<table>
<thead>
<tr>
<th>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>COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>L 000</td>
<td>INITIAL COMMENTS</td>
<td>L 000</td>
<td>No deficiencies were cited as a result of the complaint investigation Event ID #FTF111.</td>
<td></td>
</tr>
</tbody>
</table>

Division of Health Service Regulation

NAME OF PROVIDER OR SUPPLIER: THE LAURELS OF SUMMIT RIDGE

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: NH0540

MULTIPLE CONSTRUCTION

A. BUILDING: _____________________________

B. WING: _____________________________

DATE SURVEY COMPLETED: 08/17/2011

C

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

TITLE

STATE FORM 5599

If continuation sheet 1 of 1