A. BUILDING ____________________________

B. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345428

DATE SURVEY COMPLETED

STATE STREET ADDRESS, CITY, STATE, ZIP CODE

THE LAURELS OF SALISBURY 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

F 000 INITIAL COMMENTS

A unannounced on-site complaint investigation survey was conducted from 5/17/21 through 5/18/21. Event ID# R93Q11

Fifteen of the fifteen complaint allegations were not substantiated.

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

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.