DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES					FORM APPROVED OMB NO. 0938-0391		
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE	(X3) DATE SURVEY COMPLETED	
		345298	B. WING			C / <b>22/2020</b>	
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE			
THE LAURELS OF PENDER				311 S CAMPBELL STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRI (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY)	SHOULD BE COMPLETION		
E 000	Initial Comments		E 000				
F 000	An unannounced COVID-19 Focused Survey was conducted on 12/21/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# HLTI11. INITIAL COMMENTS		F 000				
	Control Survey and C conducted on 12/21/2 in compliance with 42 control regulations an CMS and Centers for Prevention (CDC) rec prepare for COVID-15	AVID-19 Focused Infection Complaint Investigation were 2020. The facility was found 2 CFR §483.80 infection ad has implemented the Disease Control and commended practices to 9. Event ID# HLTI11. 1 of 1 was not substantiated.					
						(X6) DATE	
Electronically Signed 12/22/20							

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.

DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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