PRINTED: 05/20/2015 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345438	B. WING		C 04/24/2015
NAME OF PROVIDER OR SUPPLIER			S	STREET ADDRESS, CITY, STATE, ZIP CODE	04/24/2010
THE LAUF	RELS OF SUMMIT RIDGE			00 RICEVILLE ROAD	
		•		ASHEVILLE, NC 28805	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	
F 000	INITIAL COMMENTS		F 000		
F 332	complaint investigation Event ID # ENO011.	cited as a result of the in attached to this survey	F 332		5/21/15
	RATES OF 5% OR M The facility must ensu	ORE			
	by: Based on observation interviews the facility administration error raduring the 25 medical opportunities. Novologadministered and Caladministered (Reside The findings included 1. Resident #16 was a 04/19/15 with diagnos Minimum Data Set (Noto recent admission. A record review of nudated 04/19/15 reveation disoriented to person. A review of physician indicated Resident #1 Insulin 5 units subcutabefore meals at 7:30.	ate of 8.00% observed tion administration g Insulin was not cium plus Vitamin D was not nts #16 and #69). : admitted to the facility on sis of diabetes mellitus. IDS) was not available due		Preparation and/or execution of this plof correction does not constitute admission or agreement by the provide the truth of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely becaute it is required by the provisions of Feder and State law. Resident #16 and #69 were administer omitted medications immediately. The residents are receiving their medication as ordered. No negative outcome resulted from the delay of administration. Current residents receiving medication have the potential to be affected. All licensed nurses to be in-serviced by the Director of Nursing using Relias Learning course MED-medication administration with objectives of instructing those responsible for	r of f se al ed ss n.
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE		TITLE	(X6) DATE

ABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

05/14/2015

Electronically Signed Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that

other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA (X2) MU IDENTIFICATION NUMBER: A. BUIL		E CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345438	B. WING		C 04/24/2015	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE (X4) ID SUMMARY STATEMENT OF DEFICIENCIES			1	STREET ADDRESS, CITY, STATE, ZIP CODE 00 RICEVILLE ROAD ASHEVILLE, NC 28805 PROVIDER'S PLAN OF CORRECTION		
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROF DEFICIENCY)		
F 332	scale insulin based of meals and at bedtim 201-250 = 2 units 251-300 = 4 units 301-350 = 6 units 351-400 = 8 units >400 = 10 units and A record review of th 04/30/15 for Resider 04/21/15 and reveal was to be administer meal at 4:30 PM. Sli was to be administer blood sugar results. Resident #16 was of administration on 04 was observed obtain result of 360 for Resident was observed administer mouth and sliding so subcutaneously to Rindicated she had conditionally administration for Resident. Nurse #2 on Novolog 5 units subcutaneously to Rindicated she administration for Resident. Nurse #2 on Novolog 5 units subcutaneously to Rindicated she administration for Resident with Nurse #2 on Novolog 5 units subcutaneously to Rindicated she administration for Resident. Nurse #2 on Novolog 5 units subcutaneously to Rindicated she administration for Resident. Nurse #2 on Novolog 5 units subcutaneously to Rindicated she administration for Resident #16 had a insulin to be administration be administrat	call MD the MAR dated 04/19/15 to the matter of the matte	F 332	medication administration in proper to perform a medication pass. Medication administration observation will be conducted by the Administrat Nurses and DON weekly for (4) four weeks, then randomly thereafter. Variances will be corrected at the time observation. Continued compliance will be monited through routine random medication administration observations and through facility's quality assurance program (3) three months for ongoing compliance Additional education and monitoring be initiated for any identified concerns.	ons ive ne of ored ough am for ance. will	

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345438	B. WING		C 04/24/2015		
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805	1 0412412013		
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPRODEFICIENCY)	JLD BE COMPLETION		
F 332	#16 the missed dos An interview was co 04/22/15 at 5:22 PN been off for two day had Novolog insulir not before meals. N had not checked ph Novolog insulin was Resident #16 befor An interview was co Nursing (DON) on 0 stated her expectat administer all medic 2. Resident #69 wa 10/27/13 with diagr Alzheimer's disease Minimum Data Set indicated Resident A review of physicia 04/30/15 and signe Resident #69 was t milligrams (mg) plu mouth twice daily a A record review of t Record (MAR) date Resident #69 was o revealed Calcium 6 tablet was schedule	ce of Novolog insulin now. Inducted with Nurse #2 on M. Nurse #2 stated she had As and thought Resident #16 In administered with meals and Illurse #2 further revealed she Inspician's order to verify that Is to be administered to Inducted with the Director of Inducted on Inducted with the Director of Inducted I	F 33	2			
	Resident #69 at 8:0 Resident #69 was of administration on 4 was observed admi	ed to be administered to 100 AM and 5:00 PM. Observed for medication 1/21/15 at 4:56 PM. Nurse #2 1/21/15 at 4:56 PM. Nurse #2 1/21/15 PM. Nurse #2					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	JULTIPLE CONSTRUCTION ILDING		(X3) DATE SURVEY COMPLETED	
		345438	B. WING _		0,	C 4/ 24/2015	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE				STREET ADDRESS, CITY, STATE, ZIP CODE 100 RICEVILLE ROAD ASHEVILLE, NC 28805		#12 TO	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES / MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUT CROSS-REFERENCED TO THE APPRIDEFICIENCY)	JLD BE	(X5) COMPLETION DATE	
F 333 SS=D	resident. Nurse #2 on Calcium 600 mg with An interview with Nurse #2/1/15 at 5:22 PM. administering Calcium Resident #69. Nurse is overlooked the medic stated she would administer was concluded to the conclusion of the conclusio	inpleted medication sident #69 and was ar medication to a different nitted the administration of Vitamin D to Resident #69. See #2 was conducted on Nurse #2 stated she missed in 600 mg with Vitamin D to italian with the Director of with the Calcium 600 mg ident #69 now. Iducted with the Director of w	F3		dent is red. No e delay records a was urse on	5/21/15	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			1	C 24/2015
NAME OF PI	ROVIDER OR SUPPLIER			STREET	ADDRESS, CITY, STATE, ZIP CODE	1 04/	24/2013
				100 RICE	EVILLE ROAD		
THE LAUF	RELS OF SUMMIT RIDGE	Ē			ILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 333	Continued From page	e 4	F 3	33			
	Minimum Data Set (Note to recent admission.	IDS) was not available due		the	icensed nurses will be in-serviced Director of Nursing using Relias rning MED medication pass course	-	
		's order dated 04/19/15 I 6 was to receive Novolog		Cou	irse objectives to instruct those ponsible for medication administrat		
	insulin 5 units subcuta	aneous three times a day		in p	roper way to perform a medication	OII	
	PM. Resident #16 wa	AM, 11:30 AM, and 4:30 as to receive Novolog sliding		pas			
		n blood sugar results before		1	dication administration observation	_	
	meals and at bedtime 201-250 = 2 units	? .			be conducted by the Administrative		
	251-300 = 4 units				ses and DON weekly for (4) weeks n randomly thereafter. Variances w		
	301-350 = 6 units			I	corrected at the time of observation		
	351-400 = 8 units			1 50 0	corrected at the time of observation	•	
	>400 = 10 units and o	call MD		Obs	servation results will be reported to	the	
	To drinto dria c	Jan M.D			N weekly for (4) four weeks and		
	A record review of the	e MAR dated 04/19/15 to			cerns will be reported to the quality	,	
	04/30/15 for Resident	t #16 was conducted on			urance committee during the month		
	04/21/15 and reveale	d Novolog insulin 5 Units		I	eting.	,	
		ed subcutaneously before			· ·		
	meal at 4:30 PM. Slid	ling scale Novolog insulin		Con	tinued compliance will be monitore	ed be	
	was to be administere blood sugar results.	ed at 4:30 PM based on		obs	ugh random medication administra ervations and through the facility's lity assurance program for (3) three		
	Resident #16 was ob- administration on 04/2	served for medication 21/15 at 4:45 PM. Nurse #2		mor	nths for ongoing compliance. Í litional education and monitoring w		
		ng a finger stick blood sugar dent #16. Nurse #2 was		be i	nitiated for any identified concerns		
		ng a blood thinner tablet by					
		ale Novolog insulin 8 units					
	subcutaneously to Re						
	indicated she had cor						
	administration for Res						
	1	er medication to a different					
		nitted the administration of utaneously to Resident #16.					
	_	•					
	O4/21/15 at 5:25 PM.	se #2 was conducted on Nurse #2 stated she					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		I DENTIFICATION NUMBER:		IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345438	B. WING			C 04/24/2015	
NAME OF PROVIDER OR SUPPLIER THE LAURELS OF SUMMIT RIDGE				STREET ADDRESS, CITY, STATE, ZIP C 100 RICEVILLE ROAD ASHEVILLE, NC 28805	•	04/24/2013	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACT CROSS-REFERENCED TO T DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 333	thought Resident #16 Novolog insulin before stated she administer because Resident #16 sugar was 360. Nurse Resident #16 had a s insulin to be administer Nurse #2 stated she w #16 the missed dose An interview was cone 04/22/15 at 5:22 PM. been off for two days had Novolog insulin a not before meals. Nur had not checked phys Novolog insulin was to Resident #16 before in An interview was cone Nursing (DON) on 04 stated her expectation	was only on sliding scale e dinner meal. Nurse #2 ed Novolog insulin 8 units 6's finger stick for blood e #2 stated she did not think cheduled dose of Novolog ered prior to dinner meal. would administer to Resident of Novolog insulin now. ducted with Nurse #2 on Nurse #2 stated she had and thought Resident #16 dministered with meals and rse #2 further revealed she sician's order to verify that to be administered to meals. ducted with the Director of /23/15 at 2:46 PM. The DON	F3	333			

PRINTED: 05/20/2015 FORM APPROVED

(X6) DATE

Division of Health Service Regulation

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		NH0540	B. WING		C 04/24/2015
NAME OF PI	ROVIDER OR SUPPLIER		DDRESS, CITY, STAT	TE, ZIP CODE	,
THE LAUF	RELS OF SUMMIT RIDGE		EVILLE ROAD LLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETE
D 000	Initial Comments		D 000		
D 0000	No deficiencies were	cited as a result of the in attached to this survey			
	olth Service Pegulation				

Division of Health Service Regulation LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Electronically Signed 05/14/15

STATE FORM 6899 If continuation sheet 1 of 1 ENO011

TITLE