STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345428	A. Building B. Wing	01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Salisbury	215 Lash Drive Salisbury, NC 28147

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904 Based on record review and staff and Nurse Practitioner interviews, the facility failed to ensure 1 of 3 residents (Resident #163) reviewed for medication errors received medications that were ordered by the physician. Resident #163 received Buspirone (an antianxiety medication) 10 milligrams that was intended for another resident. Medication administration observtions were made during the survey with a sample of residents and no issues were identified. Findings included: Resident #163 was admitted to the facility on [DATE] with diagnoses of heart failure and respiratory failure. A significant change Minimum Data Set assessment dated [DATE] indicated Resident #163 was severely cognitively impaired and did not receive antianxiety medications. Review of Resident #163's Medical Record revealed a Nurse's Progress Note written [DATE] at 3:18 pm by Nurse #1 which stated Nurse Practitioner #1 was notified Resident #163 was administered Buspirone 10 milligrams and orders were received to monitor for 12 hours. The Director of Nursing and the Responsible Party were also notified of Resident #163 receiving Buspirone 10 milligrams which was not ordered. The Nurse's Progress Note indicated Resident #163's respirations were even and unlabored and he had no other adverse reactions. A review of the facility's Medication Error Report completed by the previous Director of Nursing revealed Resident #163 received Buspirone 10 milligrams on [DATE] that was intended for another resident because Nurse #1 was distracted while administering medications because she was training a Medication Aide. During an interview with Nurse #1 on [DATE] at 12:58 pm she stated she did not remember the Medication Error that occurred on [DATE] when she cared for Resident #163. She stated she did have an in-service education regarding medication administration, and she did remember the facility auditing medication administration with her during ,d+[DATE]. (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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse Practitioner #1 on [DATE] at 11:36 am and she stated the medication error that occurred on [DATE] when Resident #163 received Buspirone 10 milligrams that was ordered for another resident did not result in any adverse reactions. She stated Nurse #1 reported the medication error as soon as it happened, and she instructed her to monitor his vital signs every hour for 12 hours and he did not have any issue. The previous Director of Nursing was not available for an interview after telephone messages were left for her to return the call. On [DATE] at 2:40 pm the Administrator was interviewed and stated Nurse #1 should not have been disrupted during medication administration. The Administrator stated a plan of correction was put into place that included education and auditing of the nurses and medication aides during medication administration and a plan to ensure no further medication errors. Resident #163 was under hospice care and died in the facility on [DATE]. The facility provided the following corrective action plan with a completion date of [DATE]. Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice: Resident #163 received another resident's medication, Buspirone, (an antianxiety medication) on [DATE] when a licensed nurse was training a medication aide and became distracted during the medication pass. The Nurse Practitioner was notified of Resident #163 receiving the Buspirone and the Nurse Practitioner instructed the nurse to monitor resident for 12 hours (vital signs and neurological checks) and report any changes in condition. No negative outcome was identified based on the monitoring. Address how the facility will identify other residents having the potential to be affected by the same deficient practice: All current residents had a full set of vital signs obtained by the nursing staff and Director of Nursing reviewed for 24 hours and the 24-hour report was reviewed for any acute changes in other residents' condition. This was completed on [DATE]. No negative outcomes were identified based on these observations. Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur: The licensed nurse and medication aide involved in the medication error on [DATE] received 1:1 education on the Six Rights of Medication Administration and verifying resident identity with three identifiers. The education was completed on [DATE]. The facility provided 100% education of all licensed nurses and medication aides on the Six Rights of Medication Administration and verifying resident identity with three identifiers. The education was completed on [DATE]. Licensed Nurses and Medication Aides were not allowed to work until the education was completed. (continued on next page)

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Indicate how the facility plans to monitor its performance to make sure that solutions are sustained; and Include dates when corrective action will be completed: The facility's Quality Assurance monitoring tool will be utilized to ensure compliance beginning [DATE]. The Director of Nursing/designee will observe one licensed nurse/medication aide on medication pass 5 x week x 2 weeks, then 3 x week x 2 weeks, then weekly x 2 weeks to ensure that the six rights of medication administration and the 3 resident identifiers are followed. Variances will be corrected at the time of observation and additional education provided as needed. The Director of Nursing is responsible for ensuring compliance with the plan of correction. A Quality Assurance Performance Improvement (QAPI) meeting was held on [DATE] with the Regional Clinical Nurse Consultant, Administrator, and Director of Nursing. The deficient practice and proposed plan of correction were discussed, and the plan was approved. The plan will be reviewed in the monthly QAPI committee meeting for the next 2 months or until resolved. Corrective action plan compliance date: [DATE]. The corrective action plan was validated on [DATE] by the following. Nurse Practitioner #1 instructed Nurse #1 to monitor Resident #163 every hour for 12 hours. The documentation of vital signs and neurological checks was documented by nursing every hour for 12 hours on the facility's Vital Sign and Neurological Assessment Form. The facility also reviewed vital signs and assessed all other residents, which was documented on a resident facility census, for any change in condition from [DATE] to [DATE]. The Director of Nursing educated Nurse #1 and all other nurses and medication aides on the six rights of medication administration (right resident, right medication, right dose, right time, right route, and right documentation) and verification of a resident's identity (verify name, date of birth, and medical record number) before medication administration on [DATE]. A sample of Nurses and Medication Aides were interviewed and verbalized understanding of the Six rights of medicaiton administration and the three verifications of a residents identity. A medication administration observation was made during the survey and no issues were identified. The facility did not allow nurses or medication aides to work until the education was completed. The facility provided monitoring of licensed nurses and medication aides during medication pass/administration beginning [DATE] which continued for 5 times a week for 2 weeks, 3 times a week for 2 weeks, and then weekly x 2 weeks to ensure the six rights of medication administration and resident identifiers were followed. On [DATE] the facility held a Quality Assurance Performance Improvement (QAPI) meeting to discuss and implement the plan of correction and the facility provided QAPI meeting minutes regarding continued monitoring since the initial meeting. Interviews with nurses and medication aides during the survey indicated they had the medication administration education and identification of resident education and were able to verbalize what they had learned and were audited during medication administration. The corrective action plan correction/completion date of [DATE] was validated on [DATE].