STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER: 345438

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _______________________
B. WING _______________________

(X3) DATE SURVEY COMPLETED
C 03/24/2011

NAME OF PROVIDER OR SUPPLIER
THE LAURELS OF SUMMIT RIDGE

STREET ADDRESS, CITY, STATE, ZIP CODE
100 RICEVILLE ROAD
ASHEVILLE, NC 28805

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECeded BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td></td>
<td></td>
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</tr>
<tr>
<td></td>
<td>No deficiencies cited as result of survey event ID# U9H211.</td>
<td>F 000</td>
<td></td>
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</tbody>
</table>

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

TITLE

(X6) DATE

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**

**Provider/Supplier/Clinical Laboratory Identification Number:**

NH0540

**Multiple Construction**

A. Building: 

B. Wing: 

**Date Survey Completed:** 03/24/2011

**Name of Provider or Supplier:** The Laurels of Summit Ridge

**Street Address, City, State, Zip Code:** 100 Riceville Road Asheville, NC 28805

<table>
<thead>
<tr>
<th>(X4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(X5) Complete Date</th>
</tr>
</thead>
</table>
| L 000             | INITIAL COMMENTS

No deficiencies cited as result of survey event ID# U9H211. | L 000 | | |

**Laboratory Director's or Provider/Supplier Representative's Signature**

STATE FORM  6399  U9H211  If continuation sheet 1 of 1