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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Summit Ridge	100 Riceville Road Asheville, NC 28805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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.

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

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	07/02/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Laurels of Summit Ridge	100 Riceville Road Asheville, NC 28805

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0689 Level of Harm - Actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, staff, family, and Nurse Practitioner (NP) interviews, the facility failed to implement effective interventions to prevent a resident (Resident #1) with right side hemiplegia (paralysis on the right side of the body) who took Plavix (antiplatelet medication) and aspirin (antiplatelet medication) from repeatedly falling from an air mattress and sustaining head injuries. Resident #1 sustained falls from her air mattress on 5/29/25, 6/10/25, and 6/13/25. After her fall on 5/29/25 Resident #1 had a raised lump and bruising to her head requiring her to be transferred to the emergency room (ER) for evaluation. After her third fall from the air mattress on 6/13/25, Resident #1 sustained another head injury which included a 3 centimeter (cm) laceration and hematoma. Resident #1 required ER evaluation and staples to treat the laceration to her head. This deficient practice occurred for 1 of 3 residents reviewed for supervision to prevent accidents. Findings included:Resident #1 was admitted to the facility on [DATE]. Her diagnoses included cerebral infarction (stroke), hemiplegia affecting the right dominant side, aphasia, dementia, muscle weakness, muscle wasting and atrophy, history of falling, long term use of antithrombotic/ antiplatelets.The admission Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #1 had severe cognitive impairment. She was not documented for behaviors or rejection of care. The MDS documented that she was dependent on staff for bed mobility. The MDS further documented she had a history of falling within the last month prior to admission and she received antiplatelet medication.A current care plan during June 2025 included Resident #1 was at risk for fall related injury and falls related to impaired mobility, incontinence, requires assistive device, and current diagnoses-cerebral infarction (stroke), hemiplegia affecting right dominant side. The care plan goal was for Resident #1 to be free from injury related to falls. The care plan interventions included the following interventions:- An intervention dated 5/30/25 read: bed in lowest position.-An intervention dated 6/10/25 read: physical therapy (PT) and occupational therapy (OT) evaluation. -An intervention dated 6/13/25 read: will replace air mattress with bolstered air mattress (an air mattress equipped with raised, supportive barriers along the sides. The primary function of bolsters is to create a defined edge, thereby preventing individuals from rolling off the mattress). Other interventions included on the fall care plan included encouraging her to wear non-skid footwear when out of bed. Encouraged to rest in recliner, chair, or bed when appears fatigued. Encourage to wear appropriate footwear as needed. Follow facility fall protocol. Keep the environment as safe as possible with adequate lighting, call light within reach, commonly used items within reach, avoid repositioning furniture and keep the bed in the appropriate position. Lock wheels on wheelchair prior to transfers. Orient to surroundings as needed. Monitor for side effects of medications.Resident #1's active physician orders during June 2025 included the following orders:-Plavix (Clopidogrel) 75 milligram (mg) oral tablet daily- Aspirin 81 mg chewable tablet dailyReview of a facility incident report dated 5/29/25 at 1:50 PM revealed Resident #1 sustained a fall. The incident report stated a Nurse Aide (NA) found Resident #1 lying on the floor next to her bed face down on the floor. The report indicated Resident #1 was unable to communicate about the incident. The incident report stated Resident #1 was assessed and the following injuries were noted: skin bruises on the right arm and left upper arm, bruise and swelling with lump on her upper right forehead and bruises on her right check. The physician was notified, and Resident #1 was transported to the ER for evaluation per physician orders. The incident report included Resident #1 was on an air mattress and the settings were correct. The fall intervention was to keep bed in the lowest position.An interview was conducted on 7/2/25 at 10:00 AM with NA #1. He said he had walked by Resident #1's room on 5/29/25 and saw her leg on the floor. He stated he went into her room to check on her and saw Resident #1 on the floor beside her bed. NA #1 reported he went and got Nurse #1.An interview was conducted on 7/1/25 at 11:30 AM with Nurse #1. She was the assigned nurse for Resident #1 when she fell on 5/29/25 and remembered the fall. Nurse #1 recalled Resident #1 had fallen from her bed. She stated Resident #1 was trying to get up unassisted from bed when she fell and the fall was unwitnessed. Nurse #1 said NA #1 had come and told her Resident #1 had fallen. Nurse #1 reported Resident #1 could not get up without assistance and needed the assistance of two staff members with bed mobility and transfers. Nurse #1 stated Resident #1 would move and wiggle in bed and would say she was trying to get up to go home. She recalled Resident #1 had an air mattress in place at the time of her fall on 5/29/25. Nurse #1 remembered Resident #1 hit her head when she fell on 5/29/25 from her bed and had to go to the hospital because she was on a blood thinner.A hospital note dated 5/29/25 said Resident #1 was seen in the