**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**A. BUILDING __________________________**

**B. WING __________________________**

**NAME OF PROVIDER OR SUPPLIER**

**THE LAURELS OF SUMMIT RIDGE**

**STREET ADDRESS, CITY, STATE, ZIP CODE**

**100 RICEVILLE ROAD**

**ASHEVILLE, NC  28805**

**DATE SURVEY COMPLETED**

08/13/2020

**LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE**

Electronically Signed

08/20/2020

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
<th>PROVIDER’S PLAN OF CORRECTION</th>
<th>COMPLETION DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>F 000</td>
<td>INITIAL COMMENTS</td>
<td>F 000</td>
<td>(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</td>
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An unannounced COVID-19 Focused Infection Control Survey was conducted on 08/13/2020. The facility was found in compliance with 42 CFR §483.80 infection control regulations and has implemented the CMS and Centers for Disease Control and Prevention (CDC) recommended practices to prepare for COVID-19. There were 3 allegations investigated and all were unsubstantiated. Event ID# 5VTQ11.

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.