STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345322	A. Building B. Wing	06/05/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Hendersonville	290 Clear Creek Road Hendersonville, NC 28792

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observations and staff interviews, the facility failed to remove expired and discontinued medications from 3 of 5 medication carts reviewed for medication storage (100 hall cart, 200 hall upper medication cart, and 200 hall lower medication cart).a. An observation on 6/5/26 at 10:14 AM with the Director of Nursing (DON) of the 200-hall upper medication cart revealed a medication card of Pantoprazole 40 milligram (mg) tablets that had a total of 27 pills left marked with an expiration date of 5/31/26 from the pharmacy. Review of the physician's order for Pantoprazole revealed that it had been discontinued on 3/9/26. Pantoprazole is used to treat gastroesophageal reflux disease (a condition that causes excess stomach acid). The expired Pantoprazole card was left available for use in the 200-hall upper medication cart.An interview with Nurse #1 on 6/5/26 at 10:31 AM indicated that the nurses should check medication dates before administration. She stated that the resident was no longer taking the Pantoprazole because it had been discontinued, and that it was overlooked. Nurse #1 further indicated that the expired or discontinued medications should be removed from the medication cart and placed into the return to pharmacy bin located inside the medication room. She stated the Nurse assigned to the cart for the day was responsible for removing discontinued medications when the Nurse received the order. Nurse #1 stated that she had last used the 200-hall upper medication cart earlier the in the morning of 6/5/26 when she began medication administration on the front of the 200-hall. She further stated that the Unit Managers and Administrative Nurses check the medication carts weekly for expired medications and she checked medications expiration dates before she administered them. b. During an observation of the 100-hall medication cart on 6/5/26 at 10:20 AM with Medication Aide #1 and the DON revealed there was bag of ABH Gel (Ativan 0.5mg/Benadryl 12.5mg/Haldol 0.5mg per 1 milliliter (ml)) syringes that had a total of 15 syringes left marked with an expiration date of 6/1/26 from the pharmacy. Review of the physician's order for ABH Gel revealed that it had been discontinued on 6/1/26. ABH Gel is used to treat agitation. The expired ABH Gel was left available for use in the 100-hall medication cart.An interview with Medication Aide #1 on 6/5/26 at 10:29 AM revealed that the ABH Gel was no longer being used by the resident. Medication Aide #1 stated that she was not sure why the ABH Gel was on the cart as she had never used it for the resident. She indicated that she checks expiration dates before she administered medications and would have put the ABH Gel in the return to pharmacy bin since it was expired if the resident used the medication. She stated the Nurse or Medication Aide assigned to the cart for the day was responsible for removing discontinued medications when the Nurse received the order. She further stated that all expired or discontinued medications should have been put in the return to pharmacy bin located inside of the medication room. c. An observation on 6/5/26 at 10:47 AM of the 200-hall lower medication cart with Nurse #1 and the DON revealed a medication card of Propranolol 20 mg tablets that had a total of 25 pills left marked with an expiration date of 11/30/25 from the pharmacy. Review of the physician's order for Propranolol revealed that it had been discontinued on 7/15/25. Propranolol is used to treat high blood pressure. The expired Propranolol card was left available for use in the 200-hall lower medication cart.An interview with Nurse #1 on 6/5/26 at 10:49 AM indicated that Propranolol should (continued on next page)

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.

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

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	have been placed in the return to pharmacy bin located in the medication room. She stated that the resident no longer took that medication, and that it was overlooked. Nurse #1 indicated the medication was discontinued and should have been removed from the medication cart the day it was discontinued and placed in the return to pharmacy bin located inside the medication room.An interview with the Director of Nursing (DON) on 6/5/26 at 10:15 AM revealed that all the nurses were supposed to check the medications before they were administered. She further indicated that the Unit Managers and other Administrative Nurses check the medication carts weekly for expired medications. The DON stated that her expectation was that expired and discontinued medications would be removed from the medication cart and placed in the return to pharmacy bin located inside the medication room. She further indicated that when a medication was discontinued the Nurse assigned to the cart the day it was discontinued should have removed the medication and placed it into the return to pharmacy bin located inside the medication room.An interview with the DON on 6/5/26 at 10:50 AM revealed that her expectation was that all expired medications would be removed from the medication cart and placed in the return to pharmacy bin located inside the medication room. She further stated that the breakdown was that Unit Managers and Administrative Nurses were looking through the carts too quickly and the expired medications were being overlooked as a result. An interview with the Administrator on 6/5/26 at 1:25 PM revealed that his expectation was the staff remove expired and discontinued medications from the medication carts and place them in the return to pharmacy bin located inside of the medication room.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0645 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	PASARR screening for Mental disorders or Intellectual Disabilities **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II PASRR (Preadmission Screening and Resident Review) evaluation for a resident admitted with a serious mental health diagnosis for 1 of 2 residents reviewed for PASRR (Resident #90).Findings included:A PASRR Determination Notification letter dated 7/21/25 revealed Resident #90 had a Level I PASRR with no expiration date.Resident #90 was admitted to the facility on [DATE] with diagnoses that included post-traumatic stress disorder (PTSD).Review of a physician's progress note dated 9/3/25 included a review of Resident #90's health history and noted a diagnosis of PTSD.The admission Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #90 was not currently considered by the state Level II PASRR process to have serious mental illness and/or intellectual disability or a related condition. PTSD was listed as an active psychiatric/mood disorder diagnosis.During an interview on 06/03/26 at 9:18 AM and 06/05/26 at 10:01 AM, the Social Worker (SW) Assistant confirmed she was responsible for ensuring residents had a PASRR determination letter and she requested evaluations as needed. She stated when Resident #90 was admitted , a Level I PASRR determination letter had already been done at the hospital on 7/21/25. She confirmed Resident #90 diagnosis of PTSD was present when admitted on [DATE]. After review of Resident #90's Level I PASRR screening, the SW Assistant confirmed there was no mental health diagnoses identified on the screening done on 7/21/25. She acknowledged PTSD was a mental health diagnosis and stated because the Level I PASRR was recently done, Resident #90's diagnosis of PTSD did not trigger her to request a Level II PASRR evaluation.During an interview on 06/05/26 at 4:40 PM, the Administrator stated a request for a Level II PASRR evaluation for a resident with a serious mental health diagnosis should be done.

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F 0646 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Notify the appropriate authorities when residents with MD or ID services has a significant change in condition. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and staff interviews, the facility failed to submit a request for a Level II Preadmission Screening and Resident Review (PASRR) reevaluation after a significant change in physical or mental status was identified for a resident previously determined to have a Level II PASRR. This deficient practice affected 1 of 2 sampled residents reviewed for PASRR (Resident #9).Findings included:Resident #9 was admitted to the facility on [DATE] with diagnoses that included schizoaffective disorder-bipolar type, dementia-moderate with psychotic disturbance, and unspecified psychosis.The North Carolina Medicaid Uniform Screening Tool (NC MUST, internet-based application utilized to communicate and manage PASRR requests) inquiry dated 07/13/21 revealed Resident #9 had a Level II PASRR with no expiration date. A significant change Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #9 was considered by the state Level II PASRR process to have a serious mental illness and/or intellectual disability or other related conditions. Resident #9's active psychiatric/mood disorder diagnoses included psychotic disorder and schizophrenia. She received antipsychotic medication during the MDS assessment period.Review of Resident #9's medical record revealed no evidence a request for a Level II PASRR reevaluation was submitted following the significant change MDS assessment dated [DATE].During an interview on 06/05/26 at 12:30 PM, the Social Worker (SW) Assistant confirmed she was the person responsible for submitting requests for Level II PASRR reevaluations when needed. The SW Assistant explained it was her understanding that a request for a [NAME] II PASRR reevaluation only needed to be submitted if the significant change in condition directly related to the mental illness. The SW reported she did not submit a request for a Level II PASRR reevaluation following Resident #9's significant change MDS assessment dated [DATE] because her mental status did not change.During an interview on 06/05/26 at 3:13 PM, the Administrator stated requests for Level II PASRR reevaluations should be made when a resident had a significant change in condition per the regulatory guidelines.