

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0636</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37281</p> <p>Based on record review and staff interviews, the facility failed to complete an admission Minimum Data Set (MDS) assessment within 14 days of admission for 1 of 18 residents reviewed for admission assessments (Resident #16).</p> <p>The findings included:</p> <p>Resident #16 was admitted to the facility on [DATE].</p> <p>The admission MDS was dated 1/22/25 and was listed as in progress.</p> <p>The MDS nurse was interviewed on 1/23/25 at 3:41 PM. The MDS nurse explained she was reviewing assessments for new admissions on 1/22/25 and noticed the admission assessment had not been completed for Resident #16 and she had initiated the assessment. The MDS nurse reported she does not know why the assessment was missed.</p> <p>The Administrator was interviewed on 1/24/25 at 2:23 PM. The Administrator explained the new admissions to the facility were discussed during the morning meeting and checks were completed twice per week to monitor the completion of the MDS assessment. The Administrator reported she was not aware the admission MDS assessment for Resident #16 had been missed, and she expected the admission MDS to be completed within 14 days of admission.</p>

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
---	-------	-----------

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Ensure services provided by the nursing facility meet professional standards of quality.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 38904</p> <p>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 observations were made during the survey with a sample of residents and no issues were identified.</p> <p>Findings included:</p> <p>Resident #163 was admitted to the facility on [DATE] with diagnoses of heart failure and respiratory failure.</p> <p>A significant change Minimum Data Set assessment dated [DATE] indicated Resident #163 was severely cognitively impaired and did not receive antianxiety medications.</p> <p>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.</p> <p>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.</p> <p>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].</p> <p>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.</p> <p>The previous Director of Nursing was not available for an interview after telephone messages were left for her to return the call.</p> <p>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.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Resident #163 was under hospice care and died in the facility on [DATE].</p> <p>The facility provided the following corrective action plan with a completion date of [DATE].</p> <p>Address how corrective action will be accomplished for those residents found to have been affected by the deficient practice:</p> <p>Resident #163 received another resident's medication, Buspirone, (an anti-anxiety 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.</p> <p>Address how the facility will identify other residents having the potential to be affected by the same deficient practice:</p> <p>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.</p> <p>Address what measures will be put into place or systemic changes made to ensure that the deficient practice will not recur:</p> <p>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].</p> <p>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].</p> <p>Licensed Nurses and Medication Aides were not allowed to work until the education was completed.</p> <p>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:</p> <p>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.</p> <p>The Director of Nursing is responsible for ensuring compliance with the plan of correction.</p> <p>(continued on next page)</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0658</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>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.</p> <p>Corrective action plan compliance date: [DATE].</p> <p>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 medication 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.</p> <p>The corrective action plan correction/completion date of [DATE] was validated on [DATE].</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0732</p> <p>Level of Harm - Potential for minimal harm</p> <p>Residents Affected - Some</p>	<p>Post nurse staffing information every day.</p> <p>37281</p> <p>Based on observations, record review, and staff interviews, the facility failed to accurately report staffing for 3 of 5 daily posted sheets reviewed.</p> <p>The findings included:</p> <p>1. The following daily posted nurse staffing sheets and nursing schedules were reviewed: 8/27/24, 10/1/24, 10/10/24, 12/4/24, and 12/24/24.</p> <p>a. Posted nurse staffing sheet dated 10/1/24 indicated 1 Registered Nurse (RN) and 5 nursing assistants (NAs) were scheduled to work the 11:00 PM to 7:00 AM (night) shift. Review of the schedule for 10/1/24 revealed no RN was worked and 3 NAs worked that night.</p> <p>b. Review of the daily posted nurse staffing sheet dated 10/10/24 indicated 5 NAs were working 7:00 AM-3:00 PM (day) shift. The schedule indicated 7 NAs worked that date. The 3:00 PM-11:00 PM (evening) shift posted nurse staffing sheet indicated 5 1/2 NAs were working and the scheduled showed that only 5 NAs worked that shift. The night shift daily posted nurse staffing sheet indicated 5 NAs were working and the schedule showed that only 3 NAs worked that shift.</p> <p>c. The daily posted nurse staffing sheet dated 12/4/24 indicated 1 Licensed Practical Nurse (LPN) was working the afternoon shift. The schedule indicated 2 LPNs worked that shift.</p> <p>The Scheduler was interviewed on 1/24/25 at 1:07 PM. The Scheduler reported she updated the daily posted staffing sheet during the day and afternoon shift, and the charge nurse was responsible for updating the posted staffing sheet at night. The Scheduler explained she was not making corrections to the posted staffing sheet.</p> <p>The Administrator was interviewed on 1/24/25 at 2:23 PM. The Administrator reported she was not aware the daily posted staffing sheets were not accurately reporting nursing hours and the posted staffing should accurately reflect the facility staffing.</p>		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>37281</p> <p>Based on record review, observations, and staff interviews, the facility failed to cover facial hair for 2 of 2 dietary staff (Cook #1 and Dietary Aide #1) observed working in food production and failed to have necessary supplies to test the chemical level in the sanitizing sink for 3 of 3 observations. This had the potential to affect food served to all the residents in the facility.</p> <p>The findings included:</p> <p>1. The kitchen was observed on 1/21/25 at 9:55 AM. [NAME] #1 was observed to be preparing food without a beard cover. [NAME] #1 had facial hair on his chin that measured more than 1 inch in length.</p> <p>The kitchen was observed on 1/23/25 at 11:45 AM. [NAME] #1 was noted to be serving food for residents. [NAME] #1 was asked about the beard cover and he responded that the kitchen was out of beard covers and the Dietary Manager had reordered the beard covers.</p> <p>Dietary Aide #1 was observed preparing resident meal trays 1/23/25 at 11:45 AM. Dietary Aide #1 had facial hair that measured approximately 1/2 inch on his chin and he did not have a beard cover in place. Dietary Aide #1 reported he was not aware he needed to wear a beard cover.</p> <p>The Dietary Manager was interviewed during the observation, and she reported she would need to reorder beard covers.</p> <p>The kitchen was observed on 1/24/25 at 11:02 AM and [NAME] #1 and Dietary Aide #1 were noted to apply beard covers using hair nets. During the observation, the Dietary Manager was interviewed, and she reported she was not aware beard covers were required to be worn by staff with facial hair.</p> <p>An interview was conducted with the Registered Dietitian on 1/24/25 at 12:15 PM. The Registered Dietitian reported she was not aware beard covers were not being worn by dietary staff with facial hair. The Registered Dietitian explained that any staff member with facial hair should wear a beard cover.</p> <p>The Administrator was interviewed on 1/24/25 at 2:23 PM and she reported all dietary staff with facial hair should wear a beard cover.</p> <p>2. During an observation of the kitchen on 1/21/25 at 9:55 AM, a request was made to check the chemical level in the three-compartment sink. The three-compartment sink was noted to have all three compartments filled with water and dirty dishes were noted to be soaking in the first compartment. The Dietary Manager reported the facility did not have test strips for the three-compartment sink and she was going to place an order. The Dietary Manager reported the facility ran out of test strips over the weekend and it was not reported to her until the morning of Tuesday 1/21/25.</p> <p>(continued on next page)</p>

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 01/24/2025
NAME OF PROVIDER OR SUPPLIER The Laurels of Salisbury		STREET ADDRESS, CITY, STATE, ZIP CODE 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)		
<p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Dietary Aide #2 was interviewed during the observation of the three-compartment sink and she reported she was working the weekend when they ran out of test strips. Dietary Aide #2 explained she was off on 1/20/25 and did not report to the Dietary Manager until 1/21/25. Dietary Aide #2 explained they did not check the chemical level over the weekend.</p> <p>The kitchen was observed on 1/23/25 and another request was made to check the chemical levels in the three-compartment sink. The Dietary Manager reported the test strips had not been delivered. All three compartments were filled with water and dirty dishes were noted soaking in the first compartment.</p> <p>The kitchen was observed on 1/24/25 at 11:02 AM and the Dietary Manager reported the kitchen had received a delivery just before the observation and she had not had the opportunity to look for the test strips.</p> <p>An interview was conducted with the Registered Dietician on 1/24/25 at 12:15 PM. The Registered Dietician reported the chemical supply company came in 2-3 times per month to monitor the chemical levels in the three-compartment sink, but the dietary staff should monitor the chemical levels daily. The Registered Dietician explained the test strips were delivered on 1/24/25 and the chemical level in the sink was acceptable at 200 parts per million.</p> <p>The Administrator was interviewed on 1/24/25 at 2:23 PM and she reported she expected the kitchen to keep test strips in stock.</p>		