PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345428	345428 B. WING		02/22/201		
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 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	PREFIX (EACH CORRECTIVE ACTION SH		(X5) COMPLETION DATE	
F 637 SS=D	S483.20(b)(2)(ii) With determines, or should there has been a sign resident's physical or purpose of this section means a major declinates resident's status that itself without further in implementing standar interventions, that has one area of the reside requires interdisciplinate care plan, or both.) This REQUIREMENT by: Based on record revifacility failed to complisignificant change as a fall for 1 of 15 reside comprehensive assess. Findings included: Resident #20 was ad 8/26/2017 with diagnous weakness and vascul Minimum Data Set (M. 11/26/2017 and assessiverely cognitively in one-person assistance well as the use of a reconserved in the resident experienced.	nin 14 days after the facility I have determined, that inficant change in the mental condition. (For in, a "significant change" e or improvement in the will not normally resolve intervention by staff or by ind disease-related clinical is an impact on more than ent's health status, and ary review or revision of the is not met as evidenced ew and staff interviews, the ete a comprehensive sessment on a resident after ents reviewed for esments (Resident #20). mitted to the facility on coses to include heart failure, ar dementia. The quarterly IDS) was completed on essed the resident to be impaired and required the with transfers, mobility, as collator walker for mobility, es assistance with toileting, activities.	F 6	F 637 Comprehensive Assessignificant Change The Laurels of Salisbury wis this submitted plan of corrective actions agreement with either existed agreement with existed agre	shes to have ction stand as obliance. Our before March on of this plan on to nor ence of or leed epared and/or nice with	3/15/18	
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	F	TITLE		(X6) DATE	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

03/13/2018

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

Electronically Signed

program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345428	B. WING _		0:	2/22/2018	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	•		
				215 LASH DRIVE			
THE LAU	RELS OF SALISBURY			SALISBURY, NC 28147			
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F 637		completed on 1/8/2018	F 6	Significant Change. Corrective Action for those	having the		
	assistance with trans the unit, dressing an extensive assistance assistance of one per resident was no long	uire one-person extensive sfers, locomotion on and off d hygiene, and two-person e with toileting and total erson for bathing. The ger able to ambulate with the acture of her upper right arm.		potential to be affected MDS Coordinator reviewed current long-term care resigneeth quarterly or annual I assessment to ensure all o assessments were coded of other issues were identified.	dents□ most MDS ther status correctly. No		
	Occupational Therapy 2/22/2018 at 1:29 PI resident had been or admission on 8/26/2 a rolling walker prior The COTA further reunable to ambulate I non-weightbearing or unable to use the roll the right arm. The C resident was on the	017 and she had walked with to her fall on 12/25/2017. ported the resident was		Systematic Changes Laurel Health Care Compa Clinical Resource Specialis re-educate facility MDS Co Staff, Director of Nursing, a Director of Nursing on prop status assessments on MD interdisciplinary team, led b Nursing, will review all phys times per week in order to significant changes in resid Director of Nursing and MD will initiate Significant Char assessments as identified.	et will cordinator/MDS and Assistant per coding of DSs. Clinical by Director of sician orders 5 identify any dent condition. DS Coordinator		
	coordinator on 2/22/reported the quarter 1/8/2018 was trigger not aware a compresussessment should the fall. The Director of Nurs 2/22/2018 at 1:58 Pl			Monitoring Director of Nursing, Assista Nursing, and/or Regional C Resource Specialist will uti Assurance monitoring tool quarterly and annual asses x 4 weeks. For ongoing co Director of Nursing, Assista Nursing, and/or Regional C Resource Specialist will uti Assurance monitoring tool assessments monthly x 3 r ensure proper assessment	Clinical lize a Quality to review all ssments weekly ompliance, ant Director of Clinical lize the Quality to review 5 months to		

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F 637	at 2:16 PM. He repor	e 2 as interviewed on 2/22/2018 ted it was his expectation atts were completed as	F 63	and immediately notify Administrator a MDS Coordinator of any errors. Continued compliance will be monitore through the facility s Quality Assurance and Process Improvement Plan and Quality Assurance Program for 4 mont Additional education and monitoring w be initiated for any individual concerns	ed ce hs.
F 641 SS=D	resident's status. This REQUIREMEN	of Assessments. st accurately reflect the	F 64	1	3/15/18
	This REQUIREMENT is not met as evidenced by: Based on medical record review and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) assessments for 3 of 15 residents. Resident #112 was coded inaccurately as to not having had a fall, Resident #32 was coded inaccurately as to having received an anticoagulant, and Resident #7 was coded inaccurately as to not receiving hospice services. Findings included: 1. Resident #112 was admitted on 2/9/18 whose cumulative diagnoses included: Heart Failure, abnormal heart rhythm, history of falling, generalized weakness, and dementia. Review of Resident #112's most recent Minimum Data Set (MDS) assessment revealed a comprehensive admission assessment with an Assessment Reference Date (ARD) of 2/16/18. The resident was coded as having had no falls since admission.			F 641 Accuracy of Assessments The Laurels of Salisbury wishes to have this submitted plan of correction stand its written allegation of compliance. Of date of compliance is on or before Mart 15, 2018. Preparation and/or execution of this plant does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and executed to ensure compliance with regulatory requirements. Corrective Action Minimum Data Set (MDS)Coordinator corrected respective MDS Assessment to accurately capture the fall for Reside #112, to remove the anticoagulant cod for Resident #32, and to accurately	as ur ich an d/or ts ent

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F 641	initiated on 2/10/18, r care planned for bein unsteady gait, impair falls. The resident ha initiation date of 2/12 being placed on the swheelchair A review of the resider record (EMR) for Resnurses' note dated 2/revealed the resident at the nurses' station 2:20 PM. The note sresident leaned forway wheelchair onto her blisted was the additions at of the resident's	#112's care plan, which was revealed the resident was ag at risk for falls related to eed mobility, and a history of ad an intervention with an /18 for non-slip material seat of the resident's ent's electronic medical sident #112 revealed a 10/18 and timed 3:41 PM was documented as sitting on 2/10/18 at approximately tated the resident the ard and slid out of her puttocks. The intervention of non-slip material to the wheelchair.	F	capture the Hospice servi provided for Resident #7. Corrective Action for those potential to be affected Director of Nursing and M reviewed fall log for the pato ensure all residents fall accurately captured on reassessments. MDS Coor all residents that were cur aspirin to ensure accurate respective MDS assessm Coordinator reviewed all reurrently receiving Hospic the last 6 months to ensure accurately captured on all assessments. No other is identified. Systematic Changes Laurel Health Care Comp	e having the IDS Coordinator ast three months s were spective MDS dinator reviewed rently prescribed e coding on ents. MDS residents be services within re Hospice was I MDS ssues were		
	at 10:51 AM revealed he was the nurse for Resident #112. The nurse stated the resident had a fall on 2/10/18. The nurse stated he had documented the fall in the resident's nurses' notes. The nurse further stated the intervention put into place after the fall was the addition of non-slip material being placed on the seat of the resident's wheelchair. During an interview conducted with the Director of Nursing (DON) on2/22/18 at 1:45 PM she stated Resident #112 had a fall on 2/10/18 at approximately 2:20 PM. The DON stated the fall was witnessed and documented by Nurse #1. An interview was conducted with the Registered Nurse MDS Coordinator on 2/22/18 at 2:01 PM. The MDS Coordinator stated she had missed.			Clinical Resource Special re-educate facility MDS C Staff, Director of Nursing, Director of Nursing on the assessments in order to e status is correctly coded c assessment. Focused dir provided regarding fall co anticoagulant coding, and services coding. Monitoring Director of Nursing, Assis Nursing, and/or Regional Resource Specialist will u Assurance monitoring too	ist will oordinator/MDS and Assistant accuracy of ensure resident on each MDS rection will be ding, I Hospice tant Director of Clinical tilize a Quality I to review all 5		

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coding the resident's on 2/10/18 on the act ARD of 2/16/18. During an interview of 2:44 PM she stated of MDS assessments to 2/22/18 at 2:26 PM of expectation for the Nocoded correctly. 2. Resident #32 was 10/1/15 and most resident's cumular high blood pressure, murmur, and high chassessment reveale with an ARD of 1/19/2 as having had receive thinner) medication of assessment period. A review of the Medi (MAR) for Resident and 1/13/18 the record of the resident anticoagulant medical materials was concoordinator on 2/21/21/21/21/21/21/21/21/21/21/21/21/21	with the DON on 2/21/18 at it was her expectation for the be coded correctly. with the Administrator on the stated it was his MDS assessments to be so originally admitted on controlly readmitted on 1/12/18. Itative diagnoses included: slow heartbeat, heart colesterol. #32's most recent MDS dia quarterly assessment (18. The resident was coded an anticoagulant (blood each day of the seven day) cation Administration Record #32 from the assessment ough 1/19/18 revealed no at having received an anticoagulant (blood each day of the seven day) cation Administration Record #32 from the assessment ough 1/19/18 revealed no at having received an anticoagulant received an anticoagulant stated she had as having received a daily	F 64	ongoing compliance, Director of Assistant Director of Nursing, an Regional Clinical Resource Specutilize the Quality Assurance motool to review 2 assessments momenths to ensure accuracy of assessments and immediately n Administrator and MDS Coordinatory errors. Continued compliant monitored through the facility Assurance and Process Improve Plan and Quality Assurance Progmonths. Additional education ar	d/or cialist will nitoring onthly x 3 otify ator of ce will be Quality ement gram for 4	
	ROVIDER OR SUPPLIER SUMMARY S' (EACH DEFICIENC REGULATORY OR Continued From page coding the resident's on 2/10/18 on the act ARD of 2/16/18. During an interview of 2/22/18 at 2:26 PM of expectation for the function	RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 coding the resident's fall which had taken place on 2/10/18 on the admission assessment with an ARD of 2/16/18. During an interview with the DON on 2/21/18 at 2:44 PM she stated it was her expectation for the MDS assessments to be coded correctly. During an interview with the Administrator on 2/22/18 at 2:26 PM he stated it was his expectation for the MDS assessments to be coded correctly. 2. Resident #32 was originally admitted on 10/1/15 and most recently readmitted on 1/12/18. The resident's cumulative diagnoses included: high blood pressure, slow heartbeat, heart murmur, and high cholesterol. Review of Resident #32's most recent MDS assessment revealed a quarterly assessment with an ARD of 1/19/18. The resident was coded as having had received an anticoagulant (blood thinner) medication each day of the seven day	RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 4 coding the resident's fall which had taken place on 2/10/18 on the admission assessment with an ARD of 2/16/18. During an interview with the DON on 2/21/18 at 2:44 PM she stated it was her expectation for the MDS assessments to be coded correctly. During an interview with the Administrator on 2/22/18 at 2:26 PM he stated it was his expectation for the MDS assessments to be coded correctly. 2. Resident #32 was originally admitted on 1/12/18. The resident's cumulative diagnoses included: high blood pressure, slow heartbeat, heart murmur, and high cholesterol. Review of Resident #32's most recent MDS assessment revealed a quarterly assessment with an ARD of 1/19/18. The resident was coded as having had received an anticoagulant (blood thinner) medication each day of the seven day assessment period. A review of the Medication Administration Record (MAR) for Resident #32 from the assessment period of 1/13/18 through 1/19/18 revealed no record of the resident having received an anticoagulant medication. An interview was conducted with the MDS Coordinator on 2/21/18 at 11:35. During the interview the MDS Coordinator stated she had coded Resident #32 as having received a daily dose of a 325 milligram (mg) aspirin. Upon reviewing the Resident Assessment Instrument	RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL (EACH CORRECTIVE ACTION SH CROSS-REFERENCE) TO THE OFFICIENCIES (EACH CORRECTIVE ACTION SH CROSS-REFERENCE) TO THE OFFICIENCY COntinued From page 4 coding the resident's fall which had taken place on 2/10/18 on the admission assessment with an ARD of 2/16/18. During an interview with the DON on 2/21/18 at 2.24 PM she stated it was her expectation for the MDS assessments to be coded correctly. During an interview with the Administrator on 2/22/18 at 2:26 PM he stated it was his expectation for the MDS assessments to be coded correctly. 2. Resident #32 was originally admitted on 10/1/15 and most recently readmitted on 11/2/18. The resident's cumulative diagnoses included: high blood pressure, slow heartbeat, heart murmur, and high cholesterol. Review of Resident #32 sm so recent MDS assessment revealed a quarterly assessment with an ARD of 1/19/18. The resident was coded as having had received an anticoagulant (blood thinner) medication each day of the seven day assessment period. A review of the Medication Administration Record (MAR) for Resident #32 from the assessment period of 1/13/18 through 1/19/18 revealed no record of the resident having received an anticoagulant medication. An interview was conducted with the MDS Coordinator on 2/21/18 at 11:35. During the interview the MDS Coordinator stated she had coded Resident #32 as having received an anticoagulant due to her having received an anticoagulant due to her having received an anticoagulant the Resident Assessment Instrument	

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F 641	assessments, the MDS Coordinator stated she		F 6	41			
		assessment incorrectly due assified as an anticoagulant					
		with the DON on 2/21/18 at was her expectation for the be coded correctly.					
	2/22/18 at 2:26 PM hexpectation for the M coded correctly.	DS assessments to be					
	2/15/2017 and readm diagnoses to include	admitted to the facility on itted on 6/21/2017 with non-ST elevation MI, e and gait abnormality.					
	A review of the reside hospice admission fo	ent 's chart revealed a rm dated 7/10/2017.					
		e MDS dated 7/10/2017 was n O 0100K hospice services					
		ated 12/27/2017 was coded 00K hospice services while a					
	7/10/2017 because the hospice on that date further reported she had quarterly assessment coordinator reported	I. She reported she cant change MDS dated he resident was admitted to The MDS coordinator had completed the MDS to f 12/27/2017. The MDS					

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F 641	2/21/2018 at 2:44 PM expectation that MDS correctly. The Administrator wa at 2:26 PM. He report	ng was interviewed on I. She reported it was her is assessments are coded s interviewed on 2/22/2018 ted it was his expectation	F 6	41			
F 732 SS=C	Posted Nurse Staffing CFR(s): 483.35(g)(1): §483.35(g) Nurse Staff483.35(g)(1) Data remust post the followin basis: (i) Facility name. (ii) The current date. (iii) The total number	affing Information. equirements. The facility ag information on a daily and the actual hours worked	F 7	32		3/15/18	
	resident care per shif (A) Registered nurses (B) Licensed practica vocational nurses (as (C) Certified nurse aid (iv) Resident census.	aff directly responsible for t: s. I nurses or licensed defined under State law). des.					
	specified in paragraph daily basis at the beg (ii) Data must be post (A) Clear and readab (B) In a prominent pla residents and visitors §483.35(g)(3) Public	ost the nurse staffing data In (g)(1) of this section on a inning of each shift. Ited as follows: Ile format. Index readily accessible to Index readily accessible to Index readily accessible to Index readily accessible to					
	staffing data. The fac	cility must, upon oral or					

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345428				02	02/22/2018	
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Continued From page	÷ 7	F 73	2			
available to the public	for review at a cost not to					
requirements. The far posted daily nurse stated 18 months, or as requise greater. This REQUIREMENT by: Based on record revifacility failed to correct home census for 97 or reviewed, failed to correct for licensed staff for off sheets reviewed, failed worked for unlicensed staffing sheets review between skilled nursing assisted living staff hot staffing sheets review. Findings included: 1. The Administrator	cility must maintain the affing data for a minimum of uired by State law, whichever is not met as evidenced ews and staff interviews, the city report the skilled nursing out of 97 daily staffing sheets rectly report hours worked 61 out of 97 daily staffing ed to correctly report hours distaff 34 out of 97 daily red, and failed to distinguish and hours for 97 out of 97 daily red.		this submitted plan of correction sits written allegation of compliance date of compliance is on or before 15, 2018. Preparation and/or execution of the does not constitute admission to agreement with either existence of scope and severity of the cited deficiencies. This plan is prepared.	stand as ce. Our re March his plan nor of or		
10:36 AM, with 56 res residents in the assist facility.	sidents in skilled care and 16 ted living section of the		sheet with facility name, current on number and actual hours worked	date, total by		
11:23 AM was 72. The staffing reporting observed on 2/20/201	sheet for 2/20/2018 was 8 at 8:13 AM, and the		responsible for resident care per registered nurses, licensed practi nurses, certified nursing aides, ar resident census. Statement added daily staffing sheet that reads Ce hours are reported for beds licenses.	shift, ical nd ed to new ensus and sed as		
	SUMMARY STA (EACH DEFICIENCY REGULATORY OR LE Continued From page written request, make available to the public exceed the communit §483.35(g)(4) Facility requirements. The fa posted daily nurse sta 18 months, or as requis greater. This REQUIREMENT by: Based on record revifacility failed to correct home census for 97 creviewed, failed to corfor licensed staff for 6 sheets reviewed, failed worked for unlicensed staffing sheets review between skilled nursin assisted living staff ho staffing sheets review Findings included: 1. The Administrato upon entrance to the 10:36 AM, with 56 res residents in the assist facility. The staffing reporting the front lobby. Censul 11:23 AM was 72. The staffing reporting observed on 2/20/2010	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 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 record reviews and staff interviews, the facility failed to correctly report the skilled nursing home census for 97 out of 97 daily staffing sheets reviewed, failed to correctly report hours worked for licensed staff for 61 out of 97 daily staffing sheets reviewed, failed to correctly report hours worked for unlicensed staff 34 out of 97 daily staffing sheets reviewed, and failed to distinguish between skilled nursing home staff hours and assisted living staff hours for 97 out of 97 daily staffing sheets reviewed. Findings included: 1. The Administrator reported the census as 72 upon entrance to the facility on 2/19/2018 at 10:36 AM, with 56 residents in skilled care and 16 residents in the assisted living section of the facility. The staffing reporting sheet for 2/19/2018 was in the front lobby. Census listed for 2/19/2018 at	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 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. 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The staffing reporting sheet for 2/20/2018 was observed on 2/20/2018 at 8:13 AM, and the	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 7 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. 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SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICIENCY MUST BE PECSEDD BY FULL (EACH DEPICIENCY MUST BE PECSEDD BY FULL (EACH DEPICIENCY MUST BE PECSEDD BY FULL (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE COntinued From page 7 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. 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F 732	Continued From page 8		F	732			
	A review of the daily s 19, 2017 through Feb conducted and revea	staff posting from November			Only includes staff directly responsible resident care each shift, and excludes certain other nursing positions within facility.	for	
	were interviewed on 2 DON explained the conight shift nurse and Administrator added to	d Director of Nursing (DON) 2/20/2018 at 4:11 PM. The ensus was completed by a updated during the day. The that the daily staff reporting ed assisted living resident			Corrective Action for those having the potential to be affected Director of Nursing (DON), Assistant Director of Nursing, and Nursing Staff Employees will complete staffing sheet daily with updates made at the start of each shift and as needed.	S	
	The Administrator wa at 2:16 PM and he re the daily staffing sheet nursing census accur living census to be expursing census. 2. A review of the diameter November 19, 2017 the was conducted and reporting was including the conduction of the diameter of the conducted and reporting was including the conducted and reporting t	s interviewed on 2/22/2018 ported his expectations for ets were to have the skilled rately reported and assisted reluded from the skilled aily staff posting from hrough February 19, 2018 evealed the licensed staff ing the DON and Assistant otals for direct resident care			Systematic Changes Administrator and Director of Nursing ware-educate all licensed nursing staff wit regard to information to be included in daily posted nurse staffing information required by F732 which includes facility name, current date, total number and actual hours worked by licensed and unlicensed staff directly responsible for resident care per shift, registered nurse licensed practical nurses, certified nurse aides, and resident census. Only censual labor hours for skilled nursing beds	h as , es, ing us	
	hours provided. An interview was con 2/20/2018 and she re the DON and ADON stotals for direct reside. The Administrator wa time and he reported care hours were accus.	ducted with the DON on ported that she did not know should not be included in the ent care hours. s interviewed at the same it was his expectation the			will be reported. All Adult Care Home information will be excluded from the postings. Monitoring Director of Nursing, Assistant Director of Nursing, and/or other Nurse Managers utilize a Quality Assurance monitoring to review daily staffing sheets daily x 2 weeks, and weekly x 3 months to ensu accuracy with regard to number of staff hours worked, and census reported. A discrepancies will be immediately repo	of will ool re ; ny	

Facility ID: 953441

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION A. BUILDING			SURVEY	
		345428	B. WING _			02/	/22/2018
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 215 LASH DRIVE SALISBURY, NC 28147			
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F 732	reporting was calcular. An interview was con 2/20/2018 and she rehours had not include days and miscalculation. The Administrator was time and he reported care hours were accurate. 4. A review of the discovered that the November 19, 2017 the was conducted and research.	ducted with the DON on ported that she thought the d orienting staff on some on on other days. Is interviewed at the same it was his expectation the rately reported.	F	732	to Administrator. Continued compliance will be monitored through the facility so Quality Assurance and Process Improvement Plan and Quality Assurance Program for 3 months. Additional education and monitoring will be initiate for any identified concerns.	nce	
F 812 SS=F	residents. An interview was con 2/20/2018 and she re aware the hours prov resident should not be posting. The Administrator wa time and he reported care hours were accurate food Procurement, St CFR(s): 483.60(i)(1)(2) §483.60(i) Food safet The facility must - §483.60(i)(1) - Procurapproved or consider state or local authoriti (i) This may include for	ducted with the DON on ported that she was not ided for the assisted living a included on the daily staff as interviewed at the same it was his expectation the rately reported. ore/Prepare/Serve-Sanitary 2) y requirements. re food from sources ed satisfactory by federal,	F	312			3/15/18

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIF	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED		
		345428	B. WING		02/22/2018	
	ROVIDER OR SUPPLIER	,		STREET ADDRESS, CITY, STATE, ZIP CODE 215 LASH DRIVE SALISBURY, NC 28147	,	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PREFIX (EACH CORRECTIVE ACTION SHOU		(X5) COMPLETION DATE
F 812	facilities from using pardens, subject to consider the safe growing and food (iii) This provision do from consuming food §483.60(i)(2) - Store, serve food in accordate standards for food set This REQUIREMENT by: Based on observation facility failed to date addiscovered in the mill walk in cooler, and the of two observations. clean and fresh water table. Findings Included: 1. An observation of 2/19/18 at 10:07 AM undated and unlabeled and container of liquid was cooler. The Dietary I was nectar thickened by An opened and macaroni and an open noodles were both dic. An undated and containing six hard be containing 12 undated	ulations. es not prohibit or prevent roduce grown in facility ompliance with applicable d-handling practices. es not preclude residents s not procured by the facility. prepare, distribute and ance with professional ervice safety. T is not met as evidenced an and staff interviews the and label multiple items a cooler, the stock room, the are walk in freezer during one The facility failed to maintain ar in 5 of 5 bays of the steam the kitchen conducted on revealed the following and items: unlabeled clear plastic as discovered in the milk Manager (DM) reported it at tea. undated bag of elbow and undated bag of egg scovered in the stock room. unlabeled plastic bag oiled eggs and a tray d and unlabeled plastic	F 8 ²	F 812 Food Procurement, Store/Prepare/Serve-Sanitary The Laurels of Salisbury wishes to this submitted plan of correction sits written allegation of compliance date of compliance is on or before 15, 2018. Preparation and/or execution of the does not constitute admission to ragreement with either existence of scope and severity of the cited deficiencies. This plan is prepare executed to ensure compliance with regulatory requirements. Corrective Action The container of nectar thickened bag of elbow macaroni, the bag of noodles, the plastic bag of six har eggs, the tray of 12 single use plate souffle cups with apple sauce, and	tand as e. Our e March his plan hor of or d and/or ith tea, the f egg d boiled stic d the	
	single use plastic sou were discovered in the	ıfflé cups with apple sauce		single frozen pizza were all discar or before 2/22/18. Steam table ba all drained and cleaned and refille	ded on ays were	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345428	B. WING _	B. WING		02/22/2018	
	ROVIDER OR SUPPLIER			21	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LASH DRIVE ALISBURY, NC 28147		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 812	frozen pizza was disc freezer. 2. Further observation conducted on 2/19/18 observation revealed were observed to have be cloudy and had vise. An interview was connumber Manager (DM) on 2/10 stated the steam table once per week, on Susteam table water have Sunday, 2/18/18, due power outage. The Esteam table did appears sediment and needed. An interview was connumber 2/22/18 at 11:00 AM. expectation for opened and labeled. The DM expectation for the water in cloudy and/or had vise. During an interview of PM the Administrator further is steam table water to clean-fresh water round.	approximately 6 inch wide, covered in the walk in an of the kitchen was at 10:07 AM. The further five of five steam table bays are water which appeared to sible sediment in the water. ducted with the Dietary 9/18 at 10:07 AM. The DM are water was usually changed unday. The DM stated the donot been changed on to the facility having had a bM stated the water in the fact cloudy and have visible at to clean water. ducted with the DM on The DM stated it was here at food items to be dated at further stated it was here atter in the steam table bins clean-fresh water routinely in the steam table appeared ible sediment in it. conducted on 2/22/18 at 3:10 stated it was his expectation and dated and labeled. The stated it was expectation for	F	312	clean water on 2/19/18. Corrective Action for those having the potential to be affected Dietary Manager inspected all other for storage areas in the facility and found other items stored improperly. Systematic Changes Dietary Manager and Assistant Directo Nursing will utilize Relias Learning Training computer module titled Safe Food Handling to educate all Dietary Department employees with regard to storing, preparing, distributing and service in accordance with professional standards for food service safety. Additionally, Kitchen Daily Cleaning list was updated to include steam table babeing drained and cleaned after evenimeal and as needed, and inspected (a drained and cleaned as needed) prior to morning meal. Monitoring Dietary Manager and/or Cook(s) will ut a Quality Assurance monitoring tool to review all food storage areas and steam table bays daily x 2 weeks, and weekly months to ensure compliance with all standards. Any issues will be immediate reported to Administrator. Continued compliance will be monitored through the facility Quality Assurance and Proceed Improvement Plan and Quality Assurance Program and for 3 months. Additional education and monitoring will be initiated for any identified concerns.	r of tys ng nd to illize m x x 3 ttely he ess nce	

PRINTED: 05/14/2018 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

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NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SALISBURY				2	TREET ADDRESS, CITY, STATE, ZIP CODE 15 LASH DRIVE SALISBURY, NC 28147		
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F 865 F 865 SS=D	Continued From page 12 QAPI Prgm/Plan, Disclosure/Good Faith Attmpt		F	865	F 865 QAPI Program/Plan, Disclosure/Good Faith Attempt The Laurels of Salisbury wishes to hav this submitted plan of correction stand its written allegation of compliance. Ou	e as ıг	3/15/18
	change and Minimum assessment accuracy recited again on the confiduring sequential fed showed a pattern of t	ssments after a significant			date of compliance is on or before Man 15, 2018. Preparation and/or execution of this pla does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and executed to ensure compliance with regulatory requirements.	an	

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F 865	Continued From page	e 13	F 8	365			
	on a resident after a freviewed for compreh (Resident #20). In accurately code the Massessments for 3 of #112 was coded inaccu a fall, Resident #32 whaving received an air #7 was coded inaccu hospice services. During the recertificate facility was cited for fasignificant change in 32 sampled residents accurately code an air Minimum Data Set (Mathat a resident was ta of 5 sampled resident medications. An interview was con Administrator on 2/22 Administrator stated to Assurance (QA) Componsisted of the Admit (DON), Assistant Director, Reference was coffice Management of the Mathata Componsion of the Admit (DON), Assistant Director, Reference was coffice Management of the Mathata Componsion of the Mathata Componsion of the Mathata Componsion of the Mathata Componsion of the Admit (DON), Assistant Director, Reference was confident of the Mathata Componsion of the Ma	ord review and staff failed to complete a ficant change assessment fall for 1 of 15 residents mensive assessments didition the facility failed to Minimum Data Set (MDS) 15 residents. Resident curately as to not having had was coded inaccurately as to nticoagulant, and Resident rately as to not receiving tion survey of 2/9/17 the failing to complete a status assessment for 2 of and the facility failed to mulal comprehensive MDS) assessment to reflect sking an antipsychotic for 1 ts reviewed for unnecessary ducted with the M18 at 3:10 PM. The fine facility had a Quality mittee. The QA Committee finistrator, Director of Nursing factor of Nursing (ADON), mabilitation Manager, fager, Medical		Corrective Action Minimum Data Set (MDS corrected Resident #20 Assessment originally co 1/8/2018 to accurately co Significant Change. MD corrected respective MDS to accurately capture the #112, to remove the antic for Resident #32, and to a capture the Hospice serv provided for Resident #7. Corrective Action for those potential to be affected MDS Coordinator reviewe current long-term care re- recent quarterly or annual assessments were coded other issues were identific. Nursing (DON)and MDS reviewed fall log for the p to ensure all residents fal accurately captured on re- assessments. MDS Coo all residents that were cu aspirin to ensure accurate respective MDS assessm Coordinator reviewed all currently receiving Hospic within the last 6 months to Hospice was accurately of MDS assessments. No of identified.	s Quarterly mpleted on ode it as a de it as a de Coordinator S Assessments fall for Resident coagulant coding accurately ices being se having the ed all other sidents most al MDS other status d correctly. No ed. Director of Coordinator coast three months alls were espective MDS redinator reviewed rrently prescribed e coding on nents. MDS residents ce services and o ensure captured on all		
		ply Manager, Maintenance		Systematic Changes Laurel Health Care Comp	oanv⊡s Regional		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED			
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F 865	Minimum Data Set (M Housekeeping Director Administrator stated to monthly and discussed had put into place a C Improvement program. The Administrator furth deficient practices from which ended on 2/9/1 subsequent monthly C QA process there were place regarding MDS significant change assistionals were reviewed comeetings for 3-6 mondetermined the issue	IDS) Coordinator, or, and the Pharmacist. The the QA Committee met and identified deficiencies and Quality Assurance Process of as part of the QA process. The stated the identified of the recertification survey of had been reviewed during QA meetings. As part of the remonitoring tools put into accuracy and initiating of sessments. The monitoring during the monthly QA the and it had been had been resolved and need for review in the QA	F	re-edu Staff, Direct status Clinic Direct physic order reside and M Signiff identification also r Coord Nursin on the to ensure coding. Admin will ed Proce on the and p Proce facility education concern action.		s in y□s will sing er g licy and d by s, sid	

The state of the s		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	TIPLE CONSTRUCTION NG		(X3) DATE SURVEY COMPLETED		
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F 865	Continued From page	e 15	F8	Resource Specialist will utilize Assurance monitoring tool to requarterly and annual assessm x 4 weeks to ensure all resider significant change have correst MDS assessments coded as songoing compliance, Director of Assistant Director of Nursing, a Regional Clinical Resource Sputilize the Quality Assurance in tool to review 5 assessments in months to ensure proper assessare coded and immediately not Administrator and MDS Coord any errors. Continued compliate monitored through the facility assurance and Process Improoper Plan and Quality Assurance Plan and Quality Assurance Plan and Quality Assurance mouto review 5 assessments per with the facility and for review 5 assessments per with the facility and for Regional Clinical Resource Specialist will utilize the Quality Moministrator and MDS Coord and the facility and for t	review all sents week and with a sponding such. For of Nursing and/or pecialist with an another system of the second of the seco	e f 4 g, iiii sol		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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F 865	Continued From page	. 16	F 86	The facility s Quality Assurance Committee, as part of the facility Quality Assurance and Process Improvement Plan, will re-evalua monthly monitoring results after Additional education and monito be initiated for any identified con	dete the 4 months.		