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 _____	C 01/24/2025

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THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(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
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 01/21/25 through 01/24/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # MC9Q11.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 01/21/25 through 01/24/25. Event ID # MC9Q11. The following intakes were investigated NC00226178, NC00225982, NC00224332, NC00222692, NC00221408, and NC00216914. 22 of the 22 complaint allegations did not result in deficiency.	F 000		
F 636 SS=D	Comprehensive Assessments & Timing CFR(s): 483.20(b)(1)(2)(i)(iii) §483.20 Resident Assessment The facility must conduct initially and periodically a comprehensive, accurate, standardized reproducible assessment of each resident's functional capacity. §483.20(b) Comprehensive Assessments §483.20(b)(1) Resident Assessment Instrument. A facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history and preferences, using the resident assessment instrument (RAI) specified by CMS. The assessment must include at least the following: (i) Identification and demographic information (ii) Customary routine. (iii) Cognitive patterns. (iv) Communication.	F 636		2/19/25

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

Electronically Signed | 02/19/2025

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F 636	Continued From page 1	F 636		

(v) Vision.
(vi) Mood and behavior patterns.
(vii) Psychological well-being.
(viii) Physical functioning and structural problems.
(ix) Continence.
(x) Disease diagnosis and health conditions.
(xi) Dental and nutritional status.
(xii) Skin Conditions.
(xiii) Activity pursuit.
(xiv) Medications.
(xv) Special treatments and procedures.
(xvi) Discharge planning.
(xvii) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).
(xviii) Documentation of participation in assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and nonlicensed direct care staff members on all shifts.

§483.20(b)(2) When required. Subject to the timeframes prescribed in §413.343(b) of this chapter, a facility must conduct a comprehensive assessment of a resident in accordance with the timeframes specified in paragraphs (b)(2)(i) through (iii) of this section. The timeframes prescribed in §413.343(b) of this chapter do not apply to CAHs.
(i) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)

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F 636	Continued From page 2 (iii)Not less than once every 12 months. This REQUIREMENT is not met as evidenced by: 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). The findings included: Resident #16 was admitted to the facility on 12/7/24. The admission MDS was dated 1/22/25 and was listed as "in progress". 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. 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.	F 636	The facility will continue to complete admission MDS assessments within the required time frame. Resident #16 admission MDS assessment was completed on 1.29.25. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. All current residents were audited by the Regional MDS Coordinator on 2.3.25 to ensure that admission MDS assessments were completed within the required time frame. No negative outcomes were identified relating to these audits. The MDS Coordinator was in-service by the Regional MDS Coordinator on 2.5.25 on the facility policy for completing admission MDS's within the required time frames. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional MDS Coordinator/designee beginning on 2.6.25. The Regional MDS Coordinator/designee will randommly audit 3 admission MDS assessments weekly x12 weeks to ensure that admission MDS assessments are being completed within the required time frame. Variances will be corrected at the time of audit and additional education provided when indicated.	

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F 636	Continued From page 3	F 636	Audit results will be reported to the Administrator weekly for the next 3 months beginning on 2.13.25 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits of admission MDS Assessments and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 2.19.25	
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: 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	F 658	Past noncompliance: no plan of correction required.	

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residents and no issues were identified.

Findings included:

Resident #163 was admitted to the facility on 2/22/2024 with diagnoses of heart failure and respiratory failure.

A significant change Minimum Data Set assessment dated 4/8/2024 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 5/1/2024 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 5/1/2024 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 1/23/2024 at 12:58 pm she stated she did not remember the Medication Error that occurred on 5/1/2024 when she cared for Resident #163. She stated she did

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F 658	Continued From page 5	F 658		

have an in-service education regarding medication administration, and she did remember the facility auditing medication administration with her during 5/2024.

An interview was conducted with Nurse Practitioner #1 on 1/24/2025 at 11:36 am and she stated the medication error that occurred on 5/1/2024 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 1/24/2024 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 6/20/2024.

The facility provided the following corrective action plan with a completion date of 5/3/2024.

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

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medication, Buspirone, (an antianxiety medication) on 5/1/2024 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 5/2/2024. 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 5/1/2024 received 1:1 education on the Six Rights of Medication Administration and verifying resident identity with three identifiers. The education was completed on 5/2/2024.
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 5/2/2024.

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Licensed Nurses and Medication Aides were not allowed to work until the education was completed.

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 5/3/2024. 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 5/2/2024 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: 5/3/2024.

The corrective action plan was validated on

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1/24/25 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 5/1/2024 to 5/2/2024. 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 5/2/2024. 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 5/2/2024 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 5/2/2024 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.

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F 658	Continued From page 9 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 5/3/2024 was validated on 1/24/2025.	F 658		
F 732 SS=B	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name. (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse	F 732		2/19/25

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F 732	Continued From page 10 staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews, the facility failed to accurately report staffing for 3 of 5 daily posted sheets reviewed. The findings included: 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. 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. 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 ½ 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	F 732	The facility will continue to display accurate posted nursing staffing information as compared to the staff schedule/assignment sheets. The posted nursing staffing information from 1.24.25, the date of discovery, was reviewed and corrections made as necessary by the Scheduler. No negative outcome was identified relating to this observation. Subsequent posted nursing staffing information after 1.24.25 has the potential to be affected. Posted Nursing Staffing Information from 1.25.25 through 2.13.25 was reviewed on 2.14.25 by the Administrator to ensure that Posted Nursing Staffing Information is accurate as compared to the Staff Schedule/Assignment Sheets. No negative outcomes were identified relating to these observations. The Scheduling Coordinator and Licensed Nurses will be in-service by the Administrator/designee, no later than	

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F 732	Continued From page 11 working and the schedule showed that only 3 NAs worked that shift. 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. 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. 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.	F 732	2.16.25, on the facility policy for ensuring that Posted Nursing Staffing Information is accurate as compared to the Staff Schedule/Assignment Sheets. A QA monitoring tool will be utilized to ensure ongoing compliance by the AP/Payroll Coordinator beginning on 2.17.25. The AP/Payroll Coordinator will review posted Nursing Staffing Information and Staff Schedules/Assignment Sheets 5x/week x4 weeks then 3x/week x4 weeks then weekly x4 weeks to ensure that Posted Nursing Staffing Information is accurate. Variances will be corrected at the time of the audit and additional education provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues.	
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2)	F 812		2/19/25

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F 812	Continued From page 12 §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: 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. The findings included: 1. The kitchen was observed on 1/21/25 at 9:55 AM. Cook #1 was observed to be preparing food without a beard cover. Cook #1 had facial hair on his chin that measured more than 1 inch in length.	F 812	The facility will continue to ensure that dietary staff working in food production cover facial hair. The facility will continue to ensure necessary supplies are available to test the chemical level in the sanitizing sink. The male dietary employees donned beard restraints at the time of discovery. No negative outcomes were identified relating to the observation. The chemical levels in the three compartment sink were tested on 1.24.25 and were within normal limits. No negative outcome was identified relating to this observation.	

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	345428	A. BUILDING _____ B. WING _____	C 01/24/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SALISBURY	215 LASH DRIVE SALISBURY, NC 28147

(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 812	Continued From page 13 The kitchen was observed on 1/23/25 at 11:45 AM. Cook #1 was noted to be serving food for residents. Cook #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. 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 ½ 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. The Dietary Manager was interviewed during the observation, and she reported she would need to reorder beard covers. The kitchen was observed on 1/24/25 at 11:02 AM and Cook #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. 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. 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. 2. During an observation of the kitchen on	F 812	All dietary staff were in-serviced by the RD and Administrator- on the facility policies for ensuring that dietary staff working in food production cover facial hair and ensuring that necessary supplies are available to test the chemical levels in the three compartment sink. This education will be completed no later than 2.16.25. A QA monitoring tool will be utilized by the Administrator/Designee beginning on 2.17.25 to ensure dietary staff working in food production cover facial hair. The Administrator/designee will randomly observe dietary staff with facial hair 5x/week x4 weeks then 3x/week x4 weeks then weekly x4 weeks to ensure that facial hair is covered. Variances will be corrected at the time of observation and additional education provided when indicated. A QA monitoring tool will be utilized by the Administrator/designee beginning on 2.17.25 to ensure that necessary supplies are available to test the chemical levels in the three compartment sink. The Administrator/Designee will randomly observe the three compartment sanitizing log 5x/week x4 weeks, then 3x's/week x4 weeks, then weekly x4 weeks to ensure that necessary supplies are available to test the chemical levels in the three compartment sink. Variances will be corrected at the time of observation and additional education provided when indicated.	

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F 812	Continued From page 14 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. 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. 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. 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. An interview was conducted with the Registered Dietician on 1/24/25 at 12:15 PM. The Registered Dietician reported the chemical supply	F 812	Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance 2.19.2025	

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F 812	Continued From page 15 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. 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.	F 812		