**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**THE LAURELS OF SUMMIT RIDGE**

**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**CENTERS FOR MEDICARE & MEDICAID SERVICES**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**

**THE LAURELS OF SUMMIT RIDGE**

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

100 RICEVILLE ROAD

ASHEVILLE, NC 28805

**PROVIDER'S PLAN OF CORRECTION**

*Each corrective action should be cross-referenced to the appropriate deficiency*

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

Electronic Signed

09/08/2020

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**E 000 Initial Comments**

An unannounced COVID-19 Focused Survey was conducted on 09/03/2020. The facility was found in compliance with 42 CFR §483.73 related to E-0024 (b)(6), Subpart-B-Requirements for Long Term Care Facilities. Event ID# DB9E11.

**F 000 INITIAL COMMENTS**

An unannounced COVID-19 Focused Infection Control and Complaint Investigation Survey was conducted on 09/03/2020. 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 was one allegation investigated and it was unsubstantiated. Event ID# DB9E11.