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	345438	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification and complaint investigation survey was conducted on 05/12/25 through 05/15/25. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID # 4QZ311.	E 000		
F 000	INITIAL COMMENTS A recertification and complaint investigation survey was conducted from 05/12/25 through 05/15/25. Event ID# 4QZ311. The following intakes were investigated: NC00217850, NC00219465, NC00226384, NC00226833, NC00228066, NC00229319 and NC00229864. 7 of the 19 complaint allegations resulted in deficiency.	F 000		
F 558 SS=E	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 record review, observations, and resident and staff interviews, the facility failed to maximize residents' independence with transfers and bed mobility by not providing assist bars or side rails for 2 of 4 residents reviewed for accommodation of needs (Resident #43 and Resident #28). The findings included:	F 558	The facility will continue to maximize resident independence with transfers and bed mobility by providing assist bars or side rails when appropriate. Resident #43 and Resident #28 had physical device evaluations completed jointly by therapy and nursing department staff on 5.22.25 to ensure that resident independence with transfers and bed	6/9/25

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

Electronically Signed | 06/06/2025

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F 558	Continued From page 1 1. Resident #43 was admitted to the facility on 9/8/23 with diagnoses that included chronic obstructive pulmonary disease, cervical and vertebral disc degeneration, spinal fusion, and generalized muscle weakness. The quarterly Minimum Data Set (MDS) assessment dated 2/4/25 indicated Resident #43 was cognitively intact, did not have range of motion impairment to either upper or lower extremities, and required supervision or touching assistance with rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing position, and chair/bed-to-chair transferring. A physical device evaluation dated 2/6/25 indicated Resident #43 had assist bars that were both up in his bed. The assist bars were assessed as enabler and the following reasons were listed for the device use: repositioning/support, enable/increase bed mobility, enhance mobility, enable/increase independence, improve physical status, and enable resident to reposition self. The evaluation further indicated that Resident #43 was at low risk for entrapment related to the device use. Resident #43's care plan revised on 3/20/25 indicated Resident #43 had a functional ability deficit and required assistance with self-care and mobility. He required assistive devices. Interventions included to encourage participation in therapy, and encourage to participate in self-care as much as able, provide positive reinforcement for all activities attempted, and praise resident for all efforts and accomplishments.	F 558	mobility was maximized. Resident #43 was noted on evaluation to be independent with bed mobility and transfers and assist bars/side rails were not indicated. Resident #28 was noted on evaluation to be able to roll and scoot in bed independently upon evaluation and assist bars/side rails were not indicated. No negative outcome was identified relating to these evaluations. Current residents have the potential to be affected. All current residents had physical device evaluations completed by nursing administration as of 6.6.25 to ensure that resident independence with transfers and bed mobility is being maximized and assist bars or side rails provided when appropriate. No negative outcomes were identified resulting from these evaluations. All licensed nurses will be inserviced by the ADON as of 6.8.25 on the facility policy for siderails and appropriate indications for use to maximize resident independence with transfers and bed mobility. Any newly hired licensed nurses will be inserviced on the same during orientation prior to working their first shift on the floor. A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 6.9.25. The DON/designee will complete physical device evaluations to ensure that resident independence with transfers and bed mobility is being maximized. The	

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F 558	Continued From page 2 A physical device evaluation dated 5/8/25 indicated Resident #43 did not use bed/side rails and assist bars. An observation and interview with Resident #43 on 5/12/25 at 11:31 AM revealed him sitting on his wheelchair which was right next to his bed. He did not have any side rails or assist bars in his bed. Resident #43 stated he used to have an assist bar on his bed before the nursing staff took it out and said the state made them take out all the side rails and assist bars. Resident #43 stated that he talked to the Administrator who told him that there was some way they could put the assist bar in his bed through a therapist evaluation. He further stated that he talked to the therapist, but she told him that she didn't know anything about putting an assist bar back in his bed. Resident #43 shared that he used to use his assist bar to get up from his bed and to get back in it because he was able to transfer himself without assistance from staff. He said it was easier instead of trying to hang on to his wheelchair which he kept positioned right by his bed so he could have something to hold onto whenever he was moving to or from the bed. An interview with the Rehabilitation Services Director (RSD) on 5/13/25 at 1:30 PM revealed physical therapy was currently working with Resident #43 on ambulation and transfers. The RSD stated that they originally worked with Resident #43 when he was first admitted to the facility, and they worked on trying to get him to a position to where he could manage at home, but he could not physically master toileting and effectively cleaning himself up independently. After they had finished working with him the first time, Resident #43 was able to transfer himself	F 558	evaluations will be conducted at a frequency of 5 residents weekly x 4 weeks, then 3 residents weekly x 4 weeks, then 1 resident weekly x 4 weeks. Variances will be corrected at the time of evaluation and additional education or corrective action provided when indicated. Evaluation 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 evaluations and through the facilitys 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/completion: 06.09.2025	

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independently. The RSD further stated that Resident #43 had mentioned to him about requesting for an assist bar because he had difficulty rolling himself in bed without having something to hold onto. The RSD stated that he passed it on to nursing during clinical meetings but there wasn't much of a response. He further shared that as far as he knew, it was company facility that the use of assist bars and side rails had to meet a certain criteria before they would allow their use. The RSD said that Resident #43 would benefit from the use of an assist bar in increasing his independence with bed mobility and transferring.

A second observation and interview with Resident #43 on 5/13/25 at 1:15 PM revealed he mentioned the issue about an assist bar to the Unit Manager, and she told him that she was just following what her boss told her. Resident #43 was observed transferring himself from his wheelchair to his bed while holding on to the wheelchair armrest. Resident #43 voiced difficulty in maneuvering around without the support of an assist bar. He stated that it would make it easier for him to transfer himself from the bed to his wheelchair or vice versa if he had an assist bar in his bed.

A joint interview with the Unit Manager and the Director of Nursing (DON) on 5/15/25 at 10:17 AM revealed all residents received a physical device assessment to make sure their devices were appropriate for them, and these included the use of assist bars. The DON stated that this was a gradual process which they started a couple of weeks ago because they were trying to decrease the use of side rails or assist bars and discourage their long term use. The DON further stated that

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they only wanted to use them when necessary. She shared that this was based on direction from their corporate who felt that the less devices they used, the better it would be for safety reasons. The DON stated that Resident #43 never slept in the bed, always slept in a recliner, rarely transferred himself independently, and staff was needed to help him pivot when transferring.

A follow-up observation and interview with Resident #43 on 5/15/25 at 10:47 AM revealed there was no recliner in Resident #43's room and Resident #43 stated he had always slept in his bed, and never had a recliner in his room. Resident #43 further stated that the DON did not know enough about him because she never came into his room, and that it made him so mad when they took off his assist bar because he wanted to maintain his independence with bed mobility and transfers. He also shared that the Unit Manager did not assess and observe him using the assist bar but instead all she did was look at the device and told him that they would have to take it out due to a corporate decision.

An interview with Nurse Aide #1 on 5/15/25 at 10:51 AM revealed he never had to assist Resident #43 in transferring himself, and that Resident #43 was able to do it independently.

A joint interview was conducted with the DON and the Administrator on 5/15/25 at 3:51 PM. The DON stated that most of her interaction with Resident #43 was when he was on the rehabilitation hall, so she hadn't seen his current room. The DON stated that they were given a directive from corporate to lessen device use, but they did not consult with therapy prior to discontinuing Resident #43's assist bar because

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he was not on their caseload at that time. The Administrator stated that she met with Resident #43 at least five times since she started working at the facility and he had not mentioned his concern regarding the assist bar. The Administrator added that she had seen Resident #43 holding on to his bed with the head of the bed raised up while transferring himself, and she did not think he had difficulty doing it.

2. Resident #28 was admitted to the facility on 10/29/24 with diagnoses that included chronic kidney disease, cervical disc degeneration and generalized weakness.

The significant change Minimum Data Set (MDS) dated 3/25/25 indicated Resident #28 was cognitively intact, did not have range of motion impairment to either upper or lower extremities, and was independent with rolling left and right in bed.

A physical device evaluation dated 2/6/25 indicated Resident #28 had both ½ side rails up on her bed. The ½ side rails were assessed as an enabler and the following reasons were listed for the device use: repositioning/support, enable/increase bed mobility, enhance mobility, enable/increase independence, and improve physical status. The evaluation further indicated Resident #28 was at low risk for entrapment related to the device use.

Resident #28's care plan dated 3/26/25 indicated she had a functional ability deficit, required assistance with self-care and mobility and required assistive devices. Interventions included to encourage participation in therapy and encourage to participate in self-care as much as

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able.

A physical device evaluation dated 5/07/25 indicated Resident #28 did not use bed/side rails and assist bars. The evaluation was completed by the Unit Manager and the documentation did not include a risk assessment, or the observation Resident #28 was not able to follow directions consistently and was deemed unsafe for bed rails.

An observation and interview with Resident #28 on 5/12/25 2:01 PM revealed her lying in bed with the head of her bed raised. Resident #28 indicated her side rails were taken off about three weeks ago and she had been using them to turn over and pull herself around in bed and would like to get her side rails back. She stated she would like to be able to position herself when she wants as she did before without having to ask staff for help. Resident #28 shared staff now had to assist her by pushing her to roll from side to side in bed.

A follow-up observation and interview with Resident #28 on 5/15/25 at 11:28 AM revealed a staff member came into her room about three weeks ago and removed her side rails, and she did not recall a side rail assessment being done with her at that time. She further indicated Nurse Aides now have to push her to roll left or right in bed when she could do it before by herself. Resident #28 shared she uses her bedside nightstand to assist her with rolling over in bed when she can reach it.

An interview on 5/13/25 at 2:05 PM with the Physical Therapist (PT) revealed Resident #28 would have a much easier time with bed mobility

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if side rails were in place. The PT indicated therapy was currently working with Resident #28 to increase independence with bed mobility and get her to be modified independent (taking more time to perform a task but able to do it independently with an assistive device) with bed mobility. She revealed Resident #28 would definitely benefit from having side rails for her bed mobility.

An interview on 5/15/25 at 8:51 AM with Nurse Aide (NA) #2 revealed Resident #28 had been mostly independent with rolling from side to side in bed using her side rails and had required just a little assistance now and then. She indicated Resident #28 currently moves around in bed but not quite as well as when she had side rails and needed more assistance to roll over now.

A joint interview with the Unit Manager and the Director of Nursing (DON) on 5/15/25 at 10:23 AM revealed every resident received a physical device assessment to ensure any devices used were appropriate and safe for them to use. The Unit Manager indicated when she performed the physical device assessment on 5/07/25, Resident #28 was not able to follow directions consistently and was deemed unsafe for side rails. The DON shared their corporate office directive was to use the least restrictive interventions possible for resident safety.

A joint interview with the DON and Administrator on 5/15/25 at 3:51 PM revealed they would communicate with the therapy department regarding Resident #28 and have her reevaluated for side rail safety. The Administrator shared they were given a directive from their corporate office to remove side rails and use the least restrictive

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F 558	Continued From page 8 option available for residents.	F 558		
F 584 SS=D	Safe/Clean/Comfortable/Homelike Environment CFR(s): 483.10(i)(1)-(7) §483.10(i) Safe Environment. The resident has a right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility must provide- §483.10(i)(1) A safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible. (i) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk. (ii) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft. §483.10(i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; §483.10(i)(3) Clean bed and bath linens that are in good condition; §483.10(i)(4) Private closet space in each resident room, as specified in §483.90 (e)(2)(iv); §483.10(i)(5) Adequate and comfortable lighting levels in all areas; §483.10(i)(6) Comfortable and safe temperature levels. Facilities initially certified after October 1,	F 584		6/9/25

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F 584	Continued From page 9 1990 must maintain a temperature range of 71 to 81°F; and §483.10(i)(7) For the maintenance of comfortable sound levels. This REQUIREMENT is not met as evidenced by: Based on observation and staff interviews the facility failed to maintain the shower room tile floor in good repair when missing and broken tiles were observed for 1 of 1 shower rooms reviewed for a safe, clean, comfortable and homelike environment. The findings included: An observation of the shower room conducted on 05/14/25 at 3:06 PM with the Unit Manager revealed missing and broken floor tiles at the front of the shower area. The damaged space on the floor comprised of 22 missing square tiles with tiles in the space loose and not attached to the floor. Each tile was approximately 2 inches by 2 inches. Two tiles were loose from the floor in the damaged space, four attached tiles were loose in the damaged space and one loose tile was broken into two pieces and loose in the damaged space. The entire damaged area was approximately one foot by one foot in an irregular shape and could be a tripping hazard based on the loose, irregular shaped tiles. While in a shower chair a resident's feet could come in contact with the damaged area and broken tiles. During an interview with the Unit Manager conducted immediately after the shower room observation on 5/21/25 at 3:11 PM she indicated the damage must have just happened and she would alert the Maintenance Director to get it	F 584	The facility will continue to ensure that residents have a safe, clean, comfortable, and homelike environment. The Corporate Construction and Property Management Manager conducted an on-site inspection on 4.29.25 to identify facility repairs needed and to coordinate these services. Flooring repair began on 5.12.25 by a contacted company and will be completed by 7.15.25, to include the chipped tile in the shower room. A non-slip floor mat has been temporarily placed over the area of missing tile until the repair is completed. No negative outcome was identified relating to this observation. The Administrator and Maintenance Director conducted a facility-wide inspection on 5.16.25 to identify any other areas in need of repair. No negative outcome was identified relating to this inspection. The Maintenance Director and Housekeeping staff were educated by the Administrator on the facility Environmental Rounds policy and expectation of having a safe, clean, comfortable, and homelike environment on 6.1.25. Any newly hired Maintenance or Housekeeping staff hired after 6.1.25 will be educated on the same policy prior to working their first shift on the floor.	

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F 584	Continued From page 10 fixed. The Unit Manager stated not all residents received a shower or bath in the shower room but a shower had just been completed before we entered the room as the shower area was still wet. She voiced the Maintenance Director was in the process of redoing all the floors including the shower room floor and once the other floors were done, he would start replacing the shower room floor. An interview with Nurse Aide #2 on 05/15/25 at 8:51 AM revealed the tiles in the shower room had been damaged for about six weeks but she had no problem rolling a shower chair occupied by a resident over the damaged area when using the shower room. On 05/14/25 at 3:56 PM an observation of the shower room conducted with the Maintenance Director revealed the shower room floor would be replaced in about a month, after the other flooring replacement was completed in other parts of the building. He indicated the missing and loose tiles had been there a couple of months but there was nothing that could be done to fix the damaged area as anything that was put into place would just pop up again when the water hit it. An interview with the Administrator on 05/15/25 at 4:15 PM revealed she was aware of the damage and had put it on the list to be fixed as soon as possible. She indicated the shower room was not being used by residents as all residents received a shower in their own bathroom. The Administrator was informed during the interview the shower room was being used for resident showers per observations and staff interviews and she had no response.	F 584	A QA monitoring tool will be utilized to ensure ongoing compliance. Beginning on 6.2.25 the Facility Tour Audit Tool will be completed by the Administrator/designee to ensure that areas identified as needing repair are scheduled to be corrected timely. Audits will be conducted at the following frequency by the Administrator/designee at the following frequency: 5 days per week for 4 weeks, then 3 days per week for 4 weeks, then 1 day per week for 4 weeks. Variances will be corrected at the time of audit and additional education/corrective action provided when indicated. Audits results will be reviewed by 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 facilitys 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/completion: 06.09.2025	

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F 677	Continued From page 11	F 677		
F 677 SS=D	ADL Care Provided for Dependent Residents CFR(s): 483.24(a)(2) §483.24(a)(2) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene; This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interviews, the facility failed to perform fingernail care for 1 of 2 residents reviewed for (ADL) care (Resident #8). The findings included Resident #8 was admitted to the facility on 3/8/22 with diagnoses that included dementia, Parkinson's Disease, type 2 diabetes, and osteoarthritis. Resident #8 was care planned for functional ability deficit and required assistance with self-care and mobility and frequently refusing showers revised on 1/30/25. Interventions included to document and report to a nurse as needed for any changes in functional ability, potential for improvement, and reasons for inability to perform activities of daily living. An additional intervention included to reapproach the resident later with another staff if he refuses care. A review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated 3/31/25 coded him as cognitively intact. He required maximum assistance with toileting and setup or clean up assistance with personal hygiene. A review of the facility's bathing schedule	F 677	The facility will continue to ensure that residents are assisted with nail care according to schedule and preferences. Resident #8 had nail care provided on 5.15.25 per Nurse #1. There was no negative outcome relating to this observation. Current residents that require assistance with nail care have the potential to be affected. All current residents that require assistance with nail care were audited by the nursing management team as of 5.16.25 and nail care provided by c n as as directed by DON. This was completed as of 5.16.25. There were no negative outcomes identified relating to this audit. 100% of nursing assistants and licensed nurses were inserviced by the ADON as of 6.1.25 on facility policy for providing assistance to residents that require assistance with nail care and how to accurately document. Newly hired c n as and licensed nurses that are hired after 6.1.25 will be educated by the ADON on the same facility policy during orientation prior to working their first shift on the floor.	6/9/25

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	345438	A. BUILDING _____ B. WING _____	C 05/15/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
THE LAURELS OF SUMMIT RIDGE	100 RICEVILLE ROAD ASHEVILLE, NC 28805

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F 677	Continued From page 12 revealed Resident #8 was scheduled to be bathed on Monday and Thursday. On 5/12/25 at 2:48 PM an in-room observation and interview revealed all of Resident #8's fingernails on both hands to be approximately ½ inch past the tip of his fingers. The fingernails contained black substance underneath his nails. Resident #8 stated during the observation that it had been a couple of months since his fingernails were last cut or cleaned by a nurse aide or nurse. The resident stated he was told by a nurse aide that a nurse would have to cut his nails because he had diabetes. Resident #8 said he would like to have all his nails on both hands cut and cleaned, and he had not tried to cut or clean his nails. On 5/15/25 at 11:28 AM an in-room observation and interview revealed Resident #8's nails remained unchanged. The resident stated he had not had a bath or shower during the current week. Resident #8's assigned Nurse Aide (NA) #1 was interviewed on 5/15/25 at 12:55 PM. NA #1 stated Resident #8 was scheduled to be showered or bathed 2 days each week on Monday and Thursdays. The NA stated around 9:00 AM on 5/15/25 he asked Resident #8 if he wanted a shower and the resident refused. NA #1 stated he did not notice Resident #8's fingernails and was unaware how long they were or that they needed to be cleaned when he was with the resident earlier. He also stated he had not noticed Resident #8's fingernails while providing care to him the previous day (5/14/25). The NA went on to say cleaning fingernails and trimming fingernails was part of the shower routine, but he was not allowed to trim resident nails who had	F 677	A QA monitoring tool will be utilized to ensure ongoing compliance by the DON/designee beginning on 6.2.25. The DON/designee will randomly observe 5 residents 5x/weekly x 4 weeks, then 3x/weekly x 4 weeks, then weekly x 4 weeks to ensure that assistance is being provided to residents that require assistance with nail care. 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 beginning on 6.2.25 and concerns will be reported to the Quality Assurance Committee during monthly meetings. Continued compliance will be monitored through the facilitys Quality Assurance Program and random observations. 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/completion: 06.09.25	

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F 677	Continued From page 13	F 677		

diabetes. NA #1 said he would tell his nurse when a diabetic resident needed to have their nails trimmed and he had not notified his nurse regarding Resident #8's fingernails

On 5/15/25 at 1:11 PM a follow-up observation and interview with Resident #8 revealed his fingernails remained unchanged. The resident stated he was offered a shower Monday evening (5/12/25) and he declined the shower, and he was not asked if he wanted his fingernails cleaned or cut. Resident #8 also stated he was not offered a shower during the current morning (5/15/25).

Resident #8's assigned Nurse #1 for 5/15/25 was interviewed on 5/15/25 at 1:17 PM. She stated NA #1 had reported to her a few minutes prior that Resident #8 had refused his shower today (5/15/25) and she was writing a nurse's progress note that documented the refusal. Nurse #1 stated Resident #8 did have a history of refusing showers and baths and she had not personally tried to cut his fingernails. Nurse #1 stated it was the nurse's responsibility trim the fingernails of a diabetic resident, and she was not aware Resident #8's nails were ½ inch longer than his fingers or that there was a black substance noted under the nails. Furthermore, the nurse stated the NAs should have communicated to her Resident #8's fingernails needed to be trimmed and cleaned, and she would ask the resident if she could trim his nails.

On 5/15/25 at 2:01 PM Nurse #1 stated she had trimmed Resident #8's nails. Resident #8 had not refused the nail care today and she had soaked his nails in water, cleaned and filed them down.

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F 677	Continued From page 14 On 5/15/25 at 4:02 PM the Director of Nursing (DON) stated Resident #8 did have a history of refusing care. The DON stated nail care was completed as part of showers or baths and long nails of a diabetic resident needed to be reported to a nurse. The nurse would have been able to trim and clean Resident #8's fingernails.	F 677		
F 759 SS=D	Free of Medication Error Rts 5 Prcnt or More CFR(s): 483.45(f)(1) §483.45(f) Medication Errors. The facility must ensure that its- §483.45(f)(1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication omission and administration of wrong dosage (2 medication errors out of 31 opportunities), resulting in a medication error rate of 6.45% for 1 of 3 residents (Resident #28) observed during medication pass. The findings included: Resident #28 was admitted to the facility on 9/16/24 with diagnoses that included chronic obstructive pulmonary disease (COPD), and anemia. a. The Physician's Orders in Resident #28's electronic medical record indicated an active order dated 11/26/24 for Cyanocobalamin (Vitamin B12) tablet 1000 micrograms (mcg) - give 1 tablet by mouth one time a day.	F 759	The facility will continue to ensure that all residents are free of medication errors. The physician and RP for Resident #28 were notified on 5.14.25 of the medication errors. New orders were carried out per the MD. No additional monitoring was required. No negative outcome was identified relating to this observation. Current residents have the potential to be affected. MAR and vital sign reviews of all current residents were conducted by the DON on 5.14.25 at the time of discovery with no negative observations identified. Nurse #1 was educated on the six rights of medication administration during med pass and had a competency review completed on 5.14.25 by the ADON. All licensed nurses and medication aides	6/9/25

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F 759	Continued From page 15 On 5/14/25 at 8:48 AM, Nurse #1 was observed as she prepared and administered Resident #28's medications. Nurse #1 did not administer a Cyanocobalamin tablet to Resident #28. An interview with Nurse #1 on 5/14/25 at 10:42 AM revealed she missed giving the Cyanocobalamin tablet to Resident #28 and it wasn't included in the pills she administered to Resident #28. b. The Physician's Orders in Resident #28's electronic medical record indicated an active order dated 3/18/25 for Guaifenesin (expectorant medication) extended release 12 hour 600 milligrams (mg) - give 1 tablet by mouth every 12 hours for COPD. On 5/14/25 at 8:48 AM, Nurse #1 was observed as she administered Resident #28's medications. Nurse #1 administered Guaifenesin 400 mg tablet to Resident #28. An interview with Nurse #1 on 5/14/25 at 10:42 AM revealed she didn't realize that she gave the wrong dose of Guaifenesin to Resident #28. Nurse #1 stated that she took the medication out of a stock bottle and what was available was 400 mg tablets on the label, and they did not have 600 mg tablets of Guaifenesin available. An interview with the Director of Nursing (DON) on 5/14/25 at 10:54 AM revealed Guaifenesin was normally a stock medication at the facility, and it came in different strengths. The DON stated that if the dosage ordered for Resident #28 was different from what they had available, then they could order them from the pharmacy. The	F 759	were educated by the ADON on the six rights of medication administration during med pass as of 6.1.25. All newly hired licensed nurses and medication aides hired after 6.1.25 will be educated by the ADON on the six rights of medication administration during med pass prior to working their first shift on the floor. A QA monitoring tool will be utilized starting on 6.2.25 to ensure ongoing compliance. The ADON/designee will observe medication pass for 3 residents 5x/week x 2 weeks then 3 residents 3x/week x 2 weeks then 3 residents weekly x 1 month then 3 residents bi-weekly x 1 month to ensure that the six rights of medication administration are being followed during med pass. Variances will be corrected at the time of the observation and additional education provided when indicated. Observation and 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 observations and through the facilitys 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.	

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F 759	Continued From page 16 DON stated that this was Nurse #1's first time working on the medication cart after several weeks of orientation, and she should have followed the five rights of medication administration by verifying the medication cards against the orders.	F 759	Date of compliance: 06.09.2025	
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 interviews with staff, the facility failed to date leftover food stored for use in the walk-in refrigerator. The facility also failed to maintain the walk-in refrigerator cooling unit pipe from dripping water onto the wall and floor and maintain the cooling unit pipe and walls of the walk-in refrigerator free from substance build-up. This was for 1 of 2 walk-in refrigerators	F 812	The facility will continue to ensure that leftover food items used for residents are properly dated, labeled, and stored. The facility will also continue to ensure that walk-in refrigerators are free of dripping water and substance build-up. The undated item was dated of at the time	6/9/25

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F 812	Continued From page 17 observed (walk-in refrigerator #2). Findings included An observation made in the kitchen's walk-in refrigerator #2 on 5/12/25 at 10:37 AM with the Cook revealed 2 opened and undated bags of shredded cheese located on the second shelf of the food storage rack. A pipe located behind the cooling unit was slowly dripping water onto the floor of the refrigerator. The pipe went from the back of the cooling unit and into the wall and contained a white and fuzzy in appearance substance spread across the duration of the pipe. Each wall of the walk-in refrigerator contained areas of the white fuzzy substance. The Cook was interviewed on 5/12/25 at 10:37 AM during the observation and stated the cheese was used earlier in the day and should have been dated for use within 7 days before storing it in the walk-in refrigerator. The Cook immediately dated the cheese. Additionally, the Cook said she did not know the cooling unit's pipe was dripping water and did not know the last time the walk-in refrigerator had been cleaned. On 5/15/25 at 1:59 PM an observation of the walk-in refrigerator #2 with the Maintenance Director revealed the cooling unit pipe to be dripping water. The Maintenance Director stated he was not aware the water was dripping and would contact a refrigerator repair company to look at it. The temporary Dietary Manager was interviewed on 5/15/25 at 2:30 PM. She stated the shredded cheese should have been dated before storing in the refrigerator. She also stated she was	F 812	of discovery. There was no negative outcome relating to this observation. All other food storage areas were inspected by the Administrator on 5.15.25 to ensure that all leftover food items were properly dated, labeled, and stored. There were no negative outcomes relating to these observations. A contracted refrigerator repair company did an on-site inspection of the walk-in refrigerator areas on 5.30.25. No repair needs were identified, insulation was added and no negative outcome was identified relating to this inspection. All dietary staff were inserviced by the Administrator on the facility policy for food dating, labeling, and storage as of 6.1.25. Any newly hired dietary staff hired after 6.1.25 will be educated on the same policy prior to working their first shift. A QA monitoring tool will be utilized by the Administrator/designee beginning on 6.2.25 to ensure that all food items are properly dated, labeled, and stored, as well as ensuring that walk-in refrigerators are free of dripping water and substance build-up. The Administrator/designee will randomly inspect all food storage areas 5x/week x 4 weeks, then 3x/week x 4 weeks, then weekly x 4 weeks to ensure that all food items are properly dated, labeled, and stored, as well as ensuring that walk-in refrigerators are free of dripping water and substance build-up. Variances will be	

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F 812	Continued From page 18 unaware of the dripping pipe from the cooling unit and the walk-in refrigerators should be deep cleaned on a quarterly basis, and did not know the last time they were deep cleaned. The Administrator was interviewed on 5/15/25 at 4:02 PM. She stated food stored in the walk-in refrigerator's should be dated when stored. The Administrator stated the dripping pipe from the cooling unit should be repaired to prevent water from dripping in the refrigerator. She also stated the walk-in refrigerators should be cleaned routinely and as needed.	F 812	corrected at the time of observation and additional education provided when indicated. Observation results will be reviewed by 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 facilitys 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 06.09.2025	
F 880 SS=D	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:	F 880		6/9/25

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F 880	Continued From page 19 §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 providing services under a contractual arrangement based upon the facility assessment conducted according to §483.71 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	F 880		

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F 880	Continued From page 20 identified under the facility's IPCP and the corrective actions taken by the facility. §483.80(e) Linens. 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 observations, record review, and staff interviews, the facility failed to follow their infection control policy when the Floor Technician entered a resident's room (Resident #46) on Enhanced Droplet Precautions without donning an N95 mask, gown, or eye protection. This was for 1 of 6 staff members observed for infection control practices (Floor Technician). Findings included The facility's policy titled "Multi Route Transmission Based Precautions" was last updated on 11/22/22. The droplet precautions policy stated that staff should wear an N 95 mask, gown, gloves, and eye protection. Resident #46 was diagnosed with COVID on 5/5/25. A physician order dated 5/5/25 for Contact and Droplet Isolation (Transmission Based Precautions) related to COVID-19 every shift and all care to be provided in room. On 5/12/25, at 1:41 PM Floor Technician was	F 880	The facility will continue to ensure that transmission-based precautions are followed to prevent the spread of infection. The floor technician received immediate education on the facility policy for transmission-based precautions by the ADON at the time of discovery. No negative outcome resulted from this observation. Current residents have the potential to be affected. All staff working in the facility at time of discovery were immediately educated by the ADON on the facility policy for transmission-based precautions. No negative outcomes resulted from this observation. 100% of staff were inserviced by the ADON as of 6.1.25 on the facility policy for transmission-based precautions. All newly hired employees hired after 6.1.25 will be educated on the same policy prior to working their first shift on the floor.	

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F 880	Continued From page 21 observed entering Resident #46's room. Adjacent to Resident #46's door was observed to have an Enhanced Droplet precaution sign that stated staff were to wear gown, an N95 mask, gloves and either face shield or goggles. Outside of Resident #46's door was a small 3 drawer container next to the room with masks, gowns, gloves, and eye covering. The Floor Technician entered the room wearing a surgical mask and gloves and proceeded to check the trash can in the resident's room. The trash can was located approximately 4 feet from the foot of the resident's bed. The Floor Technician was in the room for approximately 10 seconds. When the Floor Technician left Resident # 46's room, he removed his gloves and sanitized his hands with sanitizer that was available on the wall in the hallway. On 5/12/25 at 1:42 PM the Floor Technician was interviewed. He confirmed he entered Resident #46's room without wearing the required personal protective equipment (PPE). The Floor Technician stated he normally did not go into resident rooms and that he did not realize he needed to wear the PPE. The Floor Technician acknowledged the signage beside the resident's door was for enhanced droplet precautions, and he was supposed to do what the sign said before entering the room. The Floor Technician also said he had received infection control training recently. On 5/14/25 at 11:55 AM the Infection Preventionist (IP) was interviewed. She stated Resident #46 was on enhanced droplet precaution for a positive COVID test on 5/5/25. The IP stated all facility staff were expected to wear the PPE indicated on the signage for	F 880	A QA monitoring tool will be utilized to ensure ongoing compliance by the ADON/designee beginning on 6.2.25. The ADON/designee will randomly observe staff entering resident rooms with posted transmission-based precautions signs 5x/week x 4 weeks then 3x/week x 4 weeks then weekly x 4 weeks to ensure that transmission-based precautions are followed 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 facilitys 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 06.09.2025	

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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 22 enhanced droplet precautions which included a KN95 mask, gown, gloves, and face shield when entering a room on enhanced droplet barrier precautions. ON 5/15/25 at 4:02 PM the Director of Nursing stated the Floor Technician was not typically assigned as a housekeeper; he was filling in for a housekeeper on 5/12/25. The Floor Technician was not accustomed to going into resident rooms and had received infection prevention training. The DON stated he should have followed the enhanced droplet precautions before entering the room.	F 880		