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 _____	03/21/2024

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 000	INITIAL COMMENTS An unannounced recertification and complaint investigation survey was conducted on 3/18/2024 through 3/21/2024. The following intakes were investigated: NC00208724, NC00208733, NC00208943, NC00209507, NC00213287, NC00213032, NC00212849, NC00208761, NC00200692, NC00200722, NC00204098, NC00203675, NC00206451, NC00199819, NC00206971, NC00205739, and NC00199148. 36 of 36 allegations did not result in a deficiency. Event ID # 2GW411.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and interviews with residents and staff, the facility failed to maintain call bell within reach for 1 out 2 residents reviewed for accommodations of needs. (Resident #1) The findings included: Resident #1 was admitted to the facility on 9/18/17. The quarterly Minimum Data Set (MDS) dated 1/19/24 assessed Resident #1 with minimal impairment in cognition. The MDS indicated walking between locations at any time did not	F 558	F558: The facility will continue to ensure that call bells are maintained within reach. Resident # 1 will continue to have call bell maintained within reach. Resident #1's call bell was placed within reach at the time of discovery. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. An audit was conducted on 3.21.24 by the interdisciplinary team to ensure that call bells were maintained within reach. No negative outcomes were	4/15/24

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

Electronically Signed | 04/15/2024

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 _____	03/21/2024

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 558	Continued From page 1 occur for Resident #1 during the assessment period. The care plan dated 3/7/24 revealed that the that the call bell was to be placed within reach and Resident #1 encouraged to use it for assistance. During an observation conducted on 3/19/24 at 10:20 AM the call bell was hanging off the right side of the bed. The call bell was hanging down approximately 10 inches. Resident #1 has a contracted neck which leans to his left side. Resident #1 leans to the left when laying in his bed. Resident #1 was able to use his right hand. Resident #1 was not able to reach the call bell. On 3/19/24 at 3:02 PM a second observation was made. The call bell was in the same position, which was hanging down from the bed on the right side. An interview was conducted with Resident #1 on 3/19/24 at 3:02 PM. Resident #1 stated he was unable to reach his call bell. Resident #1 has asked for the call bell to be placed on his bed on the left side. Resident #1 stated he needed his urinal emptied and Resident #1 needed to use his urinal. An interview with Resident #1's roommate on 3/19/24 at 3:10 PM revealed that the roommate has used his call bell to get help for Resident #1. The roommate stated he just now rang his call bell to get assistance for Resident #1. An interview was conducted with Nurse Aide (NA) on 3/19/24 at 3:20 PM. The NA was asked about Resident #1's call bell. NA stated that Resident #1 knows how to use his call bell. The NA was	F 558	identified relating to these observations. All staff were in-serviced by the ADON as of 4.14.24 on the facility policy for ensuring that call bells are maintained within reach. A QA monitoring tool will be utilized to ensure ongoing compliance by the Administrator/designee beginning on 4.15.24. The Administrator/designee will audit 5 resident rooms 5x/week x 4 weeks, then 5 resident rooms 3x/week x 4 weeks, then 5 resident rooms weekly x 4 weeks to ensure that call bells are maintained within reach. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.15.24	

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 _____	03/21/2024

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 558	Continued From page 2 asked about the current placement of the call bell and if it was poistioned for Resident #1 to use it. The NA agreed it was not. The NA went back into Resident #1's room to help him with his urinal. Observation was made and the call bell remained in the same position which was hanging from the bed on the right side. Subsequent observation conducted on 3/20/24 at 8:47 AM revealed the call bell for Resident #1 to be in the same position, hanging down on the right side of Resident #1's bed. An interview with the Administrator on 3/21/14 at 12:10 pm revealed that the expectation was for the call bells to be within reach. For Resident #1 the call bell should be on his left side. The Administrator stated that he thought Resident #1 was not able to use the call bell and that he wouldl either yell or his roommate will push his bell for assistance. The Administrator thought it was care planned that Resident #1 was unable to use the call bell.	F 558		
F 578 SS=D	Request/Refuse/Dscntnue Trmnt;Formlte Adv Dir CFR(s): 483.10(c)(6)(8)(g)(12)(i)-(v) §483.10(c)(6) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. §483.10(c)(8) Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate. §483.10(g)(12) The facility must comply with the	F 578		4/15/24

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 _____	03/21/2024

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 578	Continued From page 3 requirements specified in 42 CFR part 489, subpart I (Advance Directives). (i) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive. (ii) This includes a written description of the facility's policies to implement advance directives and applicable State law. (iii) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. (iv) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether or not he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with State law. (v) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time. This REQUIREMENT is not met as evidenced by: Based on record reviews and interviews with resident, staff, and the Nurse Practitioner, the facility failed to have accurate advanced directive information documented throughout the medical record for 1 of 3 residents reviewed for code status (Resident #18). The findings included: Resident #18 was admitted to the facility on	F 578	F578: The facility will continue to have accurate advanced directive information documented throughout the medical record. Resident #18 was interviewed on 3.19.24 regarding advanced directive information and results were documented in the medical record by the Unit Manager. No	

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 _____	03/21/2024

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 578	Continued From page 4 2/19/22. Review of Resident #18's annual Minimum Data Set on 11/3/23 revealed he was cognitively intact. A review of Nurse Practitioner (NP) #1's order dated 11/14/23 stated "Full code, full scope of treatment, antibiotics if indicated, intravenous (IV) fluids if indicated, and feeding tube for a defined trial period per Medical Orders for Scope of Treatment (MOST) form reviewed on 11/14/23." Review of Resident #18's code status on top of his electronic health record (EHR) stated, "Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, and feeding tube for a defined trial period per MOST form reviewed on 11/14/23." A review of documents in Resident #18's EHR revealed a pink MOST form effective 12/27/23. The boxes checked were "attempt resuscitation, full scope of treatment, antibiotics as indicated, IV fluids if indicated, and no feeding tube." This form was signed by Resident #18 and NP #2. No date was written beside NP #2's signature. There were no physician or Nurse Practitioner's orders written for the 12/27/23 MOST form. Review of NP#2's progress notes on 12/27/23 stated Resident #18's code status was "Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, feeding tube for a defined trial period per MOST form reviewed on 11/14/23." The Nurse Practitioner saw Resident #18 for completion of MOST form as well as pain control management on 12/27/23. The NP wrote discussion of MOST form with the resident was	F 578	negative outcome was identified relating to this observation. Current residents have the potential to be affected. Current resident medical records were audited by the DON and Unit Managers between 3.19.24 □ 3.22.24 to ensure that each resident had accurate advanced directive information documented throughout the medical record. No negative outcome was identified relating to this audit. All licensed nurses, Social Worker, and Medical Records clerk were in-serviced by the ADON on the facility policy for ensuring that accurate advanced directive information is documented throughout the medical record as of 4.14.24. A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker beginning on 4.15.24. The Social Worker will randomly audit 10 resident charts weekly x 4 weeks then 5 resident charts weekly x 4 weeks then 5 resident charts biweekly x 4 weeks to ensure that accurate advanced directive information is documented throughout the medical record. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings.	

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 _____	03/21/2024

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 578	Continued From page 5 completed. The resident did want to remain full code with full scope of treatment at that time. Subsequent Nurse Practitioners' progress notes listed Resident #18's code status as "Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, feeding tube for a defined trial period per MOST form reviewed on 11/14/23." During the review of the original MOST form, the book in the nurses' station revealed Resident #18's two MOST forms were inside a clear plastic sleeve. The front part showed the MOST form effective 11/14/23 indicating Resident #18 wanted a feeding tube for a defined trial period. At the back of the same sleeve was the MOST form effective 12/27/23 indicating the resident did not want a feeding tube. During an interview on 3/18/24 at 3:39 pm Resident #18 stated he wanted to be resuscitated but did not want a feeding tube. During an interview on 3/18/24 at 3:42 pm, the 200 Hall Charge Nurse revealed she would check the resident's code status information in the book if there was an emergency. She stated she would also check the resident's EHR to double check. The Charge Nurse stated it would be easier to access the EHR if she was on the floor. She stated she would still go in the EHR if she was in the nurses' station to ensure the resident was not under hospice care or to ensure they did not have additional instructions from the residents or family on the EHR. During an interview on 3/19/24 at 10:23 am, the 200 Hall Nurse revealed the nurses were responsible in obtaining the resident's code status during admission. The nurses asked the	F 578	Continued compliance will be monitored through random medical record audits and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.15.24	

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 _____	03/21/2024

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 578	Continued From page 6	F 578		

representative if the resident was not alert and oriented. The nurses placed the signed form in the providers' box for signing. The providers gave the form to the nurse after they signed. The nurse entered a code status order and changed the resident's code status in the EHR. The nurse made a copy of the form and placed it in the medical record's box. The medical records staff scanned the original document into the resident's EHR. The nurse filed the original form in the book located in the nurses' station. The 200 Hall Nurse stated there was a recent directive from NP #1 that MOST forms for all residents had to be done within 90 days. They followed the same process when changing forms. She stated she would check the resident's EHR first if there was a medical emergency. She would also check the book in the nurses' station. The 200 Hall Nurse checked Resident #18's code status in the nurses' station book and read the MOST form dated 11/14/23. She did not flip the page to see the recent MOST form dated 12/27/23. She pointed at the MOST form dated 11/14/23 and stated she would give it to the Emergency Medical Services if they responded to an emergency involving Resident #18.

During an interview on 3/19/24 at 10:38 am, the 200 Hall Unit Manager stated she tried to check the book once a month. She stated NP #1 processed the MOST forms. The NP gave the signed MOST form to her or the nurse to file in the book. The medical records staff scanned them to the residents' EHR. She entered the code status order and changed it on top of the residents' EHR. She stated if there was a medical emergency, she would check the resident's code status in the EHR and in the book.

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 _____	03/21/2024

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 578	Continued From page 7 During an interview on 3/21/24 at 8:20 am, NP #2 stated she completed the MOST form with Resident#18 on 12/27/23. She stated he did not want a trial of feeding tube at that time. NP #2 revealed the resident's code status information on their company's progress note was automatically fed through the facility's EHR. She stated she gave the resident's signed MOST form to the nurse. If the nurse entered the order and changed the code status in the facility's EHR, then her progress notes would have shown the current information. During the interview on 3/19/24 at 11:18 am, the Director of Nursing (DON) revealed the emergency directive form was part of the admission packet. The code status forms were placed in the Medical Director's box to be signed by him. It was scanned by medical records. The nurse who received the completed form entered the order and changed the code status in the EHR. She stated they double checked those forms in the book. There were no checks in between. They reviewed code status in care plan meetings. The Unit Managers were supposed to audit the forms and keep them up to date when there were changes.	F 578		
F 644 SS=D	Coordination of PASARR and Assessments CFR(s): 483.20(e)(1)(2) §483.20(e) Coordination. A facility must coordinate assessments with the pre-admission screening and resident review (PASARR) program under Medicaid in subpart C of this part to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes:	F 644		4/18/24

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 _____	03/21/2024

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 644	Continued From page 8 §483.20(e)(1)Incorporating the recommendations from the PASARR level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care. §483.20(e)(2) Referring all level II residents and all residents with newly evident or possible serious mental disorder, intellectual disability, or a related condition for level II resident review upon a significant change in status assessment. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for a resident with a new mental health diagnosis for 1 of 3 residents reviewed for PASRR (Resident #36). The findings include: Resident #36 was admitted to the facility on 3/30/22. Diagnoses included adjustment disorder, unspecified mood disorder, generalized anxiety and major depressive disorder. Review of Resident #36's records revealed she had a halted Level II PASRR dated 11/2/22. The notification letter stated the resident did not meet criteria for a mental illness. Review of Resident #36's diagnoses revealed a primary diagnosis of bipolar disorder was listed on 7/25/23. Review of Resident #36's medical records revealed no new PASRR Level II had been completed. Review of physician's order revealed Resident	F 644	F644: The facility will continue to ensure that Level II PASRR screening is completed for residents with new mental health diagnoses. Resident # 36 had an updated PASRR screening application completed as of 3.27.24 by the Social Worker. No negative outcome was identified relating to this observation. Current residents with mental health diagnoses have the potential to be affected. All current residents with mental health diagnoses were reviewed as of 4.17.24 to ensure that Level II PASRR screening had been completed. No negative outcomes were identified relating to these observations. The Social Worker, MDS Coordinator, and MDS Assistant were in-serviced on 4.11.24 by the Regional Clinical Coordinator on the facility policy for Level II PASRR screening.	

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 _____	03/21/2024

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 644	Continued From page 9 #36 was started on Valproic Acid Sprinkles Extended Release 125 milligrams three times a day for mood disorder on 7/25/23. Review of Resident #36's annual Minimum Data Set (MDS) dated 8/4/23 revealed she was not considered by the state Level II PASRR to have serious mental illness. During an interview on 3/19/24 at 2:23 pm, the Social Worker (SW) revealed she started her job in July 2023 and did not have PASRR training. She stated the Admission Coordinator was completing the PASRR referrals. During an interview on 3/19/24 at 2:28 pm, the Admission Coordinator stated she was only helping with the PASRR because they did not have a trained SW. She stated she only dealt with residents that had Level II PASRR. She listed the residents' names on the erase board to keep track of who needed an update. She stated the Business Office was working with the Regional Office to complete submission requirements for residents' PASRR. During an interview on 3/19/24 at 3:05 pm, the Administrator stated the Business Office Manager was assigned to work with the Regional Manager to ensure compliance with PASRR. He revealed the facility checked on the resident's PASRR on admission. If a PASRR was due, the facility prepared the needed information to submit through the North Carolina web portal. If a resident got flagged for Level II PASRR, then a referral got submitted. He stated certain diagnoses or certain difficult behaviors were instances for submission for a Level II PASRR.	F 644	A QA monitoring tool will be utilized to ensure ongoing compliance by the Social Worker/designee beginning on 4.18.24. The Social Worker/designee will randomly audit 5 resident medical records weekly x 8 weeks, then bi-weekly x 4 weeks to ensure that Level II PASRR screening is completed when indicated. Variances will be corrected at the time of audit and additional education or corrective action provided when indicated. Audit results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.18.24	

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 _____	03/21/2024

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 644	Continued From page 10	F 644		

During an interview on 3/21/23 at 10:54 am, the Regional Business Office Manager stated she followed up on the expired PASRR only. She stated if a resident needed a PASRR, that was between nursing and social work. The facility reviewed the previous screening and looked at the resident's electronic health record for changes or additional diagnoses. The Regional Business Office Manager entered the required information into the NC MUST (North Carolina Medicaid Uniform Screening Tool - web portal for PASRR). The NC MUST office reviewed the resident's information and determined the PASRR level and length of time. If a resident was a Level II, the NC MUST staff set up a visit with the resident through the SW. She stated she got the decision regarding the resident's PASRR via email from NC MUST. The facility received the official letters through the mail. The Regional Business Office Manager stated Resident #36 had a halted PASRR in the NC MUST on 11/2/22. She stated the previous SW processed it. She stated the MDS nurse, and the current SW were new when Resident #36 had a diagnosis added on 7/25/23. She stated neither she nor the business office manager were notified when the resident's primary diagnosis changed. She stated she would immediately complete a new PASRR if she was notified.

During a follow up interview on 3/21/24 at 12:08 pm, the Administrator stated Resident #36 had behaviors since admission, but the facility was not paying too close attention to her diagnoses. The business office should have been notified when there were changes in the resident's diagnoses. He stated the management discussed it and would have a plan of correction.

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 _____	03/21/2024

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 758	Continued From page 11	F 758		
F 758 SS=E	Free from Unnec Psychotropic Meds/PRN Use CFR(s): 483.45(c)(3)(e)(1)-(5) §483.45(e) Psychotropic Drugs. §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories: (i) Anti-psychotic; (ii) Anti-depressant; (iii) Anti-anxiety; and (iv) Hypnotic Based on a comprehensive assessment of a resident, the facility must ensure that--- §483.45(e)(1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record; §483.45(e)(2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs; §483.45(e)(3) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record; and §483.45(e)(4) PRN orders for psychotropic drugs are limited to 14 days. Except as provided in §483.45(e)(5), if the attending physician or	F 758		4/18/24

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 _____	03/21/2024

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 758	Continued From page 12 prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order. §483.45(e)(5) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication. This REQUIREMENT is not met as evidenced by: Based on record review, staff and Medical Director (MD) interviews the facility failed to follow a physician's order to discontinue a psychotropic medication that resulted in the resident continuing to receive the medication for 1 of 5 residents (Resident #39) reviewed for unnecessary medications. Findings include Resident #39 was admitted to the facility on 3/6/23 with diagnoses including insomnia and anxiety. A review of the Resident #39's physician orders found trazadone 25 milligrams (mg) once daily dated ordered on 5/11/23. The annual Minimum Data Set (MDS) dated 12/22/23 revealed Resident #39 was cognitively intact and was coded for receiving psychotropic medication all 7 days during the lookback period. A review of Resident #39's care plan for pain dated 3/18/24 revealed she had an alteration in sleeping pattern related to diagnoses of insomnia	F 758	F758: The facility will continue to ensure that physicians orders for discontinuing psychotropic medications are followed. Resident #39 had an order change completed on 3.20.24 by the DON per the physicians order to decrease Trazodone to 25mg at bedtime as needed for two weeks then discontinue. No negative outcome was identified relating to this observation. Current residents with orders for psychotropic medications have the potential to be affected. All current residents with orders for psychotropic medications were audited by the DON on 4.9.24 to ensure that physicians orders for discontinuing psychotropic medications were followed. No negative outcomes were identified relating to these observations. The Nursing Administrative team was educated by the Regional Clinical	

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 _____	03/21/2024

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 758	Continued From page 13 with an intervention that included administering trazadone off label as a sleep aide. A review of monthly pharmacy recommendation dated 12/23/23 for Resident #39 was completed. The pharmacy recommendation read in part, the resident had received trazadone 25 mg since 5/11/23, please attempt a gradual dose reduction (GDR) to 12.5 mg. The physician's written response read to change trazadone 25 mg to as needed (PRN) for 2 weeks then discontinue the medication. The physician signed the order on 1/8/24. A review of Resident #39's December 2023 through March 2024 medication administration record (MAR) revealed trazadone 25 mg was administered daily for insomnia. The DON was interviewed on 3/20/24 at 2:40 PM. She stated the pharmacist sent her monthly pharmacy recommendations and she provided all recommendations to the physician to review and respond. The DON then received the response from the physician and was responsible for placing the physician order onto a resident's MAR. The DON stated she had overlooked the physician's order dated 1/8/24 for Resident # 39, and the medication was not changed. The MD was interviewed on 3/21/24 at 12:01 PM and stated his orders should be followed and the missed GDR order for trazadone did not cause harm for Resident #39.	F 758	Coordinator on 4.15.24 on the facility policy for ensuring that physicians orders for discontinuing psychotropic medications are followed. All licensed nurses will be in-serviced by the ADON as of 4.17.23 on the facility policy for ensuring that physicians orders for discontinuing psychotropic medications are followed. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator/designee beginning on 4.18.24. The Regional Clinical Coordinator/designee will audit all monthly pharmacy recommendations monthly x 3 months to ensure that physicians orders for discontinuing psychotropic medications are followed. Variances will be corrected at the time of observation and additional education or corrective action provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.18.24	

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 _____	03/21/2024

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 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 observations and interview with the Dietary Manager (DM) the facility failed to remove expired thickened liquids from 2 of 3 nourishment room refrigerators (the 100 Unit and 300 Unit nourishment rooms). The practice had the potential to affect all residents receiving thickened liquids. The Findings Included: a. An observation of the 100-unit nourishment room refrigerator with the DM on 3/20/24 at 10:28 AM found 3 unopened 4 oz thickened liquid containers with an expiration date of 3/18/24. The DM immediately disposed of the thickened liquids.	F 812	F812 The facility will continue to ensure that beverages are discarded prior to the expiration date. The expired thickened liquids were discarded at the time of discovery. No negative outcome was identified relating to this observation. All other areas in the kitchen and nourishment rooms were inspected at the time of discovery and no further issues were identified. No negative outcome was identified relating to this observation.	4/18/24

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 _____	03/21/2024

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 812	Continued From page 15 b. An observation of the 300-unit nourishment room refrigerator on 3/20/24 at 10:38 AM with the DM found 3 unopened 4 oz thickened liquid containers with expiration date of 2/8/24 and one unopened 4 oz thickened liquid container with expiration date of 3/18/24. The DM stated during the observation he was responsible for checking each nourishment room refrigerator daily for expired items and to replenish the nourishment rooms when needed. He stated he had overlooked the expired thickened liquids. The Administrator stated on 3/21/24 at 12:46 PM thickened liquids should be removed and discarded when expired. The nourishment room refrigerators should not contain any expired items.	F 812	All dietary staff were in-serviced by the Registered Dietician as of 4.14.24 on the facility policy for ensuring that beverages are discarded prior to the expiration date. All nursing staff will be educated by the ADON by 4.17.24 on the facility policy for ensuring that beverages are discarded prior to the expiration date. A QA monitoring tool will be utilized by the Dietary Manager/designee beginning on 4.18.24 to ensure that beverages are discarded prior to expiration date and according to facility policy. The Dietary Manager/designee will randomly observe beverage storage areas 5x/week x 12 weeks to ensure that beverages are discarded prior to the expiration date. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility's Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.18.24	

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 _____	03/21/2024

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 814 SS=E	Dispose Garbage and Refuse Properly CFR(s): 483.60(i)(4) §483.60(i)(4)- Dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: Based on an observation and staff interviews the facility failed to ensure all trash was disposed of inside the dumpster for 1 of 1 dumpster. This practice had the potential to attract pests and mice. The findings included: An observation of the outside dumpster area on 3/20/24 at 10:41 AM with the Dietary Manager (DM) revealed two full and tied trash bags laying on the ground beside a dumpster. The DM stated during the observation he did not know how long the trash bags had been there. He stated the kitchen, housekeeping and nursing staff dispose of trash into the dumpsters and were responsible for putting their trash into the dumpster. The DM said the dumpsters were emptied on Monday and Friday and that the dumpsters were not full. The Administrator stated on 3/21/24 at 12:46 PM that trash should be disposed of in the dumpsters and not left lying on the ground in the dumpster area. He stated it was the responsibility of everyone to dispose trash into the dumpster and not leave it on the ground.	F 814	F814 The facility will continue to ensure that trash is disposed of inside the dumpster. The trash bags were placed in the dumpster at the time of discovery. No negative outcome was identified relating to this observation. There is only one dumpster area on the facility property. All staff were in-serviced by the Administrator on the expectation that trash will be disposed of inside the dumpster. This education was completed by 4.14.24. A QA monitoring tool will be utilized by the Administrator/designee beginning on 4.15.24 to ensure that trash is disposed of inside the dumpster. The Administrator/designee will randomly observe dumpster area 5x/week x 2 weeks then 3x/week x 2 weeks then weekly x 4 weeks then bi-weekly x 4 weeks to ensure that trash is disposed of inside the dumpster. Variances will be corrected at the time of observation and additional education provided when indicated.	4/15/24

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 _____	03/21/2024

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 814	Continued From page 17	F 814	Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of Compliance: 4.15.24	
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		4/16/24

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 _____	03/21/2024

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 18	F 867		

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

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 _____	03/21/2024

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 19	F 867		

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

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 _____	03/21/2024

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 20 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 observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint survey conducted on 10/1/21. This was for a repeat deficiency that was originally cited during the complaint survey on 10/1/21 for infection control and recited during the recertification and complaint investigation survey completed on 3/21/24. The continued failure of the facility during a two federal survey of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F880 - Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for laundry services when 1 of 1 staff member (Laundry Staff) failed to follow standard precautions during the infection control	F 867	F867 The facility will continue to ensure that the QAPI Committee maintains implemented procedures and monitors interventions that the committee puts into place. The facility will continue to ensure that linens are handled, stored, processed, and transported so as to prevent the spread of infection. Linens were cleaned and stored appropriately at the time of discovery. No negative outcome resulted from this observation. The facility will continue to ensure that staff sanitize hands after depositing linen in the soiled laundry bin. No negative outcome resulted from this observation. The facility will continue to bag resident urinals prior to placing them in the bathroom. No negative outcome resulted	

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 _____	03/21/2024

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 21 observation. During the complaint survey on 10/1/21, the facility failed to implement their infection control policies and procedures when a staff member failed to sanitize her hands after depositing linen in the soiled laundry bin and before assisting a resident in her wheelchair to her room and when another staff member failed to bag a resident's urinals prior to placing them in the bathroom for 2 of 2 residents reviewed for infection control. During the interview on 3/21/24 at 12:46 pm, the Administrator stated Infection Control was a huge area of focus the facility looks at daily. They provided education and training to all staff. The infection control issue in the laundry room was an oversight from an individual worker and they would provide more education and training in laundry on infection control.	F 867	from this observation. Current residents have the potential to be affected. All laundry areas were inspected by the Housekeeping Supervisor at the time of discovery and no further issues were identified. No negative outcomes resulted from this observation. The DON and ADON consulted with Alliant on 4.9.24 for additional guidance and resources. A root cause analysis was completed by the QAPI committee on 4.15.24. All housekeeping staff were inserviced by the ADON as of 4.14.24 on the facility policy for handling, storing, processing, and transporting linens. All staff were inserviced by the ADON as of 4.14.24 on the Infection Prevention Program. The facility□s quality assurance committee was inserviced by the Regional Clinical Coordinator on the procedures for developing and implementing appropriate plans of action to correct identified quality concerns on 4.15.24. Education included determining the root cause of the identified concerns, and identifying, implementing, and monitoring the corrective action plan and recognizing when an action plan may need to be revised.	

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 _____	03/21/2024

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 22	F 867	A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 4.16.24. The ADON/designee will randomly observe housekeeping staff handling linens 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that linens are handled, stored, processed, and transported per facility policy. Variances will be corrected at the time of observation and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 4.16.24. The ADON/designee will conduct weekly facility-wide infection control surveillance rounds to ensure that Infection Control procedures are in place and interventions are implemented per facility policy. Variances will be corrected at the time of observation and additional education provided when indicated. A QA monitoring tool will be utilized to ensure ongoing compliance by the Regional Clinical Coordinator beginning on 4.16.24. 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. Audit results will be reported to the	

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 _____	03/21/2024

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 23	F 867	Administrator monthly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random audits and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee and the Regional Clinical Coordinator for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.16.24	
F 880 SS=E	Infection Prevention & Control CFR(s): 483.80(a)(1)(2)(4)(e)(f) §483.80 Infection Control The facility must establish and maintain an infection prevention and control program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. §483.80(a) Infection prevention and control program. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, the following elements: §483.80(a)(1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals	F 880		4/16/24

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 _____	03/21/2024

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 880	Continued From page 24 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.70(e) and following accepted national standards; §483.80(a)(2) Written standards, policies, and procedures for the program, which must include, but are not limited to: (i) A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility; (ii) When and to whom possible incidents of communicable disease or infections should be reported; (iii) Standard and transmission-based precautions to be followed to prevent spread of infections; (iv)When and how isolation should be used for a resident; including but not limited to: (A) The type and duration of the isolation, depending upon the infectious agent or organism involved, and (B) A requirement that the isolation should be the least restrictive possible for the resident under the circumstances. (v) The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease; and (vi)The hand hygiene procedures to be followed by staff involved in direct resident contact. §483.80(a)(4) A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens.	F 880		

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 _____	03/21/2024

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 880	Continued From page 25 Personnel must handle, store, process, and transport linens so as to prevent the spread of infection. §483.80(f) Annual review. The facility will conduct an annual review of its IPCP and update their program, as necessary. This REQUIREMENT is not met as evidenced by: Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for laundry services when 1 of 1 staff member (Laundry Staff) failed to follow standard precautions during the infection control observation. The findings included: The facility's policy on Laundry Services dated October 17, 2023, stated "All staff will use standard precautions in handling linen; therefore, all linen is handled in the same manner. "Dirty linen should be moved from the dirtiest to the cleanest areas as it is being processed. Dirty linen should be clearly separated from areas where clean linen is handled. "Laundry personnel should remove protective barriers and wash their hands before going into the clean linen area." On 3/19/24 at 10:04 am, the Laundry Staff was observed transporting a yellow soiled linen bin into the laundry room. She was wearing short white rubber gloves while pushing the soiled linen bin. Three clean resident shirts on clothes hangers were observed hanging at waist level on a white cart handle partially blocking the	F 880	F880 The facility will continue to ensure that linens are handled, stored, processed, and transported so as to prevent the spread of infection. Linens were cleaned and stored appropriately at the time of discovery. No negative outcome resulted from this observation. Current residents have the potential to be affected. All laundry areas were inspected by the Housekeeping Supervisor at the time of discovery and no further issues were identified. No negative outcomes resulted from this observation. All housekeeping staff were in-serviced by the ADON as of 4.14.24 on the facility policy for handling, storing, processing, and transporting linens. A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 4.15.24. The ADON/designee will randomly observe housekeeping staff handling	

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 _____	03/21/2024

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 880	Continued From page 26 passageway. The shirts were observed rubbing on the side of the soiled linen bin as the Laundry Staff passed through. She set the soiled linen bin in front of the sink and dryer and took off her gloves. The Laundry Staff did not wash her hands. She walked over to the folding table and leaned on it with her hands. She tapped a stack of washcloths that were on the folding table. The Laundry Supervisor came in and handed the Laundry Staff a clear plastic bag containing soiled laundry. The Laundry Staff opened the soiled linen bin and dropped the bag of soiled laundry inside. The Laundry Staff did not wash her hands after touching the soiled laundry bin with her bare hands. She opened the dryer and pulled out dried mop heads and placed them in clean mop head bucket. During the interview on 3/19/24 at 10:06 am, the Laundry Staff stated she was trained to wear gloves when handling soiled linens. She stated the laundry room was small and did not have enough workspace. The Laundry Staff stated the shirts hanging on the white cart had been washed. She used the white cart to transport the residents' clothes that were washed. She did not wash bed linens or towels. She only washed the washcloths, the residents' clothes, and the mop heads. During an interview on 3/19/24 at 10:09 am, the Housekeeping/Laundry Supervisor stated the laundry staff should wear gloves when sorting out soiled linens. She stated the Laundry Staff should have washed her hands with soap and water for hand hygiene when taking gloves off and when handling contaminated items. The clean residents' clothes were usually hung on the rod over the folding table.	F 880	linens 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that linens are handled, stored, processed, and transported per facility policy. Variances will be corrected at the time of observation and additional education provided when indicated. Observation results will be reported to the Administrator weekly for the next 3 months and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through random observations and through the facility□s Quality Assurance Program. Compliance will be monitored by the QA Committee for 3 months or until resolved and additional education/training will be provided for any issues identified. Date of compliance: 4.15.24	

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 _____	03/21/2024

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 880	Continued From page 27 During an interview on 3/21/24 at 8:49 am, the Infection Preventionist stated all staff were trained with infection control practices during orientation. The staff were expected to follow the standard precautions and wash their hands after taking off protective equipment. She stated she would follow up with the Laundry Staff. During an interview on 3/21/24 at 9:34 am, the Director of Nursing stated she would follow up with the Infection Preventionist and discuss a plan of action.	F 880		