STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	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) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey and complaint investigation was conducted 1/30/23 through 2/2/23. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID# 5I6011.	E 000		
F 000	INITIAL COMMENTS An unannounced recertification survey and complaint investigation was conducted 1/30/23 through 2/2/23. There were 16 allegations investigated. 3 allegations were substantiated without citation and 13 allegations were unsubstantiated. Intakes NC00197378, NC00192998, NC00190962, NC00188635, NC00193250, NC00189481.	F 000		
F 582 SS=D	Medicaid/Medicare Coverage/Liability Notice CFR(s): 483.10(g)(17)(18)(i)-(v) §483.10(g)(17) The facility must-- (i) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of- (A) The items and services that are included in nursing facility services under the State plan and for which the resident may not be charged; (B) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services; and (ii) Inform each Medicaid-eligible resident when changes are made to the items and services specified in §483.10(g)(17)(i)(A) and (B) of this section. §483.10(g)(18) The facility must inform each resident before, or at the time of admission, and	F 582		3/2/23

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

Electronically Signed | 02/22/2023

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F 582	Continued From page 1 periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/ Medicaid or by the facility's per diem rate. (i) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State plan, the facility must provide notice to residents of the change as soon as is reasonably possible. (ii) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change. (iii) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements. (iv) The facility must refund to the resident or resident representative any and all refunds due the resident within 30 days from the resident's date of discharge from the facility. (v) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to provide the Skilled Nursing Facility Advanced Beneficiary Notice of Non-Coverage (SNF-ABN) Form Centers for Medicare Services (CMS) 10055 prior to discharge from Medicare Part A Services for 1 of 3 sampled residents	F 582	PLAN OF CORRECTION The statements included in this plan of correction are not an admission and do not constitute agreement with the alleged deficiencies herein. The plan of correction is completed in the compliance	

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F 582	Continued From page 2 reviewed for beneficiary protection notification review (Resident #243). Findings included: 1. Resident #243 was admitted to the facility on 8/23/22. A review of the medical record revealed a CMS-10123 Notice of Medicare Non-Coverage letter (NOMNC) was issued on 10/5/22 to Resident #243 which explained Medicare Part A coverage for skilled services would end on 10/7/22. A review of the medical record revealed a CMS-10055 SNF-ABN (Skilled Nursing Facility Advanced Beneficiary Notice) was not provided to Resident #243 or their Responsible Party. On 02/02/23 at 12:24 PM, an interview was conducted with the Social Services Director. She stated she was new in the position did not realize she should have issued an advanced beneficiary notice (ABN) to Resident #243 prior to discharge. On 02/02/23 at 02:21 PM an interview with the Administrator revealed he expects the notices to be provided to the residents timely to give them the opportunity to appeal.	F 582	of state and federal regulations as outlined. To remain in compliance with all federal and state regulations, the center has taken or will take the actions set forth in the following plan of correction. The following plan of correction constitutes the center□s allegation of compliance. All alleged deficiencies cited have been or will be completed by the dates indicated. F582 The facility will continue to provide the Skilled Nursing Facility Advanced Beneficiary Notice Coverage (SNF-ABN) Form CMS 10055 to all applicable Medicare Part A residents. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. Resident #243 no longer resides in the facility. How the facility will identify other residents having the potential to be affected by the same deficient practice. An audit of all applicable Medicare Part A residents was conducted by the Social Services Director on 1.30.23 and no other residents were identified to require a NOMNC/ABN issued. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. The Social Worker and Business Office Manager were in serviced by the Regional Business Office Manager on the facility policy for issuing notifications for SNF ABN and NOMNC	

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F 582	Continued From page 3	F 582	prior to the end of benefits/services on 2.7.23. SNF ABN and NOMNC notifications will be monitored, to ensure they are issued per facility policy, by the Business Office Manager/designee beginning on 2.14.23 using a QA monitoring tool. The Business Office Manager/designee will audit records for applicable Medicare Part A residents weekly x 12 weeks. Variances will be corrected at the time of audit and additional education provided when indicated. How the facility plans to monitor its performance to make sure that solutions are sustained. Audit results will be reported to the Administrator weekly for 3 months beginning on 2.21.23 and concerns will be reported to the Quality Assurance and Performance Improvement (QAPI) Committee during monthly meetings. Continued compliance will be monitored through random record audits and through the facility□s Quality Assurance and Performance Improvement Program. The QAPI committee will make recommendations for further education or systemic changes as indicated. The results of the audits and compliance will be monitored by the QAPI Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Any staff found non-compliant with issuing a NOMNC/ABN will receive progressive discipline.	

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F 761	Continued From page 4	F 761		
F 761 SS=E	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation and interviews the facility failed to remove expired medications in accordance with the manufacturer's expiration date for 1 of 1 medication storage rooms and 1 of 2 medication carts (200 B Hall). The findings included: An observation on 2/1/23 at 10:10 AM revealed 3	F 761	F761 The facility will continue to label all drugs and biologicals in accordance with currently accepted professional principles. The facility will continue to store all drugs and biologicals in accordance with State and Federal laws.	3/2/23

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F 761	Continued From page 5 tablets of Simvastatin (a medication used to treat high cholesterol levels in the blood) 20 milligram (mg) expired on 1/31/23 and 3 tablets of Aldactone (a medication used to lower blood pressure) 25 mg expired on 1/31/23 in the Omnicell (an automated medication dispensing machine) located in the medication storage room, all available for use. An interview with the Director of Nursing (DON) on 2/1/23 at 10:10 AM revealed the pharmacy was responsible for removing expired medications from the Omnicell monthly. The DON stated the nurse removing the medication from the Omnicell would be responsible for checking the expiration date as well. An observation on 2/1/23 at 3:41 PM revealed 2 medication cards with 30 capsules in each card of Dicyclomine Hydrochloride (HCL) (a medication used to treat irritable bowel) 10 mg for a resident expired on 1/31/23, all available for use. An interview with Medication Aide #1 revealed the medication should have been removed from the medication cart and returned to pharmacy. An interview with the Pharmacy Account Manager on 2/2/23 at 10:41 AM revealed the pharmacy technician came to the facility monthly and reviewed the Omnicell for any expiring or expired medications and removed those medications. The Pharmacy Account Manager stated she expected any medication that was expiring or expired to be removed from the Omnicell. An interview with the Pharmacist in Charge on 2/2/23 at 2:07 PM revealed her expectation was	F 761	How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. The expired medications in the Omnicell were removed immediately upon discovery on 2.1.23. The expired medications in the medication cart were removed immediately upon discovery on 2.1.23. How the facility with identify other residents having the potential to be affected by the same deficient practice. All other medications in the Omnicell were inspected by the pharmacy technician on 2.1.23. No negative findings were identified as a result of this inspection. The pharmacy technician will continue to conduct monthly Omnicell inspections to ensure that expired medications are removed in accordance with the manufacturer□s expiration dates. All other medications in the medication carts were inspected on 2.1.23 by the DON, ADON, and Unit Manager. No negative findings were identified as a result of these inspections. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. Drugs and biologicals will be labeled and stored according to facility policy. Facility licensed nurses and medication aides will be in serviced by the pharmacy representative or DON on the facility policy for labeling and storage of drugs	

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F 761	Continued From page 6 the pharmacy technician would remove any expiring or expired medication out of the Omnicell when they completed their monthly review. An additional interview with the DON on 2/2/23 at 3:19 PM revealed her expectation was that the expired medications in the medication cart would be removed by the nursing staff, and the expired medications in the Omnicell removed as well.	F 761	and biologicals; completed by 2.24.22. After this date all newly hired staff nurses, agency nurses, and medication aides will be educated by the ADON on this facility policy upon hire. A QA monitoring tool will be utilized to ensure that all drugs and biologicals are labeled and stored according to facility policy by the DON/designee beginning on 2.25.23. The DON/designee will inspect all medication carts daily x 2 weeks, then 5x/week x 2 weeks, then 3x/week x 4 weeks, then weekly x 4 weeks, then continue monthly inspections thereafter. Variances will be corrected at the time of inspection and additional education provided when indicated. A QA monitoring tool will be utilized to ensure that all drugs and biologicals are labeled and stored according to facility policy by the pharmacy technician/designee beginning on 2.28.23. The pharmacy technician/designee will inspect the Omnicell monthly x 3 months then continue monthly inspections thereafter. Variances will be corrected at the time of inspection and additional education provided when indicated. How the facility plans to monitor its performance to make sure that solutions are sustained. Monitoring tool results will be reported to the Administrator weekly for the next 3 months beginning on 3.1.23 and concerns will be reported to the Quality Assurance and Performance Improvement	

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F 761	Continued From page 7	F 761	Committee during monthly meetings. Continued compliance will be monitored through monthly Omnicell and medication cart inspections and through the facility□s Quality Assurance and Performance Improvement Program. The results of the audits and compliance will be monitored by the QAPI Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Any staff found non-compliant with removing expired medications will receive progressive discipline.	
F 867 SS=E	QAPI/QAA Improvement Activities CFR(s): 483.75(c)(d)(e)(g)(2)(i)(ii) §483.75(c) Program feedback, data systems and monitoring. A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following: §483.75(c)(1) Facility maintenance of effective systems to obtain and use of feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement. §483.75(c)(2) Facility maintenance of effective systems to identify, collect, and use data and	F 867		3/2/23

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information from all departments, including but not limited to the facility assessment required at §483.70(e) and including how such information will be used to develop and monitor performance indicators.

§483.75(c)(3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

§483.75(c)(4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

§483.75(d) Program systematic analysis and systemic action.

§483.75(d)(1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

§483.75(d)(2) The facility will develop and implement policies addressing:
(i) How they will use a systematic approach to determine underlying causes of problems impacting larger systems;
(ii) How they will develop corrective actions that will be designed to effect change at the systems level to prevent quality of care, quality of life, or safety problems; and
(iii) How the facility will monitor the effectiveness

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of its performance improvement activities to ensure that improvements are sustained.

§483.75(e) Program activities.

§483.75(e)(1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

§483.75(e)(2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

§483.75(e)(3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment required at §483.70(e). Improvement projects must include at least annually a project that focuses on high risk or problem-prone areas identified through the data collection and analysis described in paragraphs (c) and (d) of this section.

§483.75(g) Quality assessment and assurance.

§483.75(g)(2) The quality assessment and assurance committee reports to the facility's

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F 867	Continued From page 10 governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI program required under paragraphs (a) through (e) of this section. The committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (iii) Regularly review and analyze data, including data collected under the QAPI program and data resulting from drug regimen reviews, and act on available data to make improvements. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility's Quality Assurance Activity (QAA) committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the facility's 04/01/21 recertification and complaint survey. The failure related to one recited deficiency that was originally cited during the 04/01/21 recertification and complaint surveys which was cited on the current recertification and complaint survey of 02/02/23. The recited deficiency was for expired medications in the area of labeling and storing drugs and biologicals. The continued failure of the facility during two surveys of record in the same area showed a pattern of the facility's inability to sustain an effective Quality Assurance program. The findings included: This tag is cross referenced to: F-761 Based on observation and interviews the facility failed to remove expired medications in accordance with the manufacturer's expiration	F 867	F867 The facility will continue to ensure that the QAPI committee meets at least quarterly to identify issues with respect to which QAPI activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. How corrective action will be accomplished for those residents found to have been affected by the deficient practice. No residents were affected by the alleged deficient practice. The facility will continue to label all drugs and biologicals in accordance with currently accepted professional principles. The facility will continue to store all drugs and biologicals in accordance with State and Federal laws. The expired medications in the Omnicell were removed immediately upon	

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F 867	Continued From page 11 date for 1 of 1 medication storage rooms and 1 of 2 medication carts (200 B Hall). This practice had the potential to affect medications administered to all residents. During the recertification and complaint survey of 04/01/21 the facility was cited for F-761 failure to discard 23 bottles of expired Aspirin in 1 of 2 medication storage rooms (Main Medication Storage room) and failed to store 1 unused Novolog FlexPen at the appropriate temperature in 1 of 5 medication carts (200 A). On 02/02/23 at 5:00 PM the Administrator was interviewed and explained the quality assurance committee met monthly and the goal was to be and remain in compliance with CMS regulations.	F 867	discovery on 2.1.23. The expired medications in the medication cart were removed immediately upon discovery on 2.1.23. No negative outcome was identified as a result of these observations. How the facility with identify other residents having the potential to be affected by the same deficient practice. All other medications in the Omnicell were inspected by the pharmacy technician on 2.1.23. No negative findings were identified as a result of this inspection. The pharmacy technician will continue to conduct monthly Omnicell inspections to ensure that expired medications are removed in accordance with the manufacturer□s expiration dates. All other medications in the medication carts were inspected on 2.1.23 by the DON, ADON, and Unit Manager. No negative findings were identified as a result of these inspections. The measures put into place or systemic changes made to ensure that the deficient practice will not recur. All drugs and biologicals will be labeled and stored according to facility policy. Facility licensed nurses and medication aides will be in serviced by the pharmacy representative or DON on the facility policy for labeling and storage of drugs and biologicals; completed by 2.24.22. After this date all newly hired staff nurses, agency nurses, and medication aides will	

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be educated by the ADON on this facility policy upon hire.

The facility□s quality assurance and performance improvement committee will be in serviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns on 2.27.23. Education will include determining the root cause of the identified concern, and identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised.

A QA monitoring tool will be utilized to ensure that all drugs and biologicals are labeled and stored according to facility policy by the DON/designee beginning on 2.25.23. The DON/designee will inspect all medication carts daily x 2 weeks, then 5x/week x 2 weeks, then 3x/week x 4 weeks, then weekly x 4 weeks, then continue monthly inspections thereafter. Variances will be corrected at the time of inspection and additional education provided when indicated.

A QA monitoring tool will be utilized to ensure that all drugs and biologicals are labeled and stored according to facility policy by the pharmacy technician/designee beginning on 2.28.23. The pharmacy technician/designee will inspect the Omnicell monthly x 3 months then continue monthly inspections thereafter. Variances will be corrected at

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 02/02/2023

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	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) COMPLETION DATE
F 867	Continued From page 13	F 867	the time of inspection and additional education provided when indicated. How the facility plans to monitor its performance to make sure that solutions are sustained. Monitoring tool results will be reported to the Administrator weekly for the next 3 months beginning on 3.1.23 and concerns will be reported to the Quality Assurance and Performance Improvement Committee during monthly meetings. Continued compliance will be monitored through monthly Omnicell and medication cart inspections and through the facility□s Quality Assurance and Performance Improvement Program. The results of the audits and compliance will be monitored by the QAPI Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Any staff found non-compliant with removing expired medications will receive progressive discipline. The Regional Clinical Coordinator will attend the facility quality assurance committee meeting monthly x 3 months to ensure committee is developing and implementing appropriate plans of action to correct quality concerns. Variances will be corrected and/or additional education provided when indicated.	