024	
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F 600	Continued From page	e 24	F 60	0			
F 600	ordered the knife and was admitted to the fawas made aware of the hospital police who allocal police department 4/2 confiscate the knife. police officers came on the want to press channot arrested and the locked nursing superstated Resident #2 with the local police due to warrants. She stated that he was taken to book poor to be an incident with prostitute to visit and contact with people with "drug community" Resident #1 and Resident #1 and Resident #1 and miss (Resident #1) grabbe glasses and the staff him to remove his hallway. The resident incident appeared to Review of the police of ficer #1 dated 4/11, check was conducted.	had it delivered after he acility. She stated after she he knife she contacted the dvised her to contact the nt. She contacted the local 11/24 and asked them to The DON stated when the on 4/11/24 Resident #1 did arges so Resident #2 was knife was secured in a visor closet. The DON as discharged on 4/18/24 to on him having two outstanding it was her understanding the local jail on 4/18/24. The ent #2 had some issues She reported there had him inviting a suspected he continued to have who were suspected to be in 1. The DON reported ident #2 had an incident in ident #2 swung to strike sed on 2/27/24. She dhis (Resident #2's) had a difficult time getting ands from the handrail in the nts were separated, and the be handled. The port completed by Police 1/24 revealed a warrant 1/24 and Resident #2 was found	F 60	at the SNU Quality Assurance Process Improvement (QAPI and documented in the minu) meetings		
	Officer #2 on 5/6/24 a came to the facility or	riew conducted with Police at 2:16 PM she stated she at 4/11/24 solely to confiscate an ed the resident, staff, and					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED			
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F 600	facility had elected no indicated the knife's to the handle of the knif stated the handle wa Officer #2 stated the blade which was spri automatically engage. A phone interview wa Officer #1 on 5/2/24 a spoke with Resident incident was disclose threatening behavior not be tolerated. Pol Resident #2 stated he Resident #2 was not Resident #1 was not prosecution. He furth was receiving medical was not taken into culturate was receiving medical was not taken into culturate was receiving medical was not taken into culturate was in a local hospital endangered. The non his discharge location. The facility and hospital transfer from the jail of his medical health. During an interview was:15 PM she stated to	ot to press charges. She blade was 4 inches long and e was blue and black. She is 4 inches long. Police knife had a flip blade (ang loaded and the blade was ed by pressing a button). It is conducted with Police at 10:42 AM. He stated he is 4 and informed him that to residents and staff would ice Officer #1 reported e would comply. He stated arrested on 4/11/24 because willing to cooperate with her explained Resident #2 al care from the facility so he istody for the outstanding discharge for Resident #2 and Resident #2 was facility on 4/18/24 due the in the facility being tice of discharge revealed	F					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	•	00/00/2024
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F 600	DON on 5/6/24 at 10 hospital was having placement. The DC not be allowed back Attempts to interview unsuccessful. The Administrator wa jeopardy on 5/1/24 at The facility provided jeopardy removal plater likely to suffer, a a result of the nonco The facility did not pube free from mental aby Resident #2. Incident On 04/11/2024 at 2:3 Director of Nursing (I reported that "day be 04/09/2024) Resider brandished a knife, at On 04/11/2024 at 3:	was conducted with the 1:00 AM. She reported the a difficult time with N stated Resident #2 would at the facility. Resident #2 were as notified of immediate to 1:15 PM. The following immediate	F6			
	resident (Resident #, which posed a secur called the local police with confiscating the to ensure no other re	any police that there was a 2) in possession of a knife, ity threat. The DON then be department for assistance knife at 3:37pm. In an effort esidents were abused, and as resting in his room with the				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			ULTIPLE CONSTRUCTION LDING		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, S 507 E FREMONT STREET BURGAW, NC 28425	•	, 00.	· · · · · · · · · · · · · · · · · · ·
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F 600	Unit (SNU) hallways of Residents were escondoors were shut by stakept safe and told the room while staff invest effort to maintain a cardisclose the details to Residents were kept by maintaining busined. In addition, staff were at 3:40pm. The DON monitoring the patien instructed the local porcom for any addition police instructed Resweapon on hospital plocated within a hosp and local police asked concerns about his safe was confiscated, the overhead page that so to move about the unit and situation by the DON. Social Worker to rour providing emotional some resources such as Corphysician consultation declined) the Social Worker to assess of abuse situation. This interviewing residents	leared the Skilled Nursing of residents and staff. Ited to their rooms and room staff. The residents were by should go and stay in their stigated the situation. In an alm environment, we did not to the other residents. Itel calm and supported by staff bess as usual. Iterelocated to the day room stayed at the nursing station to call system. The DON colice to search Resident #2's all contraband. The local stated was a roperty (the SNU was sital) is not allowed. The DON de Resident #2 if he had any after and he responded no. Ity minutes, after the knife DON announced via a unit traff and residents were free it. The Social Worker and was briefed on the staff on Resident #1. After support and offering maplain services, counseling, an etc. to Resident #1, (who worker rounded on the other exposure to or impact of the was achieved by individually and asking if there were	F	500			
	any questions, conce	to Resident #1's room on					

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F 600	discussed the situation of the local police department of the number of the place this patient o	s the situation. The DON on that happened on sident #2 entered her room in #1 explained in her normal bened and admitted that she cion and did not come out of e of days. The DON is no need for further ident #1 on 04/11/2024. Trounded on residents and eam member approach to sident #2, or when entering in the DON determined via is, no other residents had ead of assistance. This is inplaints or grievances from the time. The DON debriefed cursing supervisor who then it officer who works every is:00am to complete extra is. In monitoring the situation and the sing supervisor at 4:40pm on ing them to supervise The DON consulted the a Behavioral Health consult	F6			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	· '	33/33/2027
(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 CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	on 04/12/2024, the Idea on all residents and a non-disruptive and "g #2 and there were not the DON investigated by interviewing team oriented residents to The DON asked the any other resident or made them feel unsacognitively impaired demonstrate signs or injuries of unknown of (i.e. no pursed lips, nor labored breathing). Resident #1) and state episodes of threaten	DON called the SNU to check staff, which reported good behavior" from Resident bissues at 2:00am. In the incident on 04/12/2024 members and the alert and assess for other incidents, alert and oriented residents if staff have hurt them or the incident and oriented residents.	F 6	1		
	with legal department management, compared Clinical Outcomes to including the clinical discharge and associand Medicaid Service -On 04/12/2024 at 12 the risks vs benefits resident at current faron 04/16/2024 at 10 discharge disposition -On 04/17/2024 at 42 appropriate durable in	t, case management, risk any police and manager of establish next steps, appropriateness of resident iated Centers for Medicare es (CMS) regulations. 1:00am: The team discussed of Resident # 2 remaining a cility. 1:30am: The team discussed				

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345245	B. WING		C 05/06/2024	
	ROVIDER OR SUPPLIER	1	:	STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	, 33.35.202.	
(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 CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRO DEFICIENCY)	JLD BE COMPLETION	
F 600	team members finali 2. On 04/18/2024 at completed the Nursii Transfer/Discharge the President/Administration attending provides summary and wrote Resident #2 at 10:15 received Durable Memedications and was facility. 3. On 04/18/2024 at the context of Resident the facility policy, CN importance of resides staff via a staff meeting present received this Clinical Coordinator.	230am, the above referenced zed the discharge plan. 10:07am, the DON ng Home Notice of hat was signed by the facility ator and given to Resident #2. Her completed a discharge a discharge order for fam. At 11:45am, the patient edical Equipment (DME) and as safely discharged from the 2:00pm, the DON discussed ent #2's discharge, including	F 600			
	safety incident to the and Human Services approximately 4:30p notified. The ombuds 04/17/2024 at 11:41p 5. On 04/19/2024, the	e DON told Resident #1 that				
	incident and request nurses or leadership concerns in the futur Resident #1 for men	charged. The DON Int #1 for discussing the ed immediate reporting to the if there is any situation or e. The DON reassessed tal suffering, found the distress and offered support				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDIN	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	 	00/00/2024
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFI) TAG	PROVIDER'S PLAN OF CORF ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	services and counses she also had a conv. Worker about availat counseling, but Resi resources. - Specify the action to process or system far adverse outcome frow when the action will. On 05/01/2024, the faction to completed: 1. At 3:00pm, the DO training transcripts for the ensure they compabuse/neglect education to the completed education to the counsel of all SN assistants, activity consistents, activity of the ensure they compabuse/neglect education to the counsel of all SN assistants, activity of the ensure they compabuse for all SN assistants, activity of the ensure they compabuse for a compliance of all SN assistants, activity of the ensure they compable education to the ensure that the ensure the ensure the ensure the ensure that the ensu	support, pet therapy, chaplain sling. Resident #1 stated that ersation with the Social ble resources such as dent #1 declined all available the entity will take to alter the allure to prevent a serious of occurring or recurring, and be complete: following actions were ON reviewed the 2023 annual or of all SNU team members eleted required resident ation. Results revealed 100% (IU staff (nursing and nursing coordinator). NU Clinical Coordinator to SNU clinical team Nurses, Certified Nursing Coordinator) present on-site training: ations activation (including ff and/or patients experience arm which could be related to definition of abuse, what did and who/how to report.	F	600		
	educated team mem	om, the Nursing Supervisor abers in the following ove educational topics via ce huddles (A huddle is a				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345245	B. WING				06/ 2024
	NAME OF PROVIDER OR SUPPLIER PENDER MEMORIAL HOSP SNF			5	TREET ADDRESS, CITY, STATE, ZIP CODE 07 E FREMONT STREET BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 600	focus on care coordin face-to-face clarificati important topics. This improve productivity, teamwork within clinic typically held at shift of daily action plan, and improves efficiency a anticipating needs for huddles is to increase accountability for patia culture of empower the following units: a. SNU licensed nursic. Therapy services d. Environmental Service. Dietary f. Facilities g. Clinical outcomes The following actions 05/02/2024: 1. To continue educate that had not yet receit the DON facilitated a in-service and complesame topics outlined 2. At 8:30 AM, the Mafacilitated another in pin-service on the abusabove in the facility's Workers, Admissions Therapy Services, Die Environmental Service	ag of team members to pation, facilitate immediate on of issues and discuss a process is designed to communication, and cal practice settings and is changes. It focuses on the adjustments needed which and enhances teamwork by the day. The goal of a individual team member ent safety and to help foster ment and collaboration) on the ses and assistants wices were completed on the discovery of team members and education, at 6:50 am, SNU team meeting and the deducation regarding the above in #2. In anger of Clinical Outcomes the process of the control of the	F	600			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425		00/00/2024
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 600	ongoing by unit leader achieved and prior to the DON informed the Workers, Admissions Therapy Services, Dienvironmental Servic Nursing Supervision must attend the outlin 100% compliance is working on the SNU. 4. At 1:00pm, the Reseducation to resident concerns. The Clinical Cooresidents the importation concerns, what considered to the Unit Clinical Cooresidents the importation concerns, when to report, when to report, when to report to state of the SNU states of the SNU stat	ed above, education opics as above will be ers until 100% compliance is a staff working on the floor. The leaders of Social is, Case Management, detary Services, the Plant Engineering, and that they and all the staff and education on abuse until achieved and prior to staff and outcomes Manager and redinator explained to the ance of reporting any safety ditutes a safety concern, how bort (immediately), and how aff members or leaders. Shift change, company person, face-to-face aff (nurses, nurse assistants) out abuse. The in-service d workplace violence, the at plan, responsibilities of the ers duty to report, actual and its, activation of emergency is of abuse/potential harm. The DON or Manager of all provide SNU staff that actation via daily huddles and in This information will be who will ensure 100%	F 6			

STATEMENT OF DEFICIENCIES (X AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345245	B. WING		C 05/06/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	03/06/2024
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F 600	6. As part of onboar facility-wide orienta Resources Departm regarding the Emer reasonable suspicion computer-based leafacility's Professionabout resident abus of the SNU staff's a Additionally, the DO ensuring completion checklist that included of understanding the abuse, reportable sereport) and the emeincluding how to case of the SNU-specific kept in the employed Alleged Immediate 05/03/2024 Onsite validation of removal plan was continued in the enterpression of the sereport of the sere	rding new staff, standard, tion facilitated by the Human nent includes education gency Operations Plan and on of a crime examples. A arning module created by the all Development Department se and neglect remains a part nnual education requirements. ON will be responsible for n of a unit-specific orientation es each new hire's verification es each new hire's verification e abuse policy (definition of ituations, and who/how to ergency operations policy II for help. Proof of completion orientation checklist will be se's file. Jeopardy Removal Date: the immediate jeopardy ompleted on 5/6/24. d all staff from all departments abuse, the definition of abuse, activating the emergency including what to do when se potential or actual harm	F 60		

STATEMENT OF DEFICIENCIES (X1 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	, ,	700/2024	
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F 600		e 35 a safety concern. The opardy removal date of	F 60	00			
F 607 SS=L	CFR(s): 483.12(b)(1)- §483.12(b) The facilit implement written pol §483.12(b)(1) Prohibi neglect, and exploitat misappropriation of re §483.12(b)(2) Establisto investigate any suc §483.12(b)(3) Include paragraph §483.95, §483.12(b)(4) Establis QAPI program require §483.12(b)(5) Ensure occurring in federally-facilities in accordance Act. The policies and	y must develop and icies and procedures that: t and prevent abuse, ion of residents and esident property, sh policies and procedures the allegations, and training as required at sh coordination with the ed under §483.75. reporting of crimes funded long-term care the with section 1150B of the laprocedures must include	F 60			5/28/24	
	§483.12(b)(5)(ii) Pos employee rights, as d (3) of the Act. §483.12(b)(5)(iii) Pro retaliation, as defined (2) of the Act. This REQUIREMENT by:	the following elements. ting a conspicuous notice of efined at section 1150B(d) hibiting and preventing at section 1150B(d)(1) and is not met as evidenced ew and interviews with		In addition to the actions taken by	5/4/24		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	PLE CONSTRUCTION	, ,	(X3) DATE SURVEY COMPLETED	
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				BURGAW, NC 28425		
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F 607	Continued From page	≥ 36	F 6	07		
	failed to immediately	staff, Nurse Aide (NA) #1 report an incident of abuse r Resident #2 threatened nife on 4/9/24. The		which are already reflected document, the following actions been taken:		
	administration was not 4/11/24 when Reside Nurse #1 and who the The knife remained in until police were conticonfiscate the knife. Immediately impleme Resident #2 had access which placed all resid likelihood of suffering perpetrated by Residfailed to notify the state within the required time report the abuse to A (APS). This was for for abuse (Resident #1 Immediate Jeopardy facility failed to implementations of the suffering for abuse residents from abuse to A (APS).	ot aware of the incident until nt #1 reported the incident to en informed administration. In Resident #2's possession acted on 4/11/24 to This resulted in a failure to nt protective measures. ess to all facility residents lents (34 residents) at high harm from further abuse ent #2. The facility also ate agency of the abuse neframe and they did not dult Protective Services 1 of 3 residents investigated et 1). began on 4/9/24 when the ment measures to protect all		On 5/5/24, the DON review materials for skilled nursing team members. As part of enew staff, standard, facility-orientation facilitated by the Resources department incles regarding timely abuse repefailure to do so will result in residents at further risk. A computer-based learning members to the facility's Professional department about resident neglect remains a part of the annual education requiremed Additionally, the DON will be for ensuring completion of a corientation checklist that income hires' verification of unthe abuse policy (definition reportable situations, and we report and that failure to do	g unit (SNU) conboarding -wide e Human udes education corting and a staff putting module created al Development abuse and me SNU staff's eeresponsible a unit-specific cludes each aderstanding of abuse, who/how to	
	jeopardy was remove implemented a credit jeopardy removal. The compliance at a lowe "F" (no actual harm withan minimal harm the jeopardy) to ensure emonitoring systems pure findings included: Review of the facility Neglect and/or Theft	ed on 5/4/24 when the facility ble allegation of immediate ne facility remains out of r scope and severity level of with the potential for more at is not immediate aducation is completed and out into place are effective.		staff putting residents at ris abuse) and proof of comple SNU specific orientation che kept in the employee's file. On 5/6/24, the SNU social reported the incident to Adu Services. The Abuse, Neglect, and/or Patient Property Policy app current and future SNU resto ensure existing residents understood their rights to be	k of further etion of the ecklist will be worker ult Protective r Theft of blies to all idents. In order is (as of 5/1/24)	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		SURVEY PLETED
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	DOLUBER OF SURE	343243	D. WING_			05/	/06/2024
NAME OF P	ROVIDER OR SUPPLIER				REET ADDRESS, CITY, STATE, ZIP CODE		
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F 607	report suspected incineglect and theft to the senior nursing leader (DON), was responsive enforcement. It furth and emotional supportesident. An initial report with the submitted to the state report indicated the fincident on 4/11/24 at included a timeline of #2 entered the room [waved] a knife" and indicated that Nurse room when Resident and she (NA #1) "turn away." On 4/17/24 the permission to contact Director of Nursing (If agency by phone on An interview was cortact 4/30/24 at 11:28 AM. Minimum Data Set (Na 3/17/24 indicated her Resident #1 stated Na 4/9/24 when Resident knife. She was unsulocation within the room after the incident agreat deal of participated in activities.	B/2023 revealed staff are to dents of patient abuse, heir leader. The policy stated ship, the Director of Nursing ble for notifying law her revealed that protection art will be provided to the seagency on 4/18/24. The acility became aware of the tare 3:00 PM. The investigation of events. On 4/9/24 Resident of Resident #1, "brandished threatened her. Resident #1 Aide (NA) #1 was in the #2 threatened Resident #1 hed her head and walked he hospital legal team gave to the State agency. The DON) contacted the State 4/18/24 at 8:30 AM. Inducted with Resident #1 on (Resident #1's annual MDS) assessment dated or cognition was intact.) IA #1 was in her room on the #2 threatened her with a re of her (NA #1's) exact for when the incident #1 stated she remained in cident because she was a She stated she normally time out of her room and less throughout the day.	F	607	abuse, neglect, misappropriation of resident property, and exploitation including freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms, on 5/1/24 an ad hoc reside council meeting was facilitated by the nursing leadership to educate the residents on their rights to be free from physical and mental abuse. There was discussion about the different types of abuse and when and how to report abuse and when and how to report abuse and when and how to report abuse and belongings policy including the list of contraband items and that this same policy will be provided to each not resident upon admission. On 5/5/24, the SNU admission packet was updated by the DON to include the list of contraband items that include but are not limited to weapons (firearms, knives, explosives), lighters and other smoking materials or smokeless tobactillicit substances, and drug paraphernat which are strictly prohibited. On 5/5/24 the list of contraband items was given each resident and emailed to every resident's family member(s) and/or poor attorney by the DON. A flier outlining what constitutes contraband was place at the entrances (elevators) to the unit and in the visitor restroom on the SNU Effective 5/3/24, the DON is monitoring adherence to the corrective action	nt ause. ae ew et co, alia , to wer ded	
	Resident #1 stated th	nat she was scared "he was			measures. The DON or designee is		

STATEMENT OF DEFICIENCIES (X'AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345245	B. WING			l	06/2024
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(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 607	Continued From page	e 38	F	607			
	She stated she felt po	owerless to stop him from			confirmation that residents receive the		
		as his plan. Resident #1			personal belongings (contraband) polic	У	
	_	nember of the incident on the			upon admission. In order to monitor ou	-	
		ember told her (Resident			performance and ensure solutions are		
	#1) to report the incid	ent to the facility or she (her			sustained, the DON is monitoring		
	family member) would	d report it. Resident #1			compliance. The numerator is the num	ber	
	stated the first staff m	nember she reported the			of new residents who receive a copy of	:	
	incident to was Nurse	#1 on 4/11/24. She stated			the policy and the denominator is a total	al	
	the DON visited her re	oom on 4/11/24 after she			number of admissions.		
	initially disclosed the	incident to Nurse #1.					
					Additionally, to validate that new hires		
		ducted with Nurse #1 on			understand unit policies and procedure	S	
		She stated Resident #1			pertaining to abuse, neglect, and		
		om on 4/11/24 and told her			exploitation of residents, misappropriat		
		atened her with a knife.			of resident property, and implementation	n	
		dent #1 indicated she was			of the emergency operations policy		
	sharing this with her (,			(EOP), the DON will validate that the n	ew	
		with Resident #2 and the			hire checklist is completed. The	ubo	
	I .	ed she went immediately			numerator is the number of new hires w	VIIO	
	and reported this to the	le DON.			have completed the new hire checklist and understand their responsibilities		
	During an interview w	vith Nurse Λide #1 on			related to prohibiting and preventing		
	_	he stated she provided care			abuse, neglect and exploitation of		
		0/24 and did not see a knife			residents and misappropriation of residents	ent	
		ident #1's room. NA #1			property, and implementation of the EC		
		sident #1 and Resident #2			including timely reporting. The	, ,	
	I .	NA #1 stated she could not			denominator is the number of new hire	S.	
		y was said because she was					
		done at the time. She			Finally, SNU staff will complete annual		
		d out of Resident #1's room			mandatory abuse/neglect education. T	ne	
	and reported the conv	versation about the knife			numerator is the number of SNU staff		
	1	as in the hallway. She			completing annual abuse/neglect		
	stated she thought the	<u>-</u>			education and the denominator is the to	otal	
	Resident #2) were jol				number of SNU staff. This process is		
		ly discussed his criminal			ongoing.		
	1	a great deal about his past					
		#1 stated she "intentionally"			Effective 5/4/24, all reports of potential		
	did not look for the kn	nife. She indicated she did			abuse are reviewed by the leadership		
	not want to be involve	ed.			team (DON, President/Administrator, a	nd	

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				В	URGAW, NC 28425		
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A second interview was conducted with NA #1 with the DON present on 5/1/24 at 11:00 AM. NA #1 reported she never saw Resident #2 with the knife on 4/9/24. NA #1 stated she saw Resident #2 in the doorway of Resident #1's room (4/9/24)		F 6	607	medical director) to evaluate effectiven of the admission evaluation process, E implementation, and timeliness of reporting requirements including but no limited to Adult Protective Services.	:OP		
	#2 in the doorway of Resident #1's room (4/9/24) and heard him say something about having a knife. She reported she (NA #1) heard Resident #2 say he believed she (NA #1) and NA #2 had reported him for having the knife after it was confiscated by the police on 4/11/24 and he stated he (Resident #2) was going to get them (NA #1 and NA #2). During this interview NA #1 acknowledged that she was afraid of Resident #2 because he frequently bragged about his criminal history. She reported after the knife was discovered on 4/11/24 he yelled out frequently "who is the snitch" and "snitches get stitches".				On 5/28/24, the DON reviewed the file the one new hire and confirmed that the new hire's file verifies completion of the Emergency Operations Policy education as of 5/20/24. This education included how to call for help. This ongoing data will be reported at the SNU Quality Assurance and Process Improvement (QAPI) meeting and documented in the minutes.		
	4/30/24 at 10:53 AM. Resident #1 on 4/11/2 had threatened her (F 4/9/24. The DON stapolice department (th second floor of a hosy She reported she was police department for the knife. She reporte police on 4/11/24 who the knife was placed in a locked in the nursing reported she spoke with facility's legal tear force on 4/12/24 about and how to best hono DON stated Resident	ducted with the DON on She stated she spoke with 24 who stated Resident #2 Resident #1) with a knife on ated she called the hospital e facility was located on the bital) immediately for advice. Is advised to contact the local assistance with confiscating ed she contacted the local oresponded and confiscated int #2. The DON stated the personal belonging bag and supervisor closet. She with the hospital leadership, in and the hospital police at discharging Resident #2 or Resident #2's rights. The #2 was discharged on blice due to him having two					

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	RIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO 507 E FREMONT STREET BURGAW, NC 28425	DDE	1 00/00/2024	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	X (EACH CORRECTIVE ACTIVE CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 607	understanding that h Review of the police Officer #1 dated 4/11 check was conducted to have two felony who delected to have two felony who delected not be to the facility of the knife. She explains facility had elected not indicated the knife's of the handle of the knife the handle of the knife stated the handle was officer #2 stated the blade which was spriautomatically engaged. A phone interview was officer #1 on 5/2/24 is spoke with Resident incident was disclosed threatening behavior not be tolerated. Pol Resident #2 stated he Resident #2 was not Resident #1 was not prosecution. He furth was receiving medical was not taken into convarrants on 4/11/24. Review of a notice of dated 4/18/24 reveal discharged from the	report completed by Police /24 revealed a warrant d and Resident #2 was found arrants. view conducted with Police at 2:16 PM she stated she in 4/11/24 solely to confiscate ined the resident, staff, and out to press charges. She olade was 4 inches long and fe was blue and black. She is 4 inches long. Police knife had a flip blade (a ing loaded and the blade was ed by pressing a button). as conducted with Police at 10:42 AM. He stated he #2 on 4/12/24 after the ed and informed him that it to residents and staff would ice Officer #1 reported e would comply. He stated arrested on 4/11/24 because willing to cooperate with the explained Resident #2 all care from the facility so he istody for the outstanding.	F	607			
	safety of individuals i endangered. The no	n the facility being tice of discharge revealed					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345245	B. WING _				06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, C 507 E FREMONT ST BURGAW, NC 28		1 00/	00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFII TAG	FIX (EACH CORRECTIVE ACTION SHOULD B			(X5) COMPLETION DATE
F 607	entity and had a shar medical record reveatives in a local hospital transfer from the jail of his health. A follow up interview DON on 5/6/24 at 9:3 was unaware she need adult protective service to report allegations of supervisor as soon as NA #1 should have reknife and the incident Resident #2 to her sustated she did not was "snitch". The DON reresidents at risk. She notified on 4/11/24 by contacted the hospital implemented protection. An interview was con Administrator on 4/30 they did not report the agency until 4/18/24 of the incident was repowere conversations we ensure Resident #2's Administrator indicate were to report this incident was reported to the port that the incident was repowere to report this incident was reported to report the protection of the protection	tal were part of the same ed medical record. The aled as of 5/6/24 Resident #2 all awaiting placement after due to concerns related to was conducted with the 0 AM and she stated she eded to make a report to ces. She reported staff were of abuse to their immediate is possible. The DON stated exported her knowledge of the extension between Resident #1 and appropriate this put all other extension stated when she was a Nurse #1 she immediately all police for guidance and we measures. ducted with the facility wide at 3:33 PM. She stated incident to the State on the considered the pocause they were unsure if the pocause they were unsure if the considered. The exitension is the position of immediate were they were unaware they cident to APS.	F	507			
	The facility provided t	he following immediate					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345245	B. WING _		0,	C 5/ 06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425		010012024
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHE CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	are likely to suffer, a sa result of the noncon The facility did not implement therefore protective minmediately implement residents at risk of sure abuse perpetrated by Incident On 04/9/2024, NA #1 abuse Resident #1, and abuse policy by immediately report remeasures not being in residents. On 04/11/2024 at 3:11 (DON) notified comparesident (Resident #2 which posed a securit called the local police with confiscating the state to ensure no other resident (Resident #2 was door shut, the DON of Unit (SNU) hallways of Residents were escond doors were shut by state to maintain a cardisclose the details to disclose the disclose	ents who have suffered, or serious adverse outcome as inpliance: plement its abuse policy and heasures were not inted and this placed all ffering serious harm from Resident #2. witnessed Resident #2 and NA #1 did not follow the ediately reporting to procement. The failure to sulted in protective implemented for facility. Ipm, the Director of Nursing any police that there was a in possession of a knife, by threat. The DON then department for assistance knife at 3:37pm. In an effort sidents were abused, and is resting in his room with the leared the Skilled Nursing of residents and staff. Ited to their rooms and room aff. The residents were sy should go and stay in their stigated the situation. In an all menvironment, we did not to the other residents.	F 6	07		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			l ` '	IPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED	
		345245	B. WING _			C 05/06/2024	
NAME OF PR	ROVIDER OR SUPPLIER	0.02.0	<u> </u>	STREET ADDRESS, CITY, STATE, ZIP COL		05/06/2024	
PENDER I	MEMORIAL HOSP SNF			507 E FREMONT STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	FIX (EACH CORRECTIVE ACTION SHOULD B		(X5) COMPLETION DATE	
F 607	at 3:40pm. The DON monitoring the patient instructed the local poroom for any additional police instructed Resi weapon on hospital plocated within a hospital plocated within a hospital police asked concerns about his satisfies the local police asked concerns about his satisfies to move about the unit reported to the unit are situation by the DON. Social Worker to roun providing emotional stresources such as Chaphysician consultation declined) the Social WResidents to assess a sabuse situation. This interviewing residents any questions, concerns the DON presented to 04/11/2024 to assess discussed the situation 04/9/2024 when Residented the demeanor what happending the strength of the policy of the policy of the policy of the situation of the policy of the situation of the policy of the poli	relocated to the day room stayed at the nursing station to call system. The DON office to search Resident #2's all contraband. The local dent #2 that having a roperty (the SNU was stal) is not allowed. The DON office to search Resident #2 that having a roperty (the SNU was stal) is not allowed. The DON office Resident #2 if he had any affety and he responded no. It will minutes, after the knife DON announced via a unit taff and residents were free it. The Social Worker and was briefed on the The DON directed the offirst on Resident #1. After support and offering staplain services, counseling, an etc. to Resident #1, (who worker rounded on the other exposure to or impact of the was achieved by individually and asking if there were runs or needs. To Resident #1's room on the situation. The DON on that happened on dent #2 entered her room to the table of and admitted that she on and did not come out of	F6	507			
		on need for further dent #1 on 04/11/2024.					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345245	B. WING _				06/2024
	ROVIDER OR SUPPLIER		•	507	REET ADDRESS, CITY, STATE, ZIP CODE 7 E FREMONT STREET JRGAW, NC 28425	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	providing care to Reshis room. At the time, one-to-one interviews been harmed or in neevidenced by no comother residents at the with the oncoming nuinstructed the security day from 5:00pm to 3 rounding on the SNU. The DON was onsite handed off to the nurs 04/11/2024 instructing Resident #2 closely. Medical Director and was ordered for Residebriefed the team and place this patient on the local police depart onset of any threaten #2. The Minimum Damodified Resident #2 interventions to include reduce or eliminate in behaviors. The DON to place Resident #2 plastic utensils, Styrobags. On 04/12/2024, the Don all residents and services or enditors and services and services are to services are to services are to services and services are the services and services are to services and services are to services are to services and services are to ser	eam member approach to ident #2, or when entering the DON determined via so, no other residents had sed of assistance. This is is plaints or grievances from time. The DON debriefed trising supervisor who then by officer who works every solution to complete extra to monitoring the situation and sing supervisor at 4:40pm on go them to supervise. The DON consulted the a Behavioral Health consult dent #2. The DON and instructed the team to close supervision and call the timent immediately at the ing behaviors from Resident that Set (MDS) Coordinator 's care plan to include the interventions that would happropriate or threatening notified the dietary services on a "safe tray" that utilizes foam tray and no plastic.	F	607			
	by interviewing team	d the incident on 04/12/2024 members and the alert and assess for other incidents.					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	<u> </u>	00/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 607	any other resident of made them feel unstage cognitively impaired demonstrate signs of injuries of unknown (i.e. no pursed lips, for labored breathing Resident #1) and stage pisodes of threater 1. On the following of Nursing (DON) fawith legal department management, comportinical Outcomes to including the clinical discharge and associand Medicaid Serviction 04/12/2024 at 1 the risks vs benefits resident at current factor 0.04/16/2024 at 1 discharge disposition on 04/17/2024 at 4 appropriate durable and medications to follow 1. On 04/18/2024 at 9 team members finality 1. On 04/18/2024 at 1 completed the Nursi Transfer/Discharge for President/Administration 1. The attending provious summary and wrote Resident #2 at 10:15	alert and oriented residents if r staff have hurt them or afe. The DON assessed that residents did not f physical harm (i.e. no origin) or emotional anguish muscle tension, restlessness,). The residents (other than aff reported no additional ling behavior or abuse. Itates and times, the Director cilitated a leadership meeting and, case management, risk any police and manager of the establish next steps, appropriateness of resident ciated Centers for Medicare lies (CMS) regulations. 1:00am: The team discussed of Resident # 2 remaining a accility. 0:30am: The team discussed in options. :00pm: The team allocated medical equipment (DME) accilitate a safe discharge :30am, the above referenced zed the discharge plan.	F 6	07		

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425		310012024
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F 607	facility. 3. On 04/18/2024 at the context of Resid the facility policy, CN importance of reside staff via a staff meet present received this Clinical Coordinator one-on-one discussishift. 4. The DON self-rep safety incident to the and Human Service approximately 4:30p notified. The ombud 04/17/2024 at 11:41 5. On 04/19/2024, the Resident #2 was discommended Reside incident and request nurses or leadership concerns in the future Resident #1 for mer resident to not be in	2:00pm, the DON discussed ent #2's discharge, including MS guidelines, and ent and staff safety with SNU ing. Staff that were not seducation from the DON, or Nursing Supervisor, via ions upon arrival to their next enter the resident abuse en NC Department of Health is via fax on 4/18/2024 at ion. No other agency was sman was notified on pm.	F 60	07		
	services and counse she also had a conv Worker about availa counseling, but Res resources. Review of other abu On 05/03/2024 at 3: the DON reviewed to	eling. Resident #1 stated that ersation with the Social ble resources such as ident #1 declined all available				

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345245	B. WING			C 05/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	<u> </u>	55/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 607	measures were impinvestigation was sumember was termin with DHHS timely. - Specify the action process or system fadverse outcome frowhen the action will On 05/01/2024, the completed: 1. At 3:00pm, the Dot training transcripts for the ensure they compabuse/neglect eduction compliance of all SN assistants, activity of 2. At 4:00pm, the SI provided education members (Licensed Assistants, Activity of a consideration of the ensure they compain the significant of the s	at was immediately investigation. Protective lemented immediately. The abstantiated, and the staff ated. All reports were filed the entity will take to alter the ailure to prevent a serious of occurring or recurring, and be complete: following actions were ON reviewed the 2023 annual or of all SNU team members oleted required resident ation. Results revealed 100% JU staff (nursing and nursing coordinator). NU Clinical Coordinator to SNU clinical team Nurses, Certified Nursing Coordinator) present on-site in training: ations activation (who to eport, and the importance of etive measures).	F 61	07		
	(which could result in Resident abuse - the needs to be reported c. By failing to immed or abuse, staff are purther abuse. 3. Beginning at 5:00 educated team men	icion of a crime examples n abuse) e definition of abuse, what d and who/how to report. ediately report safety concerns outting residents at risk of upm, the Nursing Supervisor nbers in the following ove educational topics via				

PRINTED: 06/10/2024 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
		345245	B. WING				C 06/2024
	ROVIDER OR SUPPLIER			5	TREET ADDRESS, CITY, STATE, ZIP CODE 07 E FREMONT STREET BURGAW, NC 28425		<u> </u>
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 607	fixed time for gatherin focus on care coordin face-to-face clarificati important topics. This improve productivity, teamwork within clinic typically held at shift of daily action plan, and improves efficiency at anticipating needs for huddles is to increase accountability for pati a culture of empowers the following units: a. SNU licensed nursic. Therapy services d. Environmental Service. Dietary f. Facilities g. Clinical outcomes The following actions 05/2/2024: 1. To continue educate that had not yet receive the DON facilitated a in-service and comples ame topics outlined 2. At 8:30 AM, the Matacilitated another in prinservice on the abuse above in the facility's Workers, Admissions Therapy Services, Die Environmental Service	e huddles (A huddle is a g of team members to ation, facilitate immediate on of issues and discuss a process is designed to communication, and cal practice settings and is changes. It focuses on the adjustments needed which and enhances teamwork by the day. The goal of a individual team member ent safety and to help foster ment and collaboration) on es ang assistants wices were completed on ion efforts of team members wed education, at 6:50am, SNU team meeting and eted education regarding the above in #2. anager of Clinical Outcomes person, face-to-face are topic as outlined in # 2 education room for Social and Case Management,	F	307			

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425		03/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	Continued From pag	ue 49	F 6	507		
	ongoing by unit leadachieved and prior to The DON informed to Workers, Admissions Therapy Services, D Environmental Services, and Supervision must attend the outling 100% compliance is working on the SNU. 4. At 1:00pm, the Reseducation to resident concerns. The Clinical Cooresidents the importation of the Unit Clinical Onto SNU states that were present absolute provided an information of the Unit Clinical Security management leaders, team membrotential security risl response if situations and 911 notifications Clinical Outcomes were not present education on one sessions tracked by the DON,	topics as above will be ers until 100% compliance is o staff working on the floor. he leaders of Social s, Case Management, ietary Services, ces Plant Engineering, and that they and all the staff ned education on abuse until achieved and prior to staff				

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	<u> </u>	03/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORE ((EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AI DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 607	facility-wide oriental Resources Departm regarding timely aby so will result in staff further abuse. A comodule created by Development Department Departme	rding new staff, standard, tion facilitated by the Human nent includes education use reporting and failure to do putting residents at risk of emputer-based learning the facility's Professional rtment about resident abuse is a part of the SNU staff's equirements. Additionally, the sible for ensuring completion entation checklist that hire's verification of abuse policy (definition of ituations, and who/how to re to do so will result in staff risk of further abuse) and of the SNU-specific it will be kept in the employee's deliberation of should be departed to 15/6/24. It is also the definition of abuse, is, who/how to report to, and out will result in staff putting further abuse. Additionally	F 6			
	activation of the em including what to do potential or actual h situation and what o suspicion of a crime	ated on what events require ergency preparedness plan owhen residents experience earm related to an abuse constitutes reasonable as a result of abuse. Sing staff were educated by				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	IPLE CONSTRU		(X3) DATE COMF	SURVEY PLETED
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		345245	B. WING			05/	06/2024
	ROVIDER OR SUPPLIER				DRESS, CITY, STATE, ZIP CODE SONT STREET NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B ROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 656 SS=D	include situations of a The DON verified she ensuring new staff co that includes verificati of the abuse policy to protection of residents revealed they were en safety concerns and verified to concern. The facility's validated.	n multiple topics that otential security risks to abuse and the duty to report. was responsible for mplete unit specific training ion of staff's understanding include reporting and include reporting and include reporting and include a suffer with the state of the staff's was staffy a date of 5/4/24 was comprehensive Care Plan		507			5/30/24
	implement a compreh care plan for each res resident rights set for §483.10(c)(3), that incobjectives and timefra medical, nursing, and needs that are identificassessment. The condescribe the following (i) The services that a or maintain the reside physical, mental, and required under §483.2 (ii) Any services that under §483.24, §483. provided due to the reunder §483.10, includit reatment under §483.3 (iii) Any specialized services that was a complete to the reunder §483.10, includit reatment under §483.3 (iii) Any specialized services are resident to the reunder §483.10, includit the reunder §483.10 (iii) Any specialized services and timeframent under §483.3 (iiii) Any specialized services and timeframent under §483.3 (iiiii) Any specialized services and	cility must develop and tensive person-centered sident, consistent with the sthat §483.10(c)(2) and cludes measurable ames to meet a resident's mental and psychosocial fied in the comprehensive aprehensive care plan must personal fied in the strain strain strain shifts highest practicable psychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 25 or §483.40 but are not esident's exercise of rights ling the right to refuse 1.10(c)(6).					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′		E CONSTRUCTION	' '	TE SURVEY MPLETED	
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		345245	B. WING				/06/2024	
NAME OF PI	ROVIDER OR SUPPLIER		I	5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				5	507 E FREMONT STREET			
PENDER I	MEMORIAL HOSP SNF			E	BURGAW, NC 28425			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG		Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREF TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		COMPLETION DATE	
F 656	Continued From page	e 52	F	656				
		a facility disagrees with the						
		RR, it must indicate its						
	rationale in the reside							
		h the resident and the						
	resident's representa							
	-	als for admission and						
	desired outcomes.							
	(B) The resident's pre							
	future discharge. Fac							
		s desire to return to the						
	community was asse							
	_	s and/or other appropriate						
	entities, for this purpo							
		n the comprehensive care						
		in accordance with the hin paragraph (c) of this						
	section.	ir iri paragrapir (c) or triis						
		rvices provided or arranged						
		ined by the comprehensive						
	care plan, must-	, ,						
		petent and trauma-informed.						
	This REQUIREMENT	is not met as evidenced						
	by:							
		iew and staff interviews, the			The facility implemented a new electron			
	facility failed to devel	op and implement an			medical record (EMR) system on 5/4/2			
		-centered care plan in the			Care plan data was cut over into the ne			
	areas of gastroesoph	•			EMR in the first week following go-live.	On		
		n, diabetes mellitus, falls,			5/5/24, the Director of Nursing (DON)			
		pioid pain medication, mood,			initiated a care plan for each resident	MD		
	comprehensive care	of 3 residents reviewed for			(including Resident #1) into the new El By 5/8/24, the Minimum Data Set (MDS			
	Complehensive cale	pians (1163146111 #1).			coordinator completed comprehensive			
	Findings included:				care plans in the new EMR for all			
	a.i.go moiaaoa.				admitted patients.			
	Resident #1 was adm	nitted to the facility on 2/3/23						
		ncluded GERD, hypertension			On 5/8/24, the unit census was reviewed	ed		
	and diabetes mellitus				by the DON and MDS Coordinator who			
					validated that 100% residents had a			
	Resident #1's annual	Minimum Data Set (MDS)			current, individualized person-centered	ł		

		(X3) DATE SURVEY COMPLETED			
		345245	B. WING		C 05/06/2024
NAME OF PI	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/00/2024
				507 E FREMONT STREET	
PENDER I	MEMORIAL HOSP SNF			BURGAW, NC 28425	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	Continued From page	e 53	F 65	6	
	cognitively intact. Sh interest or pleasure ir down/depressed/hope			care plan and corresponding interventin place. The "team conference" component of large team conference.	the
	and bowel. She rece	ays incontinent of bladder ived routine and PRN (as tions and antidepressant		long-term care (LTC) specific module the facility's EMR will be utilized to document high-volume or high-risk pl care updates. Using this new resource the MDS coordinator or designee will	an of
	updated 2/21/23, reve hypertension, diabete chronic pain, opioid p depression. These for identified, but no corr	_		make updates to the resident's care pain real-time in the LTC module of the EMR. Additionally, the facility maintais contract with the third party company utilized during the vacancy of the MD coordinator role. This company can be engaged in the event of prolonged vacancies (i.e. turnover, FMLA, etc.) our MDS role.	ns a S e
	During an interview of MDS Nurse stated Residual have been contained and goals for each for she was recently hire month. An interview was contained and goals for each for she was recently hire month. An interview was contained and the previous MDS contained and possible for the previous MDS contained and possible for the care plans up to date assessments had been plans had not been contained and plans had not been contained and possible for the previous MDS Nurse to get the care plans up to date assessments had been plans had not been contained and plans had not been contained and plans had not	n 5/2/24 at 3:15 PM the esident #1's care plan impleted with interventions cus area listed. She stated d at the facility in the last inducted with the Director of 2/24 at 3:30 PM. She stated ordinator resigned in e stated the facility had a graneplacement. She eloped a plan with the new e MDS assessments and in the DON stated the MDS en completed but the care		Effective 6/1/24, the DON will conduct weekly chart audit for four months to ensure that a team conference note is documented for each resident each will norder to monitor our performance a ensure solutions are sustained, the Divill monitor compliance. The numerate the number of compliant medical recorded and the denominator is the number of medical records audited. If a plan of care change in noted in the team conference note, then the DON conduct an audit of the MDS navigate section corresponding to the change ensure the care plan is updated appropriately. The numerator is number updated care plans and the denomination is the number of team conference note reflecting a need for an update to the	eek. ond ON or is ords e will or to eer of ator ees

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED
		345245	B. WING			C 05/06/2024
	ROVIDER OR SUPPLIER	I		STREET ADDRESS, CITY, STATE, ZIP C 507 E FREMONT STREET BURGAW, NC 28425	ODE	1 00/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD B THE APPROPRIA	DATE
F 656	was aware the care p timely.	vious MDS coordinator she olans had not completed	F 6:	plan. This ongoing monitoring da reported at the SNU Quality and Process Improvement meetings and documented minutes.	y Assurance (QAPI)	ing
F 867 SS=D	S483.75(c) (d) Facility systems to obtain and from direct care staff, resident representativinformation will be us are high risk, high volopportunities for improvedures to dentify, c information from all d not limited to the facil §483.75(c)(3) Facility systems to obtain and from direct care staff, resident representativinformation will be us are high risk, high volopportunities for improved in the facil §483.75(c)(2) Facility systems to identify, c information from all d not limited to the facil §483.70(e) and including will be used to develop indicators.	reedback, data systems and sh and implement written res for feedback, data and monitoring, including oring. The policies and ude, at a minimum, the maintenance of effective duse of feedback and input other staff, residents, and res, including how such ed to identify problems that lume, or problem-prone, and ovement. The maintenance of effective collect, and use data and epartments, including but ity assessment required at ding how such information op and monitor performance.	F 8	67		5/31/24

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG		OATE SURVEY OMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	,	03/00/2024
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	IOULD BE	(X5) COMPLETION DATE
F 867	including the method systematically identificanalyze and use data adverse events in the facility will use the daprevent adverse events will use the daprevent adverse events. §483.75(d) Program systemic action. §483.75(d)(1) The faction aimed at performance implementing those a and track performance improvements are results. §483.75(d)(2) The faction are results. §483.75(e) Program and (iii) How the facility work its performance improvements. §483.75(e) Program are supported by the faction are results.	ring, and evaluation. r adverse event monitoring, s by which the facility will y, report, track, investigate, a and information relating to e facility, including how the ata to develop activities to ints. systematic analysis and cility must take actions e improvement and, after actions, measure its success, be to ensure that alized and sustained. cility will develop and didressing: a systematic approach to a causes of problems ems; elop corrective actions that effect change at the systems the ty of care, quality of life, or will monitor the effectiveness approvement activities to ments are sustained.	F8	67		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345245	B. WING _			C 05/06/2024
	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	'	00/00/2027
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 867	outcomes, resident seresident choice, and \$483.75(e)(2) Perfor activities must track resident events, ana implement preventive that include feedbace facility. §483.75(e)(3) As pare improvement activities distinct performance number and frequence conducted by the fact and complexity of the available resources, assessment required Improvement project annually a project the problem-prone areas collection and analyse (c) and (d) of this see §483.75(g) Quality are \$483.75(g) Quality are surrance committed governing body, or confunctioning as a governities, including in	areas; and affect health safety, resident autonomy, quality of care. Imance improvement medical errors and adverse lyze their causes, and e actions and mechanisms k and learning throughout the of their performance es, the facility must conduct improvement projects. The cy of improvement projects cility must reflect the scope e facility's services and as reflected in the facility at \$483.70(e). Its must include at least at focuses on high risk or is identified through the data as described in paragraphs	F 8	<u> </u>		
	action to correct ider	ne committee must: lement appropriate plans of ntified quality deficiencies; and analyze data, including				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIF	PLE CONSTRUCTION 3		ATE SURVEY DMPLETED
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 507 E FREMONT STREET BURGAW, NC 28425	1 33/30/2024	
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F 867	Continued From page		F 86	67		
	resulting from drug re available data to mak This REQUIREMENT by: Based on record rev	the QAPI program and data gimen reviews, and act on e improvements. is not met as evidenced ew and staff interview the ssment and Assurance		As a result of the recertification so	-	
	Committee failed to n procedures and moni committee previously recertification survey repeat deficiency in the implementing compression			initiated to include the following: the Minimum Data Set (MDS) coording running a weekly report from the electronic medical record (EMR) any newly prescribed medication resident huddles with secure spreading; the DON was added to the secure of the secure spreading of the secure sec	the nator o capture s; weekly eadsheet	
		attern of the facility's inability e Quality Assurance		plan meeting invites; the DON crestandardized care plan meeting retemplate to capture all required ethe MDS coordinator coordinated shared calendar that listed the na	eated a note lements; I a	
	The tag is cross-refer			dates of all upcoming assessmer deadlines; the DON spot-checked calendar with EMR documentation	nt d the	
	plan in the areas of g disease (GERD), hyp falls, incontinence, pa mood, and depressio	failed to develop and ualized person-centered care astroesophageal reflux ertension, diabetes mellitus, iin, opioid pain medication,		validate updated care plans. The processes were tracked and validate DON, and the MDS reported quarterly Quality Assurance Proc Improvement (QAPI) meetings. T Coordinator's last day of employr 12/23/23.	new dated by at the ess The MDS	
	#1). During the recertificat facility was cited for n place related to antidresident who was recomedication.	ion survey of 2/17/23 the ot having a care plan in epressant medication for a eiving antidepressant		On 3/13/24, the third party MDS is assumed responsibility for the MI and care plans. On 3/13/24, a revice Corrective Action Plan (CAP) was by the DON with the MDS third pourses to ensure all current residupto-date MDS assessments. Of the internal, voluntary CAP was considered.	DS data vised s initiated arty ents had n 3/14/24 discussed	
	An interview with the	Director of Nursing (DON)		by the DON at the quarterly skille	ed nursing	

	DF DEFICIENCIES CORRECTION					
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				507 E FREMONT STREET		
PENDER I	MEMORIAL HOSP SNF			BURGAW, NC 28425		
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F 867	Continued From page was conducted on 5/6 reported she led the of the facility and the facility and the facility and success to DON further stated the in the role of Minimum	,	F 8	unit (SNU) QAPI meeting. On 3/18 third party MDS nurses reported to DON that care plan data was miss. The DON instructed the third party nurses to ensure the residents in facility on that date had updated or plans documented within 3 weeks DON audited the MDS EMR, "Poil Care," (PCC) to verify that care pleen opened on every resident. Didifficulty navigating and accessibil PCC, the DON was able to verify plans had been opened but was not to visualize implementation of the interventions. On 5/5/24, the DON initiated a care for each resident admitted in the Sthat date into the new EMR. By 5/MDS coordinator completed comprehensive care plans in the reach residents admitted residents. On 5, the DON and MDS coordinator vathat 100% of residents had a curre individualized, person-centered cannot corresponding interventions in the DON began giving a SNU QA report at the monthly Clinical Excernectings beginning on 4/23/24. Os/31/24, the President/Administration.	8/24, the of the sing. / MDS he are The of Click ans had ue to ity within that care of able be plan sNU on 8/24, the new (8/24, lidated ent, ure plan of place. Plellence of the core o	
				added the SNU QAPI report to the Medical Staff meeting agenda. QAPI meetings have been occurring quarterly per regulatory requirement DON adjusted the QAPI meetings to monthly and established a stan agenda template which covers all	ng ents. The schedule	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION G		E SURVEY IPLETED		
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F 867	Continued From pag	e 59	F 86	components of the QAPI/QAA improvement activities outlined per CFR (s) 483.75 (c)(d)(e)(g)(e) Monthly, effective 6/1/24, the DC conduct a patient-centered, nursing-focused QAPI meeting encompassing the following discunit nursing leadership, MDS cosocial work, and activities coord. The following standard agendate discussed: MDS/care plan stagrievances, regulatory reporting plan of correction implementation active unit quality or process improjects with corresponding data Quarterly, the DON will continue conduct a comprehensive QAPI with all QAPI stakeholders inclused above plus the medical directlity administration, pharmacy prevention and control (IPC), the clinical outcomes. Progress registandard agenda items for the number of QAPI meeting will be evaluated to reports shared on the following quarterly standing agenda items regulatory quality reports (e.g. Macenters for Medicare and Medical Services star ratings), pharmacy IPC reports, and unit education. The DON adjusted the QAPI meschedule to monthly and establistandard agenda which covers a components of QAPI/QAA improactivities as per CFR (s) 483.75 (g)(2)(i)(ii). The more frequent Components allocate more time for	ciplines: coordinator, linator. items will tatus, and/or on, and provement a review. to to meeting ding those rector, y, infection erapy, and arding the monthly in addition ng s: facilities, MDS and caid y reports, needs. teting ished a all the ovement o (c)(d)(e) QAPI			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345245	B. WING			C	
NAME OF PROVIDED OR CURRUER	343243	1 5: 11:10	CTREET ADDRESS CITY STATE 7/D CODE		05/06/2024	
NAME OF PROVIDER OR SUPPLIER			, , ,			
PENDER MEMORIAL HOSP SNF						
			BURGAW, NC 28425			
X4) ID SUMMARY STATEMENT OF DEFICIENCIES REFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION SH	PROVIDER'S PLAN OF CORRECTION (X5) (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5) COMPLETION DATE		
F 867 Continued From page	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE			