STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 survey was conducted on 04/01/19 through 04/05/19. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID NGN011.	E 000		
F 641 SS=E	Accuracy of Assessments CFR(s): 483.20(g) §483.20(g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. This REQUIREMENT is not met as evidenced by: Based on observation, record review, and staff interviews the facility failed to accurately code the Minimum Data Set (MDS) functional status needs, a facility acquired pressure ulcer, and urinary continence for 5 of 15 residents whose MDS assessments were reviewed (Residents #5, #8, #21, #24, and #34). Findings included: 1. Resident #8 was admitted to the facility on 03/03/16 with diagnoses which included obstructive uropathy (functional or structural hindrance of normal urine flow), and Parkinson disease. The quarterly Minimum Data Set (MDS) dated 10/22/18 assessed Resident #8 as cognitively intact and needed extensive assist for toilet use, bed mobility, and transfers. Section M assessed skin conditions and determined Resident #8 was at risk for but currently had no unhealed pressure ulcers.	F 641	The Laurels of Summit Ridge wishes to have this submitted plan of correction stand as its written allegation plan of compliance. Our Compliance date is May 3, 2019. Preparation and/or execution of this plan does not constitute admission to nor agreement with either existence of or scope of severity of the cited deficiencies. This plan is prepared and/or executed to ensure compliance with regulatory requirements. F641 Accuracy of Assessments Corrective Action: MDS Coordinator has corrected identified errors for Resident #5, Resident #8, Resident #21, Resident #24 and Resident #34 on 04/04/2019. Corrective Action for those having the potential to be affected: All residents have the potential to be affected by the alleged deficient practice.	5/3/19

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

Electronically Signed | 04/29/2019

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 1 A skin assessment dated 01/05/19 identified a stage 3 pressure ulcer to the coccyx. The wound was first noted on 12/28/18 with dimensions of 0.7 centimeters (cm) x 1.3 cm x 1 cm. A significant change MDS dated 01/07/19 under section M assessed Resident #8's skin conditions and identified a stage 3 pressure ulcer was present upon admission. The Care Area Assessment (CAA) revealed a significant change occurred due to a new stage 3 pressure ulcer to the coccyx with treatment in place and the resident was followed by the wound physician. A wound physician note dated 02/12/19 documented the progress of Resident #8's coccyx ulcer was healing with dimensions of 0.5 cm x 1 cm x 0.6 cm. The note included the duration of the wound was at least 43 days. During an interview on 04/04/19 at 12:37 PM the MDS Coordinator explained the significant change MDS assessment was done for a newly identified stage 3 pressure ulcer. She reviewed wound care notes and skin evaluations to obtain information used for coding. After reviewing the facility census and a wound physician note dated 12/31/18 with the duration of the pressure ulcer longer than 4 days, she determined Resident #8 was in the facility at that time. She confirmed the pressure ulcer was facility acquired and coded wrong and indicated she would do a modification to show it was facility acquired. During an interview on 04/04/19 at 3:51 PM the Director of Nursing revealed it was her expectation the MDS Coordinator and her assistant double check their work for accuracy. The MDS Coordinator and assistant were	F 641	All resident tasks in PCC were audited to ensure they all had personal hygiene, dressing and bathing tasks for CNA documentation in Point of Care. All residents with pressure ulcers and foley catheters had their MDS audited by Regional Clinical Resource Specialist to ensure MDS coding was correct. No negative outcome noted due to this alleged deficient practice. Systematic Changes: Regional Clinical Resource Specialist will educate MDS staff on proper coding of the MDS for foley catheters, pressure ulcers, bathing, dressing and personal hygiene by 4/26/2019. Monitoring: Director of Nursing or designee will audit sections G,H and M of completed assessments weekly for accuracy x 4 weeks, then every 2 weeks x 1 month, then monthly x 2 months to ensure MDS coding is accurate for sections G,H and M. Audits to begin 5/6/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 2	F 641		

provided copies of the Medical Doctor (MD) wound progress notes and a copy of the wound/pressure ulcer log which identified stage, size, and location. The log also contained information related to if the ulcer was facility acquired or present upon admission and the treatment.

2. Resident #34 was admitted to the facility on 03/10/16 with diagnoses which included neurogenic bladder (lack of bladder control due to the brain, spinal cord, or nerve problem), and dementia.

The annual Minimum Data Set (MDS) dated 03/03/19 assessed Resident #34 as cognitively intact and needed extensive assistance with transfers and toileting. The annual MDS indicated an indwelling catheter was in place and Resident #34 was always incontinent with no episodes of continent voiding.

A review of MDS 3.0 manual for urinary continence instructed if during the 7-day look-back period the resident had an indwelling bladder catheter, or no urine output for the entire 7 days enter not rated as the code.

During an interview on 04/05/19 at 2:53 PM the MDS Coordinator explained she coded Resident #34's urinary section always incontinent based on the Nurse Aides (NA) documentation. She was unsure how to accurately code the MDS section for urinary continence for a resident with an indwelling catheter. She confirmed Resident #34 had an indwelling catheter and to her knowledge it wasn't leaking. She was going to reach out to the Regional Corporate MDS Nurse to clarify coding for residents with a patent indwelling

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 3	F 641		

catheter and modify the MDS based on guidance.

During an interview on 04/04/19 at 1:01 PM the Director of Nursing revealed it was her expectation for MDS coding to be accurate.

3. Resident #21 was admitted to the facility on 12/03/16 with diagnoses including non-Alzheimer's dementia among others.

Review of the annual Minimum Data Set (MDS) dated 02/01/19 revealed Resident #21 had impaired short and long-term memory. The MDS also revealed for activities of daily living, dressing, hygiene and bathing did not occur during the lookback period.

Review of the most recent quarterly MDS dated 12/10/18 also revealed for activities of daily living (ADL), dressing, hygiene and bathing did not occur during the lookback period.

During an interview on 04/03/19 at 10:18AM, Nursing Assistant (NA) #8 stated Resident #21 received extensive assistance with hygiene and dressing daily. NA #8 also stated Resident #21 was total assistance with bathing, which she received twice a week. The interview further revealed Resident #21 had not experienced any changes in the amount of assistance that she needed with her ADL in the past 3 months.

During an interview on 04/03/19 at 10:38AM, Nurse #11 stated Resident #8 required extensive assistance with dressing, hygiene and bathing. Nurse #8 further stated Resident #8 had no changes in her ADL ability in the past 6 months.

During an interview on 04/04/19 at 12:23PM, the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 4	F 641		

MDS Coordinator stated the ADL information came from the NA documentation in the kiosk. She also stated that she knew Resident #8 was extensive assistance for dressing, hygiene and bathing, but since it was not documented by the NAs she was not going to code it on the MDS. She was further observed to review the ADL task sheet in the computer and recognized the coding was not set up for the NAs to answer questions for dressing, hygiene and bathing so the answers would flow from the kiosk to the MDS.

During an interview on 04/04/19 at 3:51PM, the Director of Nursing (DON) stated it was her expectation for the MDS Coordinator and her assistant to double check their work to ensure the MDS was accurate.

4. Resident #24 was admitted to the facility on 03/26/11 with a diagnosis of high blood pressure among others.

Review of the quarterly Minimum Data Set (MDS) dated 2/11/19 revealed Resident #24 had impaired short and long-term memory. The MDS also revealed for activities of daily living (ADL), dressing, hygiene and bathing did not occur during the lookback period.

Review of the previous quarterly MDS dated 11/11/18 also revealed for activities of daily living (ADL), dressing, hygiene and bathing did not occur during the lookback period.

During an interview on 04/04/19 at 12:14PM, Nursing Assistant (NA) #9 stated Resident #24 was extensive to total assistance for all her ADL including dressing, hygiene and bathing. NA #9 further stated Resident #24 had no changes in

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 5	F 641		

her ADL in over a year.

During an interview on 04/04/19 at 12:17PM, Nurse #1 stated Resident #24 required assistance with all her ADL. Nurse #1 also stated Resident #24 was dressed and had personal hygiene assistance daily, received showers at least twice a week, and he had noticed no declines or improvements in her ability in the last few months.

During an interview on 04/04/19 at 12:23PM, the MDS Coordinator stated the ADL information came from the NA documentation in the kiosk. She also stated that she knew Resident #24 was extensive assistance for dressing, hygiene and bathing, but since it was not documented by the NAs she was not going to code it on the MDS. She was further observed to review the ADL task sheet in the computer and recognized the coding was not set up for the NAs to answer questions for dressing, hygiene and bathing so the answers would flow from the kiosk to the MDS.

During an interview on 04/04/19 at 3:51PM, the Director of Nursing (DON) stated it was her expectation for the MDS Coordinator and her assistant to double check their work to ensure the MDS was accurate.

5. Resident #5 was admitted to the facility on 11/01/17 with diagnoses including diabetes among others.

Review of the annual Minimum Data Set (MDS) dated 01/02/19 revealed Resident #5 was alert and oriented. The MDS also revealed for activities of daily living (ADL), dressing, hygiene and bathing did not occur during the lookback

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 641	Continued From page 6 period. During an interview on 04/04/19 at 12:23PM, the MDS Coordinator stated the ADL information came from the NA documentation in the kiosk. She also stated that she knew Resident #5 was limited to extensive assistance for dressing, hygiene and bathing, but since it was not documented by the NAs she was not going to code it on the MDS. She was further observed to review the ADL task sheet in the computer and recognized the coding was not set up for the NAs to answer questions for dressing, hygiene and bathing so the answers would flow from the kiosk to the MDS. During an interview on 04/04/19 at 3:51PM, the Director of Nursing (DON) stated it was her expectation for the MDS Coordinator and her assistant to double check their work to ensure the MDS was accurate.	F 641		
F 656 SS=D	Develop/Implement Comprehensive Care Plan CFR(s): 483.21(b)(1) §483.21(b) Comprehensive Care Plans §483.21(b)(1) The facility must develop and implement a comprehensive person-centered care plan for each resident, consistent with the resident rights set forth at §483.10(c)(2) and §483.10(c)(3), that includes measurable objectives and timeframes to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following - (i) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as	F 656		5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 656	Continued From page 7 required under §483.24, §483.25 or §483.40; and (ii) Any services that would otherwise be required under §483.24, §483.25 or §483.40 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(c)(6). (iii) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident's medical record. (iv)In consultation with the resident and the resident's representative(s)- (A) The resident's goals for admission and desired outcomes. (B) The resident's preference and potential for future discharge. Facilities must document whether the resident's desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose. (C) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in paragraph (c) of this section. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident and staff interview the facility failed to follow the care plan for 1 of 1 resident reviewed for pain management (Resident #5). The findings included: 1. Resident #5 was admitted to the facility on 07/06/16 with diagnoses including pain in right and left knees among others. The annual Minimum Data Set (MDS) dated 01/02/19	F 656	F656 Develop/Implement Comprehensive Care Plan Corrective Action: Resident #5 was assessed for pain using a scale of 1-10 and pain medication provided per her request. Corrective Action for those having the potential to be affected: All residents experiencing pain have the potential to be affected by this alleged deficient practice. ADON put pain	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 656	Continued From page 8 indicated Resident #5 was alert and oriented and required extensive assistance with most activities of daily living. The MDS also indicated Resident #5 was on scheduled pain medication and had occasional pain up to a 3 on a pain scale of 1-10. Review of a care plan dated 01/08/19 revealed the following: "at risk for pain and acute pain related to chronic physical diabetic neuropathy, shingles, resident states acceptable pain level is 3." Interventions listed to manage pain included: "Evaluate characteristics of pain on a scale of 1-10 or on a verbal description scale: mild, moderate, severe, very severe, horrible." During an observation on 04/03/19 at 1:59 PM, Nurse #6 was observed examining Resident #5's buttocks and lower back. Resident #5 was observed to have extensive bruising across both buttocks and her lower back. Nurse #6 was observed informing Resident #5 she could have pain medication and she would get that for her. Nurse #6 was observed exiting the room of Resident #5 without questioning her pain level on a scale of 1-10 or a verbal description of mild, moderate, severe, very severe, or horrible pain. During an interview on 04/03/19 at 2:10 PM, Nurse #6 stated she did not ask Resident #5 about her pain level, but she should have before she offered her pain medication. Review of the Medication Administration Record (MAR) for April 3, 2019 revealed pain medication was given at 2:38 PM to Resident #5 and a follow-up pain scale was done at 2:44 PM when Nurse #6 asked the resident "what her pain level was on a scale of 1-10."	F 656	assessment scale 1-10 per shift in PCC for all residents. All new admits/readmits will have pain assessment scale 1-10 per shift added to their chart in PCC. No negative outcome noted due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will in-service all nurses to complete pain assessment scale 1-10 per shift and the importance of intervention per residents care plan in a timely manner by 5/3/2019 Monitoring: Unit Mangers will audit 5 random residents pain assessment scales on their units 3 x week x 1 month, then 1x week x 1 month , then monthly x 2 months to ensure any resident with reported pain has an intervention in place per residents care plan, intervention is documented and intervention provided in a timely manner. Audits will begin 5/6/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 656	Continued From page 9 Review of a nurses note dated for 04/03/19 at 3:08 PM, Nurse #6 documented the following: "guest informed this nurse that her buttocks was hurting and was an 8 on a pain scale of 1-10." During an interview on 04/05/19 at 1:49 PM, the Director of Nursing (DON) stated her expectations were for nurses to determine what the pain level was before offering pain medication and to follow the care plan.	F 656		
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 record review, observations, resident, and staff interviews the facility failed to provide nail and oral care for 1 of 5 residents reviewed for activities of daily living (Resident #6). Findings included: Resident #6 was admitted to the facility 12/06/18 with diagnoses which included depression, and weakness. A care plan revised 01/08/19 described Resident #6 was at risk for infection, pain, or bleeding with oral/dental health problems. The goal was to be free of infection, pain, or bleeding in the oral cavity through review date. Interventions included provide mouth care as per activities of daily living with personal hygiene. The care plan also described activities of daily living (ADL) self-care	F 677	F677 ADL Care Provided for Dependent Residents Corrective Action: Resident #6 Dentures were soaked and cleaned and nails were cut cleaned and filed. Corrective Action for those having the potential to be affected: All residents have the potential to be affected by this alleged deficient practice. All residents nails were cut, cleaned and filed by activities and or nursing. All residents with dentures had their dentures cleaned by nursing. There was no negative outcome due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will educate nursing staff on importance of cleaning	5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 677	Continued From page 10 performance deficit requiring assistance with ADL and mobility related to limited mobility, cognitive defects, and depression. The goal was to meet therapy goals and continue to assist with ADL task completion without a sign of decline through next review. Interventions included setup supplies, provide instruction and/or cues and assist with ADL task completion as needed. Required assistance with personal hygiene and oral care. A quarterly Minimum Data Set (MDS) dated 01/09/19 assessed Resident #6's cognition as moderately intact for daily decision making with no behaviors or rejection of care. Resident #6 required extensive assistance by staff for bed mobility, transfer, personal hygiene, and dressing. The dental assessment of the MDS indicated no existing dental problems. An observation made on 04/01/19 at 10:11 AM revealed Resident #6's right hand index, middle, and ring finger nails were approximately 3 centimeters (cm) long with brown colored debris under the nails. The left hand fingernails were approximately 3-4 cm long. The upper dentures had a white and brown colored debris build-up at the gum line and along individual teeth. An additional observation on 04/02/19 at 8:20 AM revealed dentures remained unchanged with white and brown colored debris. The fingernails remained unchanged with brown colored debris and approximately 3-4 cm long. During an interview on 04/02/19 at 2:15 PM Resident #6 explained staff had provided assistance with a shower earlier in the morning. The fingernails remained untrimmed with brown	F 677	dentures and keeping residents nails clean, cut and filed by 5/3/2019. Monitoring: Unit managers will perform random audits of residents on their units for denture cleaning and nails being cut, clean and filed 3 x week x 4 weeks, then monthly x 3 months. Audits will begin 5/6/2019. Results of the audits will be taken to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 677	Continued From page 11	F 677		

debris under the nails. The dentures remained unchanged with build-up debris. Resident #6 revealed staff didn't offer to clean dentures or clean and trim her fingernails during or after her shower.

During an interview on 04/02/19 at 4:04 PM Nurse Aide (NA) #1 explained Resident #6 required extensive assistance with bed mobility, transfers, and personal hygiene. NA #1 stated he had showered Resident #6 earlier this morning and checked the fingernails which appeared okay, so he didn't clip or clean underneath the nails. He explained Resident #6's dentures were cleaned every day when he worked and today during her shower he rinsed them with water. NA #1 observed Resident #6's fingernails and dentures and agreed the nails needed clipped and cleaned and the dentures continued to have a buildup debris. NA #1 stated he didn't clean the dentures with a dental brush and could have done a better job.

An additional interview on 04/03/19 at 2:17 PM NA #1 explained he provided Resident #6 with a denture cup and cleanser. He confirmed the resident's dentures were cleaned today and yesterday using a dental brush and explained the dentures had buildup and he had to scrub them to remove and they shouldn't have been that way.

During an interview on 04/04/19 at 3:44 PM the Director of Nursing (DON) revealed it was her expectation fingernails were cut and cleaned on shower days and as needed when visibly dirty or excessively long. The DON further stated dentures should be cleaned at bedtime by using a dental brush and soaked in a denture cleanser. The DON revealed department mangers do daily

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 677	Continued From page 12 rounds to ensure residents' fingernails were clipped. The interview further revealed the NAs should be cleaning dentures on evening shift and nurses should ensure dentures were being soaked. The morning shift nurses should ensure residents dentures were clean and placed in their mouth.	F 677		
F 690 SS=D	Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2)For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible. §483.25(e)(3) For a resident with fecal	F 690		5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 690	Continued From page 13 incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to prevent urinary catheter tubing from touching the floor for 1 of 1 resident reviewed for urinary catheter (Resident #34). Findings included: Resident #34 was admitted to the facility on 03/10/16 with diagnoses which included multiple sclerosis, dementia, and a neurogenic bladder (lack of bladder control due to a brain, spinal cord or nerve problem). A review of the annual Minimum Data Set (MDS) dated 03/03/19 assessed Resident #34 as cognitively intact and required extensive assistance with bed mobility, transfers, and toilet use. Appliances in place for bladder continence revealed the use of an indwelling urinary catheter. The Care Area Assessment described Resident #34 continued to self-propel in a wheelchair on the unit to attend activities and meals and required a suprapubic catheter for a neurogenic bladder. The care plan last revised on 03/04/19 identified Resident #34 was at risk for a urinary tract infections related to trauma due to a suprapubic catheter for a neurogenic bladder with a history of urinary tract infections. Resident #34 chose not to	F 690	F690 Bowel/Bladder Incontinence, Catheter, UTI Corrective Action: Resident #34 catheter tubing was immediately secured off the floor. Corrective Action for those having the potential to be affected: All residents with catheters have the potential to be affected by this alleged deficient practice. All residents with catheters were assessed by unit managers to ensure their catheter tubing was not touching the floor. No negative outcome noted due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will in-service all nursing staff on proper way to secure catheter tubing to ensure it is not touching the floor by 5/3/2019. Monitoring: Unit Managers will audit residents with catheters on their units 3x week x 4 weeks, then 1x week x 1 month, then monthly x 2 months to ensure catheter tubing is not on the floor. Audits will begin 5/6/2019. Results of the audits will be brought to QA by Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 690	Continued From page 14 wear a leg bag or strap at times. The goal of the care plan was for Resident #34 not to demonstrate signs or symptoms of a urinary tract infection through the next review date. Interventions in place which included change catheter and tubing per facility policy, position catheter bag, and tubing below the level of the bladder. During an observation on 04/01/19 at 3:43 PM Resident #34 was sitting in a wheelchair with the catheter bag attached underneath the chair. The tubing exited from bottom right pant leg and was touching the floor. During an observation 04/02/19 at 8:30 AM Resident #34 was self-propelling in a wheelchair down the unit hallway with the catheter bag attached underneath the chair. The tubing was dragging on the floor. Nurse Aide #1 (NA) stopped the resident to adjust clothing but didn't reposition the catheter tubing off the floor. Resident #34 continued to self-propel down the hallway. During an interview on 04/03/19 at 1:48 PM Resident #34 was sitting in a wheelchair when Nurse #6 indicated she last checked on the resident after lunch but didn't notice the catheter tubing on the floor. She confirmed the tubing was touching the floor and Resident #34 had self-propelled back and forth from the main dining room. She explained the tubing runs on the inside of the pant leg and with the bag attached underneath the wheelchair seat when the resident propels the clip comes off and the tubing touches the floor. Nurse #6 reattached the tubing to the privacy bag to keep it off the floor and stated infection control included to ensure tubing didn't	F 690	Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 690	Continued From page 15 touch the floor. During an interview on 04/03/19 at 2:24 PM NA #1 revealed he was assigned to provide catheter care for Resident #34 which included to ensure tubing didn't touch the floor to prevent contamination. He had attached the bag underneath the wheelchair and identified there was a clip to attach to the privacy bag to keep tubing off the floor. He checked tubing placement throughout his shift and didn't note it touch the floor today or yesterday. During an interview on 04/04/19 at 3:36 PM the Director of Nursing revealed it was her expectation nursing staff ensure catheter tubing was secure and didn't touch the floor which was part of infection control.	F 690		
F 697 SS=D	Pain Management CFR(s): 483.25(k) §483.25(k) Pain Management. The facility must ensure that pain management is provided to residents who require such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. This REQUIREMENT is not met as evidenced by: Based on observations, record review, resident, staff and physician interviews, the facility failed to assess and treat pain for 1 of 1 resident (Resident #5) reviewed for pain management. The findings included: Resident #5 was admitted to the facility on 07/06/16 with diagnoses including pain in right	F 697	F697 Pain Management Corrective Action: Resident #5 was assessed for pain per pain scale 1-10 and pain medication provided per her request. Corrective Action for those having the potential to be affected: All residents experiencing pain have the potential to be affected by this alleged	5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 697	Continued From page 16 and left knees among others. The annual Minimum Data Set (MDS) dated 01/02/19 indicated Resident #5 was alert and oriented and required extensive assistance with most activities of daily living. The MDS also indicated Resident #5 was on scheduled pain medication and had occasional pain up to a 3 on a pain scale of 1-10. Review of a care plan dated 01/08/19 revealed the following: "at risk for pain and acute pain related to chronic physical diabetic neuropathy, shingles, resident states acceptable pain level is 3." Interventions listed to manage pain included: "Evaluate characteristics of pain on a scale of 1-10 or on a verbal description scale: mild, moderate, severe, very severe, horrible." During an observation and interview on 04/03/19 at 1:54 PM with Resident #5, she had a pained look on her face as evidenced by furrowed brows and clenched jaw and stated her right side and hip were hurting and burning. Resident #5 further stated she had asked the nurse to look at her right side and hip over an hour before, but she had not come in yet. During an interview on 04/03/19 at 3:17PM, Nursing Assistant (NA) #9 stated on 04/03/19 she had assisted Resident #5 with incontinence care at some time between 10:00 AM and 11:15AM when Resident #5 told her hip was hurting. NA #9 stated Resident #5 had a very large bruise and could hardly be touched without being in pain, so she went out and told Nurse #6 about her pain after she completed her incontinence care. During an observation and interview on 04/03/19 at 1:59PM, Nurse #6 was asked if she was aware of Resident #5's pain. She stated she became	F 697	deficient practice. ADON put pain assessment scale 1-10 per shift in PCC for all residents. All new admits/readmits will have pain assessment scale 1-10 per shift added to their chart in PCC. No negative outcome noted due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will in-service all nurses to complete pain assessment scale 1-10 per shift and the importance of intervention in a timely manner by 5/3/2019 Monitoring: Unit Mangers will audit 5 random residents pain assessment scales on their units 3 x week x 1 month, then 1x week x 1 month , then monthly x 2 months to ensure any resident with reported pain has an intervention in place, intervention is documented and intervention provided in a timely manner. Audits will begin 5/6/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 697	Continued From page 17 aware of it when she took her capillary blood glucose (CBG) before lunch (at 11:26AM) and informed Resident #5 she would be back to assess her. Nurse #6 and an NA were observed assessing for an injury to Resident #5's right side and hip. Resident #5 was observed to have extensive bruising across both buttocks and her lower back. Nurse #6 was observed informing Resident #5 she could have pain medication and she would get that for her but did not ask Resident #5 what her pain level was. Nurse #6 verified as of 1:59 PM had not been back to check on Resident #5 to assess her for pain since 11:26 AM. Nurse #6 further stated she should have checked on her sooner, but staff was helping with lunch and she had no one to help roll her over. During an interview on 04/05/19 at 9:27AM, the Medical Director (MD) stated within an hour was a reasonable time to assess for muscular skeletal pain and for determining if medication administration is needed. During an interview on 04/05/19 at 1:52PM, the Director of Nursing (DON) stated her expectation was for a resident complaining of pain to be assessed as soon as possible and if medication for pain was needed, the resident should receive medication as soon as possible for pain relief.	F 697		
F 732 SS=C	Posted Nurse Staffing Information CFR(s): 483.35(g)(1)-(4) §483.35(g) Nurse Staffing Information. §483.35(g)(1) Data requirements. The facility must post the following information on a daily basis: (i) Facility name.	F 732		5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 732	Continued From page 18 (ii) The current date. (iii) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: (A) Registered nurses. (B) Licensed practical nurses or licensed vocational nurses (as defined under State law). (C) Certified nurse aides. (iv) Resident census. §483.35(g)(2) Posting requirements. (i) The facility must post the nurse staffing data specified in paragraph (g)(1) of this section on a daily basis at the beginning of each shift. (ii) Data must be posted as follows: (A) Clear and readable format. (B) In a prominent place readily accessible to residents and visitors. §483.35(g)(3) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. §483.35(g)(4) Facility data retention requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations and staff interview, the facility failed to post the correct nurse staffing ratio for skilled nursing facility (SNF) residents for 4 of 4 days reviewed. The findings included:	F 732	F732 Posted Nurse Staffing Information Corrective Action: Daily posted nurse staffing information included ALF residents in total census. Director of Nursing immediately corrected the posted nurse staffing information.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 732	Continued From page 19 Observations on 04/01/19 at 11:13AM, 04/02/19 at 8:56AM, 04/03/19 at 8:14AM and 04/04/19 at 9:19AM revealed the daily posted nursing schedule entitled "Report of Nursing Staff Directly Responsible for Resident Care" at the nurse's station upon entry into the facility at the 200-hall level was observed to have a higher resident census daily than the actual census for the SNF. The daily posting revealed the resident census at the start of shift for 7AM to 3PM, 3PM to 11PM and 11PM to 7AM; the total of licensed and non-licensed staff per shift; and the number of hours worked by the licensed and non-licensed staff per shift. The daily posting also had the date and Director of Nursing (DON) signature on each report. During an interview with the Director of Nursing (DON) on 04/03/19 at 8:17 AM, the DON stated that she always posted the SNF and Assisted Living Facility (ALF) together and did not break staffing down according to the 2 different areas. During a second interview with the DON on 04/04/19 at 9:32 AM, the DON stated that she was not aware that the SNF and ALF staffing could not be listed together. The DON stated they were all facility patients and so she put the numbers for residents and staffing together on the daily posting and did not separate them out between areas. During an interview with the Administrator on 04/04/19 at 9:38AM, the Administrator stated he knew the daily staffing was posted daily but was unaware it had been posted incorrectly. The Administrator stated his expectation was for the	F 732	Corrective Action for those having the potential to be affected: 100% audit with corrections made performed by Director of Nursing on daily staffing posting for the past year. No residents were affected by this alleged deficient practice. Systematic Changes: Administrator will educate Director of Nursing on policy and procedures for daily posting of staffing numbers by 5/3/2019. Monitoring: Administrator will audit daily posting of staffing numbers 3x week for 4 weeks then monthly x 3 months to ensure only skilled census numbers are being used. Audits to begin 5/6/2019. Results of the audits will be taken to QA by Administrator and reviewed monthly at the Quality Assurance Committee Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 732	Continued From page 20 daily staffing schedule to be posted correctly and be reflective of the actual number of staff and residents separated out between the SNF and the ALF.	F 732		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals §483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. §483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on record review, observations, resident and staff interviews the facility failed to ensure medications were under direct observation by the administering nurse who left medications	F 761	F761 Label/Store Drugs and Biologicals Corrective Action: Medications on floor and at bedside for Resident #45 were removed immediately	5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 761	Continued From page 21 unattended at the bedside for 1 of 5 residents reviewed for unnecessary medications (Resident #45). Findings included: Resident #45 was admitted to the facility 03/18/19 with diagnoses which included hypertension, depression, and septicemia. Review of physician orders written on 03/19/19 revealed: 1. Midodrine 5 milligrams (mg) give 2 tablets by mouth three times a day for blood pressure with meals. 2. Potassium chloride extended release 10 milliequivalents give 1 tab by mouth one time a day for supplement hold potassium if bumetanide (medication used to treat fluid retention and high blood pressure) was held. 3. Tamsulosin 0.4 mg give 1 capsule by mouth one time a day for urinary problems. The admission Minimum Data Set (MDS) dated 03/25/19 staff assessment determined Resident #45's cognitive skills were independent for making daily decisions. The MDS identified Resident #45 demonstrated rejection of care behaviors 1 to 3 days and received antidepressant, anticoagulant, and opioid medications for 7 days during the look back period of the assessment. The Care Area Assessment of the MDS described behaviors which included refusing medications with a referral for psychological consult. Review of the Medication Administration Record for March revealed: 1. Potassium chloride extended release 10	F 761	by Nurse #1. Corrective Action for those having the potential to be affected: All resident rooms were audited by department managers during daily rounds on 04/08/2019 to ensure no medications were on the floor or at the bedside. No negative outcome noted due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will in-service all nurses on importance of staying with the resident when administering medications to ensure they were taken per MD order by 5/3/2019. Nurses will also be in-serviced on self- administration policy and procedure by 5/3/2019. Monitoring: Department Managers will audit resident rooms during daily rounds M-F x 4 weeks, then weekly x 1 month, then monthly x 2 months to ensure there are no medications on the floor or at the bedside. Audits will begin on 5/6/2019. Unit Managers will observe random med passes 2 x week x 4 weeks, then weekly x 1 month, then monthly x 2 months to ensure nurses are not leaving medications at the bedside. Audits will begin 5/6/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 761	Continued From page 22	F 761		

milliequivalents initialed by Nurse #1 as administered at 7:20 AM on 03/31/19 and again at 7:31 AM on 04/01/19,
2. Tamsulosin 0.4 mg initialed by Nurse #1 as administered at 8:42 AM on 03/31/19 and again at 8:29 AM on 04/01/19,
3. Midodrine 5mg initialed by Nurse #1 as administered at 7:20 AM, 11:35 AM, and 4:21 PM on 03/31/19, and again at 7:31 AM on 04/01/19.

An observation made on 04/01/19 at 10:48 AM upon entrance to Resident #45's room revealed a small 30 ounce medication cup was left on a bedside table containing 1 blue capsule labeled 103, and 1 brown/orange capsule labeled 53 D. On the floor beside Resident #45's bed were 2 round white tablets labeled 846.

An interview conducted on 04/01/19 at 10:48 AM Resident #45 revealed the 2 white pills were spilled out of the cup and that's why they were on the floor. Resident #45 didn't recall how long the medications were left on the floor or in the medication cup at the bedside. When asked if nurse staff observe or leave medications at the bedside to self-administer the resident requested the interview be stopped and didn't want to answer any more questions.

During an interview on 04/01/19 at 10:59 AM Nurse #1 revealed he administered and observed Resident #45 take his morning medications. Nurse #1 observed 2 white pills on the floor and 2 capsules in a cup on the bedside table. He asked the resident why he didn't take the medications in the cup. Resident #45 revealed the medications were too big and he couldn't swallow them. Nurse #1 revealed he did not notice medications were left in Resident #45's room. Nurse #1 explained

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 761	Continued From page 23 when he administered morning medications on 04/01/19 he stayed in the room and watched Resident #45 swallow the pills. Nurse #1 confirmed the two white pills on the floor were midodrine, the brown/orange capsule was tamsulosin, and the blue capsule was potassium. Nurse #1 also had worked 03/31/19 at the time the same medications were administered and had initialed they were administered. Nurse #1 revealed it wasn't his practice to leave medication at the bedside. An interview conducted on 04/04/19 at 3:15 PM the Director of Nursing (DON) reviewed self-administer assessments and confirmed none were documented in the last 3 months for any resident at the facility. She revealed it was her expectation if medications were left at the bedside there would be a self-administer assessment and if the resident was capable a physician's order would be obtained. The DON expected the nurse staff to administer medications as ordered and make sure the resident took them. If medications were noted on the floor, or anywhere in the room she expected the nurse to remove them and notify her immediately to determine if the medication was given per physician orders.	F 761		
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.	F 880		5/3/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 24 §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: §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 §483.70(e) 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	F 880		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 25 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 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 record review, observations, and staff interviews the facility failed to perform hand hygiene when providing treatment for two separate wounds for 1 of 1 resident reviewed for pressure ulcers (Resident #45). Findings included: A review of the facility's policy revised 11/16 entitled: "Hand Hygiene." Read in part, the employee will perform hand hygiene as a primary means of preventing the spread of infection. Directions of when to wash your hands directed staff to perform hand hygiene before and after changing a dressing and after removing gloves. During an observation on 04/03/19 at 3:35 PM Nurse #11 performed hand hygiene, applied gloves and cleaned an open area on the right	F 880	F880 Infection Prevention and Control Corrective Action: Resident #45 wounds were assessed and dressings changed by Wound Care MD on 4/5/2019. Corrective Action for those having the potential to be affected: All residents with wounds have the potential to be affected by this alleged deficient practice. All residents with wounds were assessed and dressings changed by Wound Care MD on 4/5/2019. No negative outcome noted due to this alleged deficient practice. Systematic Changes: SDC/Director of Nursing will in-service all nurses on proper hand hygiene when doing wound care by 5/3/2019. Monitoring:	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345438	A. BUILDING _____ B. WING _____	C 04/05/2019

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 26 buttocks. Nurse #11 identified a new open area on the left buttocks and without removing her gloves or performing hand hygiene she cleaned the wound. She removed her gloves and without performing hand hygiene donned new gloves. She finished the treatment by applying separate dressing to cover the right and left buttock wounds while wearing the same gloves. During an interview on 04/03/19 at 4:03 PM Nurse #11 revealed she cleaned Resident #45's right and left buttock wounds without performing hand hygiene and while wearing the same gloves. After cleaning both wound sites she then removed her gloves and without performing hand hygiene re-gloved to apply dressings to both areas. Nurse #11 revealed she was trained to consider each wound separate and perform hand hygiene between treatments. Nurse #11 revealed she didn't perform hand hygiene because Resident #45 had no soiled dressings after receiving a shower prior to wound care and felt the areas were clean. During an interview on 04/04/19 at 3:28 PM the Director of Nursing revealed it was her expectation nurse staff perform hand hygiene before and after wound care and prior to re-gloving.	F 880	Infection Control Nurse will audit random wound dressing changes 3 x week x 4 weeks, then 1 x week x 1 month, then monthly x 2 months to ensure proper hand hygiene is being followed during wound care. Audits will begin 5/6/2019. Results of the audits will be brought to QA by the Director of Nursing and reviewed monthly at the Quality Assurance Meeting for any further recommendations. The Administrator will be responsible for ensuring any further recommendations are carried out. Completion Date: 05/03/2019	