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 01/25/2019

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

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E 000	Initial Comments An unannounced Recertification survey was conducted on 01/22/19 through 01/25/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID #JVFE11.	E 000		
F 000	INITIAL COMMENTS No deficiencies were cited as a result of an onsite complaint investigation of 1/22/19 through 1/25/19. Event ID #JVFE11.	F 000		
F 604 SS=D	Right to be Free from Physical Restraints CFR(s): 483.10(e)(1), 483.12(a)(2) §483.10(e) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: §483.10(e)(1) The right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms, consistent with §483.12(a)(2). §483.12 The resident has the right to be free from abuse, neglect, misappropriation of resident property, and exploitation as defined in this subpart. This includes but is not limited to freedom from corporal punishment, involuntary seclusion and any physical or chemical restraint not required to treat the resident's medical symptoms. §483.12(a) The facility must- §483.12(a)(2) Ensure that the resident is free from physical or chemical restraints imposed for purposes of discipline or convenience and that	F 604		2/21/19

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

Electronically Signed | 02/14/2019

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F 604	Continued From page 1 are not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints. This REQUIREMENT is not met as evidenced by: Based on observations, staff interviews and record review, the facility failed to specify the medical symptom to be treated with the use of a physical restraint and facility failed to assess for the least restrictive physical restraint for 1 (Resident #26) of 1 resident reviewed for a physical restraint. The findings included: Resident #26 was originally admitted to the facility on 4/22/17 and was most recently readmitted on 2/15/18. The resident's cumulative diagnoses included: Dementia and generalized weakness. Review of Resident #26's cumulative physician orders revealed an order dated 2/19/18 for a self-release belt to be applied to the resident's wheelchair, every shift, while out of bed, for safety as tolerated. Further review of the order revealed the order continued and read the self-release belt was to be used on the resident every shift and was to be released every shift when the resident was out of bed. The note further stated the device was to be used as tolerated by the resident. The order did not include the medical symptom to be treated with the use of the device and there was no documented evidence of an assessment for the least restrictive device. A review was completed of a document named	F 604	The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before February 21, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Physician Order for self-release lap belt for Resident #26 was updated to specify treatment of medical symptoms posterior pelvic tilt and abnormal posture. Occupational Therapist evaluated Resident #26 for positioning alternatives to self-release lap belt. Through treatment by Occupational Therapist and Certified Occupational Therapist Assistants, Resident #26's self-release lap belt was removed. Resident #26 was previously evaluated and treated for positioning alternatives to self-release lap belt in October 2018. Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC)	

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F 604	Continued From page 2 the Pre-Restraint Intervention Evaluation, dated 2/15/18, for Resident #26, completed by the Assistant Director of Nurses (ADON). The review revealed the resident was documented as not understanding safety with standing/transfers, was alert, had poor decision making, long and short-term memory deficits, was only oriented to person, and was always not aware of safety risk during the day and during the night. The evaluation documented not all interventions had been attempted through the therapy screening/evaluation due to not all interventions addressed the resident's specific needs. The device put into place at the time of the evaluation was an alarming self-release lap belt to the wheelchair while the resident was out of bed as tolerated. Further review of the evaluation revealed documentation the resident was unable to remove the lap belt independently and consistently. The device was categorized as an enabler for the evaluation; the evaluation advised to document the reason for use and to update the care plan. A review was completed of the Treatment Administration Record (TAR) for January for Resident #26 revealed the device was signed off as having been applied to the resident daily from January 1, 2019 through January 25, 2019. Review of Resident #26's Minimum Data Set (MDS) assessments revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/2/19. Review of the assessment revealed the resident was coded as having had severe cognitive impairment, required extensive assistance of 1-2 people for all Activities of Daily Living (ADLs) except for bathing which was total assist, was always incontinent of both bowel and	F 604	reviewed all other residents. No other residents were noted to have self-release lap belts in use or ordered for their self-propelled wheelchairs. ADON/SDC and Rehabilitation Manager will re-educate nursing and therapy staff with regard to physical restraints with specific focus given to specifying medical symptoms to be treated with the use of a physical restraint and assessment before initiating device and ongoing while device is in use. ADON/SDC will utilize a Quality Assurance monitoring tool to review all residents with self-release lap belt weekly x 4 weeks. Facility□s interdisciplinary team will review physician orders 5 times per week in Clinical meeting to ensure documentation of medical symptoms being treated and that proper evaluation(s) were completed prior to initiating self-release lap belt. For ongoing compliance, all residents with self-release lap belts will be reviewed at least monthly by facility□s Behavior Management team. Residents will be referred to therapy as needed for alternative device evaluations. Additionally, Physical Therapist or Occupational Therapist will screen all residents at least quarterly and evaluate and treat any residents with self-release lap belts as needed. ADON/SDC and/or interdisciplinary team will immediately notify Administrator, Director of Nursing (DON), and MDS Coordinator of any issues or concerns. Continued compliance will be monitored through the	

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F 604	Continued From page 3 bladder, unable to move from a seated to a standing position without stabilization assistance from a staff member, and was not coded as having had a restraint of any kind, including a trunk restraint. A review was completed of Resident #26's care plan, which was most recently reviewed after the quarterly MDS assessment dated 1/2/19. The review revealed the resident had an identified need of having required assistance with ADLs related to impaired cognition and impaired mobility. A listed intervention, dated 5/10/18, was for the resident to have had a self-release lap belt to her wheelchair as an enabler. The resident also had an identified need of having been at risk for fall related injury related to impaired mobility and impaired cognition. An intervention listed for the need of falls was for the resident to have had a quick release seat belt when in the wheelchair to act as an enabler, which was dated 5/8/18. A review was completed of a document named Physical Device Evaluation-V5, dated 1/24/19, and timed 5:29 PM for Resident #26. The evaluation was completed almost a year after the Pre-Restraint Intervention Evaluation which was completed on 2/15/18. The review revealed the resident had been evaluated for three different types of devices, a self-releasing belt, a concave/contour mattress, and the resident's bed was against the wall. In addition, the resident was also documented as having had one half side-rail up on the bed. The self-releasing belt was documented as having met the criteria of having been an enabler due to the device having only met one of three criterium which was it was attached or adjacent to the resident. The documented reasons for the self-release seat belt	F 604	facility□s Quality Assurance and Process Improvement Program for 4 months. Additional education and monitoring will be initiated as needed.	

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F 604	Continued From page 4	F 604		

was for repositioning/support and safety awareness. The evaluation was completed by Nurse #1.

An observation was conducted of Resident #26 on 1/22/19 at 3:51 PM. The resident was sitting in a wheelchair at the nurses' station. The resident was observed to have a click type lap belt on her which appeared to have been affixed to the wheelchair she was sitting in. The resident was unable to unbuckle the seat belt from her lap upon request and responded with speech which was unintelligible. Despite Further requests the resident was unable to release the lap belt.

A second observation was conducted of Resident #26 on 1/23/19 at approximately 2:15 PM. The resident was observed sitting at the nurses' station in a wheelchair with a click type lap belt on her which appeared to have been affixed to the wheelchair she was sitting in. The resident was unable to unclick the lap belt upon request despite multiple attempts to communicate to the resident.

A third and continuous observation was conducted of Resident #26 on 1/25/19 from 9:06 AM to 9:35 AM. The resident was observed sitting at the dining room entrance door in the hallway. The resident was observed sitting in a wheelchair with a click type lap belt on her which appeared to have been affixed to the wheelchair she was sitting in. The resident was unable to unclick the lap belt upon request despite multiple attempts to communicate to the resident from multiple staff members including the Director of Nursing (DON).

An interview was conducted on 1/25/19 at 9:24

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F 604	Continued From page 5	F 604		

AM with the Rehabilitation Manager (RM) and the Certified Occupational Therapist (COTA). The RM stated the resident was unable to remove the lap belt on demand, but she had seen the resident remove the lap belt periodically on her own. The RM stated the resident had attempted to stand in the past, and she had scooted forward in her wheelchair in the past. The RM stated the last time she had observed the resident undue the lap belt was in October 2018 and it was not on command, the RM further stated due to the resident's cognitive loss the resident had little ability to follow commands. The COTA and RM stated they did not view the seat belt as a restraint because the device did not limit the resident in any way.

An interview was conducted on 1/25/19 at 10:10 AM with the ADON and the ADON stated she had completed the February 2018 evaluation for Resident #26 and the lap belt was not considered a restraint at the time of the evaluation.

An interview was conducted with the DON and the Assistant Director of Nursing (ADON) on 1/25/19 at 9:35 AM. The DON stated the resident had on a self-release lap belt. The DON stated the definition of a self-release lap belt would be a lap belt the resident could remove themselves. The DON and the ADON stated they had not observed the resident releasing the self-release lap belt. The DON stated the resident had had a Pre-Restraint Physical Device Evaluation. The DON reviewed the evaluation form and stated the type of device was a self-releasing lap belt, the device was to enable and increase independence, enhance ability, and the resident was still able to participate in activities. The DON stated the device was in place for the resident's

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F 604	Continued From page 6 safety, the device did not restrict mobility, movement, freedom, and she did not believe the device was a restraint. The DON stated there was not a frequency at which residents who had an intervention, like the lap belt, were re-evaluated for the appropriateness of the intervention. During an interview conducted with the Administrator on 1/25/19 at 1:57 PM the Administrator stated Resident #26 had been witnessed by himself and other staff releasing the lap belt and due to the resident having had the ability to remove the lap belt on her own, it was a device which worked best for the resident.	F 604		
F 641 SS=D	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. 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 2 of 18 residents. Resident #42 was coded inaccurately as to not having received nutrition all seven days during the assessment period and Resident #51 was coded inaccurately as to not having received an antianxiety and was also coded inaccurately as to having received an antipsychotic. Findings included: 1. Resident #42 was originally admitted on 7/1/17 and was most recently admitted on 3/26/18. The	F 641	The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before February 18, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Minimum Data Set (MDS) Coordinator	2/18/19

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F 641	Continued From page 7 resident's cumulative diagnoses included: Stroke, dysphagia (difficulty swallowing), and presence of a feeding tube. Review of Resident #42's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/10/19. The resident was coded as having had received assistance with eating, which was to include nourishment by other means such as a feeding tube, only once or twice during the seven-day assessment period. The resident was coded as having received 51% or more of her total caloric intake and more than 500 cubic centimeters (ccs) per day via a feeding tube during the assessment period. A review of Resident #42's care plan, which was reviewed after the 1/10/19, revealed the resident had an identified need of having been unable to tolerate nutritionally adequate food and fluids orally resulting in the need for tube feeding via a gastrostomy tube. Review of Resident #42's Medication Administration Record (MAR) revealed the resident was documented as having had received nutritional supplement via the feeding tube at least twice a day during the assessment period from 1/4/19 through 1/10/19. An interview was conducted with the Registered Nurse MDS Coordinator on 1/25/19 at 11:47 AM. The MDS Coordinator stated she had inaccurately coded Resident #42's quarterly MDS assessment with an ARD of 1/10/19 and the resident should have been coded as having had received total assistance daily for eating during the assessment period.	F 641	corrected respective MDS assessments to accurately capture the nutritional intake for Resident #42 and accurately capture the use of antianxiety vs. antipsychotic for Resident # 51. MDS Coordinator reviewed all other residents with feeding tubes most recent MDS Assessment to ensure accurate coding of nutritional intake. MDS Coordinator also reviewed all other residents with physician orders for antianxiety medications to ensure antianxiety medications were accurately coded on most recent MDS Assessment. No other issues were identified. Laurel Health Care Company s Regional Clinical Resource Specialist will re-educate facility MDS Coordinator, Director of Nursing (DON), Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) on the accuracy of assessments in order to ensure resident status is correctly coded on each MDS assessment. Focused direction will be provided regarding coding nutritional intake of residents with feeding tubes and coding of residents receiving antianxiety medications. ADON/SDC and/or Regional Clinical Resource Specialist will utilize a Quality Assurance monitoring tool to review all residents with feeding tubes most recent MDS assessments weekly x 4 weeks to ensure accurate coding of nutritional intake. ADON/SDC and/or Regional Clinical Resource Specialist will also	

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F 641	Continued From page 8 During an interview with the Administrator on 1/25/19 at 1:57 PM he stated it was his expectation for the MDS assessments to be coded accurately. 2. Resident #51 was originally admitted on 5/27/17 and most recently readmitted on 7/17/17. The resident's cumulative diagnoses included: Dementia and anxiety. Review of Resident #51's most recent MDS assessment revealed a quarterly assessment with an ARD of 1/14/18. The resident was coded as having had received an antipsychotic each day of the seven-day assessment period and was coded as not having received antianxiety medication. A review was completed of the Medication Administration Record (MAR) for Resident #51 from the assessment period of 1/8/19 through 1/14/19. The review revealed no record of the resident having received antipsychotic medication and the resident had received antianxiety medication (clonazepam) each day of the assessment period. An interview was conducted with the Registered Nurse MDS Coordinator on 1/25/19 at 11:55 AM. The MDS Coordinator stated she had inaccurately coded the Resident #51's quarterly MDS assessment with an ARD of 1/14/19. She stated she had inadvertently coded the resident as having had received and an antipsychotic each day during the assessment period and had meant to code the resident as having had received an antianxiety medication each day during the assessment period.	F 641	utilize a Quality Assurance monitoring tool to review all residents with physician orders for antianxiety medications most recent MDS assessment weekly x 4 weeks to ensure accurate coding of antianxiety usage. For ongoing compliance, ADON/SDC and/or Regional Clinical Resource Specialist will review 2 assessment monthly x 3 months to ensure accuracy and immediately notify Administrator, DON, and MDS Coordinator of any errors or concerns. Continued compliance will be monitored through the facility s Quality Assurance and Process Improvement Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 641	Continued From page 9 During an interview with the Administrator on 1/25/19 at 1:57 PM he stated it was his expectation for the MDS assessments to be coded accurately.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes.	F 656		2/18/19

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F 656	Continued From page 10 (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to implement a care plan addressing the use of psychotropic medications, including an antidepressant medication and an antianxiety medication, for one of five residents reviewed for unnecessary medication review (Resident #51). Resident #51 was originally admitted on 5/27/17 and most recently readmitted on 7/17/17. The resident's cumulative diagnoses included: Dementia, depression, and anxiety. Review of Resident #51's most recent MDS assessment revealed a quarterly assessment with an ARD of 1/14/18. The resident was coded as having had received an antipsychotic each day of the seven-day assessment period and was coded as not having received antianxiety medication. The resident was also coded as having had received antidepressant medication each day of the seven-day assessment period. A review was completed Resident #51's current physician's orders on 1/25/19. The review revealed the resident had physician's orders for mirtazapine (an antidepressant medication), 30 milligrams (mg), one tablet, orally, once a day, at	F 656	The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before February 18, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Minimum Data Set (MDS) Coordinator created a care plan addressing use of psychotropic medications for Resident #51. MDS Coordinator reviewed all other residents with physician orders for psychotropic medications to ensure a care plan addressing the use of these medications was in place. No other issues were noted. Laurel Health Care Company□s Regional	

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F 656	Continued From page 11 bedtime for depression/anxiety. In addition, the resident had a physician's order for clonazepam (an antianxiety medication), 0.5 mg, one tablet, orally, twice a day, for anxiety. There were no orders discovered for an antipsychotic medication. A review was completed of the Medication Administration Record (MAR) for Resident #51 from the assessment period of 1/1/18 through 1/23/18. The review revealed no record of the resident having received antipsychotic medication. The resident was documented as having had received antianxiety medication (clonazepam) and antidepressant medication (mirtazapine) each of days which were reviewed. A review was completed of Resident #51's care plan which had been most recently updated on 1/3/19. Review of the care plan did not reveal an identified need regarding the use of antidepressant and antianxiety medications nor were antidepressant and antianxiety medications addressed as an intervention. An interview was conducted with the Registered Nurse MDS Coordinator on 1/25/19 at 11:55 AM. The MDS Coordinator stated she had inaccurately coded Resident #51's quarterly MDS assessment with an ARD of 1/14/19. She stated she had inadvertently coded the resident as having had received and an antipsychotic each day during the assessment period and had meant to code the resident as having had received an antianxiety medication each day during the assessment period. The MDS Coordinator further stated the resident had been receiving antianxiety medication and antidepressant medication. The MDS Coordinator stated the	F 656	Clinical Resource Specialist will re-educate MDS Coordinator, Director of Nursing (DON), and Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) with regard to ensuring every resident taking psychotropic medications has a care plan addressing those medications and their potential side effects. ADON/SDC and/or Regional Clinical Resource Specialist will utilize a Quality Assurance monitoring tool to review all residents with physician orders for psychotropic medications weekly x 4weeks to ensure a care plan exits for each resident that address psychotropic medications and their potential side effects. To ensure ongoing compliance, ADON/SDC and/or Regional Clinical Resource Specialist will review the care plans of 2 residents with physician orders for psychotropic medications monthly x 3 months to ensure medications and side effects are addressed. ADON/SDC and/or Regional Clinical Resource Specialist will immediately notify Administrator, DON, and MDS Coordinator of any concerns. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 656	Continued From page 12 resident's use of psychotropic medications, including the anti-depressant medication, the antianxiety medication, and their side-effects should have been addressed in the resident's care plan. During an interview with the Administrator on 1/25/19 at 1:57 PM he stated it was his expectation for psychotropic medications and their potential side effects to be addressed in the care plan.	F 656		
F 693 SS=D	Tube Feeding Mgmt/Restore Eating Skills CFR(s): 483.25(g)(4)(5) §483.25(g)(4)-(5) Enteral Nutrition (Includes naso-gastric and gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on a resident's comprehensive assessment, the facility must ensure that a resident- §483.25(g)(4) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident's clinical condition demonstrates that enteral feeding was clinically indicated and consented to by the resident; and §483.25(g)(5) A resident who is fed by enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers. This REQUIREMENT is not met as evidenced by:	F 693		2/18/19

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F 693	Continued From page 13 Based on observation and staff interviews, the facility failed to store the piston and the syringe, separated, for one of one resident reviewed for tube feeding (Resident #42). Findings included: 1. Resident #42 was originally admitted on 7/1/17 and was most recently admitted on 3/26/18. The resident's cumulative diagnoses included: Stroke, dysphagia (difficulty swallowing), and presence of a feeding tube. Review of Resident #42's most recent Minimum Data Set (MDS) assessment revealed a quarterly assessment with an Assessment Reference Date (ARD) of 1/10/19. The resident was coded as having had a feeding tube and had received 51% or more of her total caloric intake and more than 500 cubic centimeters (ccs) per day via a feeding tube during the assessment period. An observation conducted on 1/22/19 at 3:40 PM revealed a clear plastic bag hanging on an intravenous (IV) pole at resident #42's bedside. Inside the clear plastic bag, a 2-ounce syringe was observed with the plunger fully depressed into the barrel of the 2-ounce syringe. Visible droplets of moisture were observed in the tip of the syringe. An observation conducted on 1/23/19 at 2:42 PM revealed a clear plastic bag hanging on an intravenous (IV) pole at resident #42's bedside. Inside the clear plastic bag, a 2-ounce syringe was observed with the plunger fully depressed into the barrel of the 2-ounce syringe. Visible droplets of moisture were observed in the tip of the syringe. Nurse #4 was observed to have	F 693	The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before February 18, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. The nurse assigned to Resident # 42 removed and discarded the feeding tube syringe that was incorrectly stored. Assistant Director of Nursing/Staff Development Coordinator (ADON/SDC) reviewed all residents with physician orders for tube feedings to ensure proper storage of the piston and syringe. No other issues were noted. ADON/SDC will re-educate all licensed nursing staff regarding the care of enteral feeding syringes, with emphasis on the storage of the device with the piston separated from the syringe. ADON/SDC will utilize a Quality Assurance monitoring tool to review all residents with physician orders for tube feedings to ensure proper storage of syringe. The monitoring tool will be used 5 times per week for 2 weeks and then weekly x 6 weeks. ADON/SDC will immediately notify Administrator and	

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F 693	Continued From page 14 removed the syringe from the clear plastic bag and then use the syringe on the feeding tube to check placement. An observation conducted on 1/24/19 at 2:53 PM revealed a clear plastic bag hanging on an intravenous (IV) pole at resident #42's bedside. Inside the clear plastic bag, a 2-ounce syringe was observed with the plunger fully depressed into the barrel of the 2-ounce syringe. Visible droplets of moisture were observed in the tip of the syringe. An interview was conducted with Nurse #4 on 1/25/19 at 10:28 AM. The nurse stated she had been assigned to Resident #42 during the day shift (from approximately 7:00 AM to 3:00 PM) on 1/22/19, 1/23/19, and 1/24/19. The nurse stated she did store the plunger, inside the barrel of the syringe, in the bag hanging on the IV pole. The nurse stated after she had was finished utilizing the syringe she rinsed with syringe with water, dried the syringe with paper towels, inserted the plunger in the barrel of the syringe, and then placed the 2-ounce syringe into the plastic bag with the plunger depressed into the barrel of the syringe. The nurse stated the syringe should not be placed returned to the bag or placed into the bag if the syringe is wet or has any moisture. The nurse stated she utilized the 2-ounce syringe to check placement of the feeding tube for Resident #42 and to administer medications via the feeding tube. A second interview was conducted with Nurse #4 on 1/25/19 at approximately 11:00 AM. The nurse stated the plunger should be removed from the barrel of the syringe and then placed in the bag separately.	F 693	Director of Nursing (DON) of any concerns. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 693	Continued From page 15 During an interview with the Director of Nursing on 1/25/19 at approximately 2:00 PM she stated it was her expectation for the plunger and barrel of the 2-ounce syringe be separated when stored in the clear plastic bag.	F 693		
F 812 SS=E	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §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 perform cleaning in food preparations areas on 3 of 7 heating vents on the ceiling and 1 of 1 air conditioner (AC) unit door on the ceiling for 3 of 4 observations of the kitchen. Findings included:	F 812	The Laurels of Salisbury wishes to have this submitted plan of correction stand as its written allegation of compliance. Our date of compliance is on or before February 18, 2019. Preparation and/or execution of this plan does not constitute admission to nor	2/18/19

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F 812	Continued From page 16 The logbook documentation for scheduled tasks completed in December 2018 revealed the tasks "remove dust from vents and clean fans" were completed on 12/11/2018. A review of the logbook documentation for scheduled tasks due in the month of January 2019 revealed tasks for the kitchen "HVAC (Heating Ventilation Air Conditioning) clean and change air filter ... and HVAC air handlers, inspect air filter and verify operation." These tasks were marked as due "this week" (week of 1/21/2019). 1. A tour of the kitchen on 1/22/2019 at 9:20 AM revealed dark particles hanging out from the AC unit door on the ceiling. The particles were noted to move in the air flow of the kitchen. The kitchen was observed on 1/22/2019 at 11:35 AM and the dark particles were noted to remain on the AC unit door on the ceiling. The particles were noted to move in the air flow of the kitchen. The kitchen was observed on 1/24/2019 at 11:07 AM and the dark particles were noted to remain on the AC unit door on the ceiling. The particles were noted to move in the air flow of the kitchen. An interview was conducted with the Maintenance Director (MD) on 1/24/2019 at 11:38 AM. He reported that cleaning the AC unit was a task he was supposed to complete the week of 1/21/2019 but he had not done it because of the survey. An interview was conducted with the Dietary Manager (DM) on 1/25/2019 at 2:13 PM. The DM reported it was her expectation to have the	F 812	agreement with either existence of or scope and severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. Maintenance Director cleaned all kitchen heating vents and kitchen air conditioning unit ceiling doors on 1/24/2019. Administrator and Maintenance Director inspected all other heating vents and air conditioning unit ceiling doors throughout the facility to ensure cleanliness on 1/24/2019. No other issues noted. Administrator and Dietary Manager will re-educate all Dietary department employees and Maintenance department employees with regarding to preventative maintenance scheduled cleanings of ceiling vents and ceiling doors. These in-services occurred between 2/14/2019 and 2/18/2019. Dietary Manager and/or Maintenance Director will utilize a Quality Assurance monitoring tool to inspect all kitchen ceiling vents and doors 3 times per week for 4 weeks, and immediately notify Administrator of any issues. For ongoing compliance, Maintenance Director will clean ceiling vents and ceiling doors monthly. Additionally, Maintenance Director will perform weekly inspections of the kitchen ceiling vents and ceiling doors and clean as needed. Inspections and cleanings will be documented on Quality Assurance monitoring tool and/or in the	

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F 812	Continued From page 17 kitchen staff observe the ceilings for dirt, debris and dust and to contact maintenance if the AC unit door appeared dirty or dusty. The MD was interviewed on 1/25/2019 at 2:29 PM. He reported he used an application to manage the cleaning and maintenance tasks of the facility. He reported he dusted off the vents in the kitchen every month and removed the vent covers and cleaned them every three months. The Administrator was interviewed on 1/25/2019 at 2:41 PM and he reported it was his expectation the AC unit door was kept clean and free from debris. 2. A tour of the kitchen on 1/22/2019 at 11:35 AM revealed 3 of 7 heating vents with fluffy dark grey material on the vents, and dark black splotches noted. One vent was noted above food preparation areas, one vent over the food serving area and tray preparation area and one vent was noted over the dishwashing area. The kitchen was observed on 1/24/2019 at 11:07 AM. A heating vent above the food preparation area was noted to have fluffy dark grey material and dark black splotches on it, a heating vent above the food serving area was noted to have fluffy dark gray material and dark black splotches and the heating vent above the dishwashing area was noted to have fluffy dark grey material and dark black splotches. An interview was conducted with the Maintenance Director (MD) on 1/24/2019 at 11:38 AM. He reported that cleaning the heating vents was a task he was supposed to complete the week of 1/21/2019 but he had not done it because of the	F 812	electronic preventative maintenance/asset management software with application. Maintenance Director will immediately notify Administrator of any concerns. Continued compliance will be monitored through the facility□s Quality Assurance and Process Improvement Program for 4 months. Additional education and monitoring will be initiated for any individual concerns.	

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F 812	Continued From page 18	F 812		

survey.

An interview was conducted with the Dietary Manager (DM) on 1/25/2019 at 2:13 PM. The DM reported it was her expectation to have the kitchen staff observe the ceilings for dirt, debris and dust and to contact maintenance if the vents appeared dirty.

The MD was interviewed on 1/25/2019 at 2:29 PM. He reported he used an application to manage the cleaning and maintenance tasks of the facility. He reported he dusted off the vents in the kitchen every month and removed the vent covers and cleaned them every three months.

The Administrator was interviewed on 1/25/2019 at 2:41 PM and he reported it was his expectation that all kitchen vents were kept clean and free from debris.