PRINTED: 03/01/2022 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER THE LAURELS OF PENDER (X4) ID PREFIX TAG (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments The survey team entered the facility on 01/25/22 to conduct a Recertification survey. The survey team was onsite 01/28/22. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# YPJZ11. F 000 INITIAL COMMENTS The survey team entered the facility on 01/25/22 to conduct a recertification survey and complaint investigation. The survey team was onsite 01/25/22, and 01/27/22. Additional information was obtained offsite on 01/28/22. Therefore, the exit date was 01/28/22. Event ID# YPJZ11. It of the 12 complaint allegations were not substantiated.	STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
THE LAURELS OF PENDER Comparison of Compa			345298	B. WING		C 01/28/2022	
PREFIX TAG (EACH OFFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) E 000 Initial Comments E 000 The survey team entered the facility on 01/25/22 to conduct a Recertification survey. The survey team was onsite 01/25/22, 01/26/22, and 01/27/22. Additional information was obtained offsite on 01/28/22. Therefore, the exit date was 01/28/22. The facility was found in compliance with the requirement CFR 493.73, Emergency Preparedness. Event ID# YPJZ11. F 000 The survey team entered the facility on 01/25/22 to conduct a recertification survey and complaint investigation. The survey team was onsite 01/25/22, 01/26/22, and 01/27/22. Additional information was obtained offsite on 01/28/22. Therefore, the exit date was 01/28/22. Event ID# YPJZ11. 12 of the 12 complaint allegations were not substantiated. F 641 SS=D CFR(s): 483.20(g) \$483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced	NAME OF PROVIDER OR SUPPLIER				311 S CAMPBELL STREET	V.120/2422	
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The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced		01/25/22, 01/26/22, information was obtatherefore, the exit description of the 1 not substantiated. Accuracy of Assessr	and 01/27/22. Additional ained offsite on 01/28/22. ate was 01/28/22. Event ID# 2 complaint allegations were	F 64	41	2/25/22	
Based on record review and staff interviews the facility failed to code the Minimum Data Set (MDS) assessment accurately in the areas of level II Preadmission Screening and Resident Review (PASRR) for 1 of 1 resident (Resident # 78) identified as PASRR Level II. Findings included: Resident #78 was admitted to the facility on 1. The facility will continue to complete assessments that accurately reflect the resident's status. Resident #78 had an MDS correction completed at the time of discovery. No negative outcome was identified relating to this observation. 2. Residents who have a Level II PASRR Determination have the potential to be affected. All current residents with a Level II PASRR Determination were reviewed to the solution were reviewed to the solution were reviewed to the facility on the solution were reviewed to the facility or the solution were reviewed to the facility		The assessment muresident's status. This REQUIREMEN by: Based on record refacility failed to code (MDS) assessment level II Preadmission Review (PASRR) for 78) identified as PASFINDINGS included: Resident #78 was as	T is not met as evidenced view and staff interviews the the Minimum Data Set accurately in the areas of a Screening and Resident 1 of 1 resident (Resident # SRR Level II.		assessments that accurately reflect the resident's status. Resident #78 had an MDS correction completed at the time of discovery. No negative outcome was identified relating to this observation. 2. Residents who have a Level II PASR Determination have the potential to be affected. All current residents with a Level II PASR Determination have the potential to be	of RR vel	
11/29/18 and most recently readmitted on 1/18/21 II PASRR Determination were reviewed to ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATI	ADOBATE					I to (X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

(X6) DATE

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.

Electronically Signed

02/14/2022

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
345298			B. WING			C 01/28/2022	
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 017	LOILULL
					11 S CAMPBELL STREET		
THE LAUF	RELS OF PENDER				BURGAW, NC 28425		
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH COR			PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 641	Continued From page	e 1	F 641				
	after hospitalization w	vith multiple diagnoses that			ensure that assessments had been		
		rder, bipolar disorder, and			completed that accurately reflect each		
	major depressive disc				resident's status. No negative		
					observations were identified.		
	The significant chang	e MDS assessment dated					
		k to question A1500 which			3. The MDS Coordinator was inservice	d	
		B had been evaluated by a			by the Clinical Resource Specialist on		
	level II PASRR and d			completing assessments that accurate	ly		
		intellectual disability or a			reflect the resident's Level II PASRR		
	related condition.				Determination. All MDS Coordinators		
	Record review indicated Resident #78 had a				were inserviced by the Clinical Resource Specialist on completing assessments	ce	
		ning and Resident Review			that accurately reflect the resident's Le	wel	
	(PASRR) Level I Screen completed dated 9/14/21				II PASRR Determination.	VCI	
for a change in condition review.				in the tit Betermination:			
					4. A QA monitoring tool will be utilized	to	
	Record review indica	ted Resident #78 had a			ensure ongoing compliance by the Soc		
	Preadmission Screen	ing and Resident Review			Worker. The Social Worker will random		
		ermination Notification dated			audit residents with Level II PASRR MI	os	
	9/16/21.				assessments monthly x 3 months to		
					ensure that MDS assessments are bei	ng	
		ducted with the Social			completed that accurately reflect the		
	, ,	//22 at 10:40 AM. The SW			resident's Level II PASRR Determination		
	· ·	had a completed Level II			Variances will be corrected at the time		
		Social Worker was not aware			audit and additional education provided	t	
		e MDS data files. The			when indicated. Audit results will be	۵.	
		she usually sends an email in and informs staff of the			reported to the Administrator monthly for the next 3 months and concerns will be		
		ed a copy of the updated			reported to the Quality Assurance	;	
		rmination Notification dated			Committee during monthly meetings.		
	9/16/21.	minduon Notinoation dated			Continued compliance will be monitore	d	
					through random audits of MDS		
	An interview was con	ducted with the MDS Nurse			assessments and through the facility's		
	on 1/27/22 at 11:35 A	M. The MDS Nurse was not			Quality Assurance Program. Complian	ce	
	aware of the Level II	PASRR for Resident #78			will be monitored by the QAPI Committ		
		e MDS Nurse stated she			for 3 months or until resolved and		
		SRR Level II, and the care			additional education/training will be		
	plan was updated, bu	it it did not get updated in the			provided for any issues identified.		
	MDS data. She state	ed she would immediately do					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3	(X3) DATE SURVEY COMPLETED	
		345298	B. WING _			C 01/28/2022	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF PENDER				STREET ADDRESS, CITY, STATE, ZIP COD 311 S CAMPBELL STREET BURGAW, NC 28425	DE	0112012022	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE	
F 644 SS=D	PM with the Director Consultant regarding The Director of Nursi Worker sends in the staff via email after register #78 was up was not updated on I The Director of Nursi missed; but should his significant change up During a telephone in Administrator on 1/28 explained he had been II PASRR coding and stated it should have significant change will Determination Notific Coordination of PASA (CFR(s): 483.20(e)(1) §483.20(e) Coordination A facility must coordinate pre-admission screen (PASARR) program of this part to the material avoid duplicative test includes: §483.20(e)(1)Incorpor from the PASARR legal PASARR evaluation	ducted on 1/27/22 at 12:00 of Nursing and the Facility PASRR II documentation. Ing explained the Social PASRR changes and notifies eceiving the updates. In particular particula	F 6	5. All corrective actions as stawill be completed by 2/25/202		2/25/22	

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X3) DATE SURVEY COMPLETED	
	345298	B. WING		C 01/28/2022	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF PENDER			311 S CAMPBELL STREET	1 0 11 20 12 22 2	
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG			
§483.20(e)(2) Referral residents with new serious mental disormelated condition for a significant change. This REQUIREMENT by: Based on record revision for a significant change. This REQUIREMENT by: Based on record revision for the significant change. The serious (PASARR) and diagnosis for 1 of 4 more reviewed for level III. Findings included: Resident #80 was and diagnosis including of disturbance 10/27/20 disorder 10/	ring all level II residents and why evident or possible der, intellectual disability, or a level II resident review upon in status assessment. T is not met as evidenced view and staff interviews the a resident for screening for a n Screening and Resident and Screening and Resident (Resident #80) PASARR. Idmitted 11/10/2021 with dementia with behavioral 221 and major depressive and The Minimum Data Set 2021 had Resident #80 coded by impaired and needed for activities of daily living care plan dated 12/31/2021 pain and/or has chronic pain and distress hallucinations, as, and decreased mobility, adverse reactions and side multiple psychotropic ant takes an antidepressant antipsychotic (Seroquel) for viors. Vealed Resident #80 was sional disorders 11/12/2021,	F 644	1. A referral for a PASARR Level II for Resident #80 was completed at the tin of discovery. If a Level II PASARR is determined, then a MDS Significant Change will be submitted within14 day the determination. The care plan will b updated to reflect the level change. 2.An in-house audit of all current Residents with a Level I PASRR noted with a newly evident or possible seriou mental disorder, intellectual disability, related condition for level II resident review assessment will be completed i accordance with 483.20(e) by. The current affected Residents will have a Level II review submitted to North Carolina PASRRMUST. In accordance with 483.20(e)(1) the recommendation from a PASARR level II determination the PASARR evaluation report will be incorporated into the Residents assessment, care planning, and transitions of care. The IDT team (admissions/marketing, SS, MDS) will in-serviced by the Administrator on the process for referring residents for	ne rs of e ss of e ss or a n ss and	
on 12/20/2021.	, , , ,		3.The Laurels of Pender will coordinate	e	
	SUMMARY S (EACH DEFICIENCE REGULATORY OR Continued From page §483.20(e)(2) Referrall residents with new serious mental disor related condition for a significant change This REQUIREMEN by: Based on record reversed facility failed to refer level II Preadmission Review (PASARR) and diagnosis for 1 of 4 reviewed for level II Findings included: Resident #80 was and diagnosis including of disturbance 10/27/20 disorder 10/27/20 disorder 10/27/20 disorder 10/27/20 disorder 10/27/20 find for the serious depression, delusion arthritis, is at risk for related to (r/t) emotion depression, delusion arthritis, is at risk for effects r/t receiving redications. Reside for depression and a dementia with behave. The diagnosis list rediagnosed with delust hallucinations 11/12/	CORRECTION JA5298 ROVIDER OR SUPPLIER RELS OF PENDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident for screening for a level II Preadmission Screening and Resident Review (PASARR) after a new mental health diagnosis for 1 of 4 residents (Resident #80) reviewed for level II PASARR. Findings included: Resident #80 was admitted 11/10/2021 with diagnosis including dementia with behavioral disturbance 10/27/2021 and major depressive disorder 10/27/2021. The Minimum Data Set (MDS) dated 11/16/2021 had Resident #80 coded as severely cognitively impaired and needed extensive assistance for activities of daily living (ADL). The comprehensive care plan dated 12/31/2021 had focus' of risk for pain and/or has chronic pain related to (r/t) emotional distress hallucinations, depression, delusions, and decreased mobility, arthritis, is at risk for adverse reactions and side effects r/t receiving multiple psychotropic medications. Resident takes an antidepressant for depression and a antipsychotic (Seroquel) for dementia with behaviors. The diagnosis list revealed Resident #80 was diagnosed with delusional disorders 11/12/2021, hallucinations 11/12/2021, and anxiety disorder	A BUILDING 345298 B. WING ROVIDER OR SUPPLIER RELS OF PENDER SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 3 \$483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident for screening for a level II Preadmission Screening and Resident Review (PASARR) after a new mental health diagnosis for 1 of 4 residents (Resident #80) reviewed for level II PASARR. Findings included: Resident #80 was admitted 11/10/2021 with diagnosis including dementia with behavioral disturbance 10/27/2021. 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The diagnosis list revealed Resident #80 was diagnosed with delusional disorders 11/12/2021, hallucinations 11/12/2021, and anxiety disorder	A BUILDING 345298 345298 31 S CAMPBELL STREET BURGAW, NC 28425 SUMMARY STATEMENT OF DEFICIENCIES SUMMARY STATEMENT OF DEFICIENCY COntinued From page 3 \$483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to refer a resident for screening for a level II Preadmission Screening and Resident #80 was completed at the tin of discovery. If a Level II PASARR i determined, then a MDS Significant Change will be submitted within14 day the determination. The care plan will be updated to reflect the level change. 2.An in-house audit of all current Residents with a Level I PASARR not and the accordance with a newly evident or possible serious mental disorder, intellectual disability, related condition for level II resident review assessment will be completed in accordance with 483.20(e) by. The current affected Residents will have a Level II Preadming and transitions of care. The IDT team (admissions/marketing, SS, MDS) will in-serviced by the Administrator on the process for referring residents for screening for a level II PASARR after new mental health diagnosis.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
345298		B. WING			C 01/28/2022		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CO	•	172072022	
THE LAUI	RELS OF PENDER			311 S CAMPBELL STREET BURGAW, NC 28425			
(X4) ID PREFIX TAG			ID PREFIX TAG	EFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE	
F 644	major depressive dishealth diagnoses. The January Medicar (MAR) revealed and MG (Quetiapine Furmouth at bedtime relhallucinations, unspeted to recurrent, unspecified. An interview with the conducted on 01/27/stated Resident #80 hallucinations, and a 11/12/2021. On 12/2 anxiety 12/20/2021. new PASARR level If the resident was theroverlooked. An interview with the conducted on 01/27/stated And interview with the conducted on PASARR's and expressions.	creen dated 11/01/2021 had order as one of the mental tion Administration Record order for Seroquel Tablet 25 harate) Give 2 tablet by ated to delusional disorders, ecified, 11/15/2021 Sertraline ve 1 tablet by mouth one major depressive disorder, d 11/11/2021. Social Worker (SW) was 2022 at 10:35 AM. The SW was diagnosed with delusional disorder on 0/2021 a new diagnosis of There was supposed to be a 1 screening completed but the a short time and it was	F 64	assessments with the pre-act screening and resident revier program. New admissions we screened prior to admission of a possible serious mental intellectual disability, or a rel for a level II review. Based of Level II review will be request Laurels of Pender. During dameeting, any Resident noted evident or possible serious in disorder, intellectual disability condition with a current Level will be submitted for a Level All Residents will be assessed their ARD for a newly evident serious mental disorder, intellectual disability, or a related condition are a related condition with a current Level will be submitted for a Level will be submitted for a Level All Residents will be assessed their ARD for a newly evident serious mental disorder, intellectual disability, or a related condition and the serious mental disorder, intellectual disability, or a related condition and will be submitted for PASARR. 4.On 2/10/2022, the QAPI or the Medical Director present findings of the 2567 from the to January 28, 2022 recertification monitoring of the Level II proreviewed daily in Clin-Ops xin weekly x 4 weeks and follow QAPI monthly meetings x 3 as needed thereafter. 5. All corrective actions as similar will be completed by 2/25/20 Determinations by North Call MUST will be completed as based on reviews as received.	ew(PASARR) will be for evidence disorder, lated condition on findings, a sted by The aily Clin-Ops d with a newly mental ey, or a related lel I PASARR II PASARR. led prior to out or possible ellectual ion for a level a significant out and will be th 483.20(e) a Level II committee with extra parallel be a January 25 cation survey. by cess will be a Veeks; then a ded up in the months and tated above out of the parallel be a parallel be a ded up in the months and tated above out of the parallel be a p		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER.		PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
345298			B. WING		C 01/28/2022	
NAME OF PR	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	01/20/2022	
THE LAHR	DELS OF DENDED			311 S CAMPBELL STREET		
I TE LAUK	RELS OF PENDER			BURGAW, NC 28425		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION		