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 04/06/2017

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 205 SS=B	483.15(d)(1)(i)-(iv)(2) NOTICE OF BED-HOLD POLICY BEFORE/UPON TRANSFR (d) Notice of bed-hold policy and return- (1) Notice before transfer. Before a nursing facility transfers a resident to a hospital or the resident goes on therapeutic leave, the nursing facility must provide written information to the resident or resident representative that specifies- (i) The duration of the state bed-hold policy, if any, during which the resident is permitted to return and resume residence in the nursing facility; (ii) The reserve bed payment policy in the state plan, under § 447.40 of this chapter, if any; (iii) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (c)(5) of this section, permitting a resident to return; and (iv) The information specified in paragraph (c)(5) of this section. (2) Bed-hold notice upon transfer. At the time of transfer of a resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed-hold policy described in paragraph (e)(1) of this section. This REQUIREMENT is not met as evidenced by: Based on record review, family interview and staff interview, the facility failed to provide 3 of 3 sampled residents and responsible parties the written bed hold notice upon transfer to the	F 205	Preparation and/or execution of this plan of correction does not constitute admission or agreement by the provider of the truth of the facts alleged or	4/6/17

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

Electronically Signed | 04/25/2017

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 04/06/2017

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 205	Continued From page 1 hospital (Residents #3, #4, and #5). The findings included: 1. Resident #5 was admitted to the facility on 10/20/14. His Minimum Data Set, a quarterly dated 01/18/17, coded him as usually understanding and usually being understood, having moderately impaired cognition, and having disorganized thinking. Nursing notes dated 03/21/17 at 10:21 AM revealed Resident #5 was having periods of extreme confusion, was argumentative with staff and was exhibiting exit seeking behaviors. The nursing note dated 03/21/17 at 3:03 PM noted Resident #5 was transferred to a hospital for psychiatric evaluation and treatment. The medical record did not include any documentation or evidence that Resident #5 or his family were notified of the bed hold policy. Resident #5 was admitted to the hospital and remained at the hospital during this survey. Review of the discharge packet used by nursing staff when a resident was discharged to the hospital revealed a transfer to hospital form, a personalized elder care information sheet, and the facility's bed hold agreement. Nurse #1 was interviewed on 04/05/17 at 11:51 AM. She confirmed she was the nurse who transferred Resident #5 to the hospital. She related that she did not send any paperwork with Resident #5 to the hospital as all information was faxed to the hospital for prior approval for admission. She further stated that she had no	F 205	conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of Federal and State law. The facility will ensure that the bed-hold policy/notice upon transfer will be provided to the resident or resident representative upon transfer to the hospital. Residents #3 and #4 currently do not reside at The Laurels of Summit Ridge. Resident #5 was readmitted on 4/22/2017 and currently resides at The Laurels of Summit Ridge. All Residents have the potential to be affected. All Nurses were in-serviced on April 6, 2017 by the Regional Clinical Specialist. In-servicing reviewed the following: a. proper paperwork needed to be sent with Resident upon transferring/discharging to the Hospital, including the bed-hold agreement. b. What to do if Resident is alert and oriented. c. What to do if Resident Representative is present at time of transfer/discharge. Resident's charts who have transferred to Hospital will be reviewed by DON or Unit Manager or Social Services Director for the next 3 months. Any variances will be addressed at the time identified and	

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 04/06/2017

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 205	Continued From page 2 idea about information related to a bed hold and Resident #5 would not have understood the bed hold agreement. Family was interviewed via phone on 04/05/17 at 12:17 PM. Family related that he did not receive any information upon discharge related to the bed hold agreement, nor had anyone from the faclity called him about holding a bed for Resident #5. Family further stated that he expected Resident #5 to return to the facility following hospital discharge. On 04/06/17 at 9:34 AM, interview with the Marketing Director revealed that after a transfer to the hospital, she called the family and ask them over the phone if they desired to hold the bed. She stated she did not send a written notice but noted on the bed hold form the date and time she spoke to the family and their desire to hold the bed or not hold the bed. She further stated that she did not know how bed holds were handled for the psychiatric hospital and she did not call the family for Resident #5. Interview on 04/06/17 at 9:40 AM with the Business Office Manager, who maintained the bed hold forms, revealed she had no bed hold agreement for Resdient 5 as he was admitted to a psychiatric hospital and the facility would automatically take him back. The Director of Nursing was interviewed on 04/06/17 at 10:53 AM. She stated that the facility automatically readmitted residents from the psychiatric hospital so that the hospital will continue to accept their residents as needed. She confirmed there was no bed hold agreement sent to the hospital with Resident #5.	F 205	re-education will take place as needed. All findings will be reported by the Director of Nursing to the QA committee monthly for 3 months and quarterly thereafter for 3 quarters.	

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 04/06/2017

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 205	Continued From page 3	F 205		

2. Resident #3 was admitted to the facility on 09/12/15. The quarterly Minimum Data Set dated 01/10/17 coded her as understanding and being understood, having intact cognition, and disorganized thinking.

Nursing notes dated 03/12/17 at 10:08 PM revealed Resident #3 was found lying on the floor. Resident #3 complained of severe right arm and shoulder pain. Resident #3 was subsequently sent to the emergency room. There was no documentation to support that a bed hold agreement was sent to the hospital with Resident #3.

Record review revealed Resident #3 was not readmitted to this facility.

Nurse #1 was interviewed on 04/05/17 at 12:05 PM. She confirmed she was the nurse who transferred Resident #3 to the hospital. Nurse #1 provided the discharge packet used by nursing staff when a resident was discharged to the hospital. This packet included a transfer to hospital form, a personalized elder care information sheet, and the facility's bed hold agreement. Nurse #1 stated that Resident #3 could not understand the bed hold agreement and she routinely removed the bed hold agreement form from the packet before sending the other information to the hospital with the resident. She stated family was generally not present in the facility as was the case with Resident #3. Nurse #1 repeated that she did not send the bed hold agreement with Resident #3 to the hospital.

Family was interviewed via phone on 04/05/17 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 04/06/2017

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 205	Continued From page 4	F 205		

12:21 PM. Family confirmed that she received no written bed hold agreement. She stated that the morning following the discharge, the Marketing Director called her and explained the bed hold policy over the phone. Family stated that they did not want to hold Resident #3's bed.

On 04/06/17 at 9:34 AM, interview with the Marketing Director revealed that after a transfer to the hospital, she called the family the following office day and asked them over the phone if they desire to hold the bed and noted their response on the bed hold agreement. She stated she did not send a written notice but noted on the bed hold form the date and time she spoke to the family and their desire to hold the bed or not hold the bed.

Review of this form revealed the Marketing Director noted on the form she spoke to the family the week of 03/12/17 after Resident #3 was hospitalized and provided her the cost of the bed hold amount. The form indicated that the family did not choose to hold the bed. The Marketing Director wrote a second note on this form for a second phone call to the family (no date) that indicated family was considering moving Resident #3 to a facility closer to home.

Interview with the Director of Nursing on 04/06/17 at 10:53 AM revealed that the packet which the nurses fill out for a hospital transfer included the bed hold agreement. She expected that form to accompany the resident to the hospital.

3. Resident #4 was admitted to the facility on 03/21/17. There was no Minimum Data Set, however, a Brief Interview for Mental Status form dated 03/28/17 noted he had intact cognition.

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 04/06/2017

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 205	Continued From page 5	F 205		

Nursing notes dated 03/31/17 at 3:46 AM revealed Resident #4 experienced a change in condition including vomiting resulting in a physician's order to send him to the hospital. There was no documentation relating to the bed hold agreement.

Attempts to reach Nurse #2, who was responsible for sending Resident #4 to the hospital, via phone were unsuccessful.

Resident #4 was readmitted to the facility on 04/05/17.

A phone interview with family on 04/06/17 at 8:52 AM revealed she received nothing in writing about the bed hold agreement. She stated that she called the facility about collecting his belongings sometime after he was went to the hospital. She was then informed (by whom she could not say) about the bed hold agreement and amount. Family stated she opted to not hold his bed.

On 04/06/17 at 9:34 AM, interview with the Marketing Director revealed that after a transfer to the hospital, she called the family and asked them over the phone if they desired to hold the bed. If the transfer occurred on a weekend, she called the following week. She stated she did not send a written notice but noted on the bed hold form the date and time she spoke to the family and their desire to hold the bed or not hold the bed.

Review of the bed hold agreement revealed Resident #4's family called and spoke to the Marketing Director on 04/01/17 stating she would pick up his belongings. She opted not to hold his

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 04/06/2017

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 205	Continued From page 6 bed, however, the note indicated family wanted Resident #4 to return to the facility. Interview with the Director of Nursing on 04/06/17 at 10:53 AM revealed that the packet which the nurses fill out for a hospital transfer included the bed hold agreement. She expected that form to accompany the resident to the hospital.	F 205		