

Division of Health Service Regulation

| | | | |
|--|---|---|---|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0540 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED C 08/27/2013 |
|--|---|---|---|

| | |
|--|--|
| NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE | STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805 |
|--|--|

| (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) COMPLETE DATE |
|--------------------|--|---------------|---|--------------------|
| L 000 | <p>INITIAL COMMENTS</p> <p>No deficiencies cited as result of survey event ID# 318911.</p> | L 000 | | |

| | | |
|--|-------|-----------|
| Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
|--|-------|-----------|