DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/03/2020 FORM APPROVED OMB NO. 0938-0391

OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
	345428	B. WING _			12/02/2020	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SALISBURY			STREET ADDRESS, CITY, STATE, ZIP CODE 215 LASH DRIVE SALISBURY, NC 28147			
SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) (X5 COMPLE DAT		
Initial Comments		E 0	E 000			
An unannounced COVID 19 Focused Survey was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID #MIER11.						
00 INITIAL COMMENTS		F 0	00			
An unannounced COVID 19 Focused Infection Control Survey was conducted 12/1/2020 go 12/2/2020. The facility was found in compliance with CFR 483.30 Infection Control Regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID 19. Event ID #MIER11						
	ROVIDER OR SUPPLIER SUMMARY ST (EACH DEFICIENC REGULATORY OR Initial Comments An unannounced CO was conducted on 12 facility was found in 483.73 related to E-C Requirements for Lo Event ID #MIER11. INITIAL COMMENTS An unannounced CO Control Survey was of 12/2/2020. The facil with CFR 483.30 Info and has implemented Disease Control and recommended practi	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced COVID 19 Focused Survey was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID #MIER11. INITIAL COMMENTS An unannounced COVID 19 Focused Infection Control Survey was conducted 12/1/2020 go 12/2/2020. The facility was found in compliance with CFR 483.30 Infection Control Regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID	IDENTIFICATION NUMBER: 345428 B. WING_ ROVIDER OR SUPPLIER RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Initial Comments An unannounced COVID 19 Focused Survey was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID #MIER11. INITIAL COMMENTS F 0 An unannounced COVID 19 Focused Infection Control Survey was conducted 12/1/2020 go 12/2/2020. The facility was found in compliance with CFR 483.30 Infection Control Regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID	A BUILDING B. WING ROVIDER OR SUPPLIER RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) An unannounced COVID 19 Focused Survey was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID #MIER11. INITIAL COMMENTS A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CO 215 LASH DRIVE SALISBURY, NC 28147 PREFIX TAG PREFIX TA	A BUILDING 345428 B. WING COMPETED TO SUPPLIER RELS OF SALISBURY SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) An unannounced COVID 19 Focused Survey was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR 483.73 related to E-0024(b)(6) subpart B Requirements for Long Term Care Facilities. Event ID #MIER11. INITIAL COMMENTS A BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 215 LASH DRIVE SALISBURY, NC 28147 PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) B 000 An unannounced COVID 19 Focused Survey Was conducted on 12/1/2020 to 12/2/2020. The facility was found in compliance with 42 CFR An unannounced COVID 19 Focused Infection Control Survey was conducted 12/1/2020 go 12/2/2020. The facility was found in compliance with CFR 483.30 Infection Control Regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) PREFIX TAG PREFIX TAG PROVIDER'S PLAN OF CORRECTION (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE F 000 F 000	

Electronically Signed

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE

(X6) DATE