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	02/13/2026

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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and resident, staff, Urology Nurse, Nurse Practitioner and Medical Director interviews, the facility failed to schedule a urology appointment for follow up of the suprapubic catheter (a thin, flexible tube inserted through a small incision in the lower abdomen directly into the bladder to drain urine) placement and infection per the physician order for 1 of 2 residents reviewed for catheters (Resident #7).Findings included:A hospital Discharge summary dated [DATE] revealed Resident #7 was in the hospital from [DATE] through 12/8/2025. During this hospital stay Resident #7 was given an active diagnosis of bilateral hydronephrosis (swelling of both kidneys) status post ureteral stent (a small tube inserted into the ureter to facilitate urine flow from the kidney to the bladder). While in the hospital, Resident #7 had placement of a suprapubic catheter and was discharged with the suprapubic catheter in place. The hospital urology consult documentation dated 12/8/2025 for Resident #7 revealed he needed the stents changed out in 4 to 6 months and the 14 French suprapubic catheter tube to be upsized to a 16.Resident #7 was admitted to the facility on [DATE] and had diagnoses that included hydronephrosis with renal and ureteral calculus obstruction (a condition where kidney swelling occurs because a stone is blocking urine flow in the renal pelvis and/or ureter), urinary tract infection (UTI), and presence of urogenital implants (the existence of artificial materials in the urinary or genital organs).A physician's order dated 12/10/2025 indicated Resident #7 had a suprapubic catheter and to maintain as needed for leakage and clogging every shift for urinary obstruction. A Minimum Data Set (MDS) admission assessment dated [DATE] indicated Resident #7 was cognitively intact. The MDS further revealed he was admitted with an indwelling catheter (including suprapubic catheter).Reviewed care plan dated 12/9/2025 for Resident #7 revealed he had the potential for UTIs related to suprapubic catheter in place related to bilateral nephroptosis/bilateral stents and urinary obstruction. The goal for the care plan indicated no evidence of infection. Further review of the care plan revealed an intervention dated 1/12/2026 stating urology appointment for purulent (consisting of pus) drainage around suprapubic site and leakage around penis. A radiology procedure note dated 12/22/2025 for suprapubic change revealed Resident #7 had a successful suprapubic tube exchange from a 14 to a 16-[NAME] retention.A Nurse Practitioner note dated 12/26/25 revealed Resident #7 had a suprapubic catheter in place and leakage was noted around inserted site. The note further revealed to continue urology follow up for catheter/stent management. A Nurse Practitioner note dated 12/30/2025 revealed Resident #7 needed a urology appointment for purulent drainage around suprapubic site, antibiotic started and continued leakage from the penis. Further review of the note indicated infection and inflammatory reaction due to cystostomy (also known as suprapubic) catheter with scant purulent drainage. Started clindamycin (an antibiotic) 300 milligrams by mouth every 6 hours on 12/30/2025. Urology appointment to be scheduled as soon as possible, discussed with scheduler. The Nurse Practitioner wrote a physician (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 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	order on 12/30/25 for a urology consultation and to start antibiotic medication Clindamycin 300mg for 7 days. The Nurse Practitioner transcribed the order and Nurse #1 signed off on the order.The medical record review for Resident #7 from date 12/30/2025 to date 2/12/2026 showed no documented evidence that a urology consultation was scheduled.An interview with Nurse #1 confirmed Resident #7 received antibiotic ordered on 12/30/2025. She confirmed Resident #7 received Clindamycin 300mg capsule every 6 hours for cellulitis to supra-pubic catheter site for 7 days.Record review of the Medication Administration Record (MAR) for December 2025 and January 2026 revealed Resident #7 received the antibiotic medication as prescribed.A telephone interview with the clinic Urology Nurse on 2/12/2026 at 10:12 AM revealed the clinic staff had not seen Resident #7 in the office. The Urology Nurse revealed the physician had seen Resident #7 in the hospital and needed to see Resident #7 back in the office after the upsize of the suprapubic catheter on 12/22/2025. The Urology Nurse indicated Resident #7 did not need the follow up back in the office as documented in the hospital discharge summary from 12/9/2025, until the upsize of the suprapubic catheter was performed and this was done on 12/22/2025. She indicated the follow up visit should have been scheduled for Resident #7 within 30 days after the upsize of the suprapubic catheter. She further revealed Resident #7 needed a follow-up visit in the office as soon as possible for the suprapubic catheter to be changed and the facility had not contacted the office to schedule the appointment since the upsize of the suprapubic.An interview conducted on 2/12/2026 at 10:48 AM with Nurse Aide (NA) #3 indicated she was normally assigned to Resident #7. She indicated Resident #7 had concerns with his suprapubic catheter and on more than 2 to 3 occasions during her shift and she would have to provide incontinent care for him due to the leaking suprapubic catheter. NA #3 stated she had not reported the concerns to the charge nurse because she believed they were already aware.An interview conducted with the Scheduler on 2/12/2026 at 11:00 AM revealed she was not aware of Resident #7's need for a urology consultation ordered by the Nurse Practitioner (NP) on 12/30/2025. She stated she was not aware of the physician order, and no one had informed her of this order. The Scheduler did not recall speaking with the Nurse Practitioner about the appointment needed for Resident #7. The Scheduler stated normally when there was an order written for an appointment someone from nursing would give her the order and let her know. She further revealed she did not get the order for Resident #7.A telephone interview with Nurse Practitioner (NP) on 2/12/2026 at 12:18 PM revealed she wrote the order for a urology consult on 12/30/2025 and the need for this consult to be performed as soon as possible. The NP stated the appointment was needed as soon as possible due to the infection with drainage and leaking around the suprapubic. She stated she was unaware this appointment had not been scheduled for Resident #7. She stated she spoke directly to the Scheduler when she wanted this appointment made on 12/30/2025 and assumed they had made this appointment for Resident #7. The NP further revealed she was concerned Resident #7 had not had a follow up appointment with the urologist.A telephone interview conducted with the Medical Director on 2/12/2026 at 5:48 PM revealed he was unaware the follow up appointment was never scheduled for Resident #7. The Medical Director stated that this appointment should have been escalated due to Resident #7's leaking suprapubic catheter and infected area.During an interview with Resident #7 on 2/10/2026 at 12:10 PM he stated his catheter worked sometimes. He stated at times he would urinate outside of the catheter but denied pain. Observation of the catheter bag was performed, and 100 ccs (cubic centimeters, volume of urine collected) was noted in the catheter drainage bag at 12:12 PM. Observation of the urine color in the catheter bag was pale yellow. Resident #7 stated the staff had emptied the catheter drainage bag earlier in the morning.The Director of Nursing (DON) was interviewed on 2/13/2026 at 9:33 AM. She stated her expectation was that all physician orders were followed and (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #7 should have seen the urologist as per the physician order. The DON stated there was some delay and confusion initially trying to set up an appointment for Resident #7 because the facility was initially told Resident #7 had to see the nephrologist first. She further revealed the Scheduler had attempted to make an appointment for Resident #7 but was given conflicting information from the urology office. The DON believed the Scheduler had been given the information to make the appointment for Resident #7.During an interview with the Administrator on 2/13/2026 at 10:43 AM he stated he expected staff to follow procedures to make appointments for all residents as per the physician order. The Administrator stated the order should have been followed.