DEPARTI	MENT OF HEALTH AN	ID HUMAN SERVICES					M APPROVED
CENTER	S FOR MEDICARE &	MEDICAID SERVICES				OMB NO	D. 0938-0391
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED C 08/20/2015	
		345438	B. WING				
NAME OF PE	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	00/20/2015	
				10	0 RICEVILLE ROAD		
THE LAUP	ELS OF SUMMIT RIDGE			AS	SHEVILLE, NC 28805		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS		F	000			
		cited as a result of the apleted 8/20/15(Event ID					
LABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATU	JRE		TITLE		(X6) DATE

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.

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## PRINTED: 09/01/2015 FORM APPROVED

Division of Health Service Regulation STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0540			(X2) MULTIPLE CO			3) DATE SURVEY COMPLETED	
			A. BUILDING:				
		B. WING		08/20/2015			
AME OF PF	ROVIDER OR SUPPLIER	STREET	ADDRESS, CITY, STATE,	ZIP CODE			
	RELS OF SUMMIT RIDG	E	EVILLE ROAD LLE, 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) COMPLET DATE	
D 000	Initial Comments		D 000				
		e cited as a result of the npleted 8/20/15 (Event ID					
	alth Service Regulation			דודו ר			
RATORY	UIRECTOR'S OR PROVIDER	SUPPLIER REPRESENTATIVE'S SIGNATU	KE	TITLE		(X6) DATE	