STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024

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

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49000 Based on observation, record review, and interviews with residents and staff, the facility failed to maintain call bell within reach for 1 out 2 residents reviewed for accommodations of needs. (Resident #1) The findings included: Resident #1 was admitted to the facility on [DATE]. The quarterly Minimum Data Set (MDS) dated [DATE] assessed Resident #1 with minimal impairment in cognition. The MDS indicated walking between locations at any time did not occur for Resident #1 during the assessment period. The care plan dated 3/7/24 revealed that the that the call bell was to be placed within reach and Resident #1 encouraged to use it for assistance. During an observation conducted on 3/19/24 at 10:20 AM the call bell was hanging off the right side of the bed. The call bell was hanging down approximately 10 inches. Resident #1 has a contracted neck which leans to his left side. Resident #1 leans to the left when laying in his bed. Resident #1 was able to use his right hand. Resident #1 was not able to reach the call bell. On 3/19/24 at 3:02 PM a second observation was made. The call bell was in the same position, which was hanging down from the bed on the right side. An interview was conducted with Resident #1 on 3/19/24 at 3:02 PM. Resident #1 stated he was unable to reach his call bell. Resident #1 has asked for the call bell to be placed on his bed on the left side. Resident #1 stated he needed his urinal emptied and Resident #1 needed to use his urinal. An interview with Resident #1's roommate on 3/19/24 at 3:10 PM revealed that the roommate has used his call bell to get help for Resident #1. The roommate stated he just now rang his call bell to get assistance for Resident #1. (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: 345438	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 03/21/2024
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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	An interview was conducted with Nurse Aide (NA) on 3/19/24 at 3:20 PM. The NA was asked about Resident #1's call bell. NA stated that Resident #1 knows how to use his call bell. The NA was asked about the current placement of the call bell and if it was poistioned for Resident #1 to use it. The NA agreed it was not. The NA went back into Resident #1's room to help him with his urinal. Observation was made and the call bell remained in the same position which was hanging from the bed on the right side. Subsequent observation conducted on 3/20/24 at 8:47 AM revealed the call bell for Resident #1 to be in the same position, hanging down on the right side of Resident #1's bed. An interview with the Administrator on 3/21/14 at 12:10 pm revealed that the expectation was for the call bells to be within reach. For Resident #1 the call bell should be on his left side. The Administrator stated that he thought Resident #1 was not able to use the call bell and that he wouldl either yell or his roommate will push his bell for assistance. The Administrator thought it was care planned that Resident #1 was unable to use the call bell.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945 Based on record reviews and interviews with resident, staff, and the Nurse Practitioner, the facility failed to have accurate advanced directive information documented throughout the medical record for 1 of 3 residents reviewed for code status (Resident #18). The findings included: Resident #18 was admitted to the facility on [DATE]. Review of Resident #18's annual Minimum Data Set on 11/3/23 revealed he was cognitively intact. A review of Nurse Practitioner (NP) #1's order dated 11/14/23 stated Full code, full scope of treatment, antibiotics if indicated, intravenous (IV) fluids if indicated, and feeding tube for a defined trial period per Medical Orders for Scope of Treatment (MOST) form reviewed on 11/14/23. Review of Resident #18's code status on top of his electronic health record (EHR) stated, Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, and feeding tube for a defined trial period per MOST form reviewed on 11/14/23. A review of documents in Resident #18's EHR revealed a pink MOST form effective 12/27/23. The boxes checked were attempt resuscitation, full scope of treatment, antibiotics as indicated, IV fluids if indicated, and no feeding tube. This form was signed by Resident #18 and NP #2. No date was written beside NP #2's signature. There were no physician or Nurse Practitioner's orders written for the 12/27/23 MOST form. Review of NP#2's progress notes on 12/27/23 stated Resident #18's code status was Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, feeding tube for a defined trial period per MOST form reviewed on 11/14/23. The Nurse Practitioner saw Resident #18 for completion of MOST form as well as pain control management on 12/27/23. The NP wrote discussion of MOST form with the resident was completed. The resident did want to remain full code with full scope of treatment at that time. Subsequent Nurse Practitioners' progress notes listed Resident #18's code status as Full code, full scope of treatment, antibiotics if indicated, IV fluids if indicated, feeding tube for a defined trial period per MOST form reviewed on 11/14/23. During the review of the original MOST form, the book in the nurses' station revealed Resident #18's two MOST forms were inside a clear plastic sleeve. The front part showed the MOST form effective 11/14/23 indicating Resident #18 wanted a feeding tube for a defined trial period. At the back of the same sleeve was the MOST form effective 12/27/23 indicating the resident did not want a feeding tube. During an interview on 3/18/24 at 3:39 pm Resident #18 stated he wanted to be resuscitated but did not want a feeding tube. (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 3/18/24 at 3:42 pm, the 200 Hall Charge Nurse revealed she would check the resident's code status information in the book if there was an emergency. She stated she would also check the resident's EHR to double check. The Charge Nurse stated it would be easier to access the EHR if she was on the floor. She stated she would still go in the EHR if she was in the nurses' station to ensure the resident was not under hospice care or to ensure they did not have additional instructions from the residents or family on the EHR. During an interview on 3/19/24 at 10:23 am, the 200 Hall Nurse revealed the nurses were responsible in obtaining the resident's code status during admission. The nurses asked the representative if the resident was not alert and oriented. The nurses placed the signed form in the providers' box for signing. The providers gave the form to the nurse after they signed. The nurse entered a code status order and changed the resident's code status in the EHR. The nurse made a copy of the form and placed it in the medical record's box. The medical records staff scanned the original document into the resident's EHR. The nurse filed the original form in the book located in the nurses' station. The 200 Hall Nurse stated there was a recent directive from NP #1 that MOST forms for all residents had to be done within 90 days. They followed the same process when changing forms. She stated she would check the resident's EHR first if there was a medical emergency. She would also check the book in the nurses' station. The 200 Hall Nurse checked Resident #18's code status in the nurses' station book and read the MOST form dated 11/14/23. She did not flip the page to see the recent MOST form dated 12/27/23. She pointed at the MOST form dated 11/14/23 and stated she would give it to the Emergency Medical Services if they responded to an emergency involving Resident #18. During an interview on 3/19/24 at 10:38 am, the 200 Hall Unit Manager stated she tried to check the book once a month. She stated NP #1 processed the MOST forms. The NP gave the signed MOST form to her or the nurse to file in the book. The medical records staff scanned them to the residents' EHR. She entered the code status order and changed it on top of the residents' EHR. She stated if there was a medical emergency, she would check the resident's code status in the EHR and in the book. During an interview on 3/21/24 at 8:20 am, NP #2 stated she completed the MOST form with Resident#18 on 12/27/23. She stated he did not want a trial of feeding tube at that time. NP #2 revealed the resident's code status information on their company's progress note was automatically fed through the facility's EHR. She stated she gave the resident's signed MOST form to the nurse. If the nurse entered the order and changed the code status in the facility's EHR, then her progress notes would have shown the current information. During the interview on 3/19/24 at 11:18 am, the Director of Nursing (DON) revealed the emergency directive form was part of the admission packet. The code status forms were placed in the Medical Director's box to be signed by him. It was scanned by medical records. The nurse who received the completed form entered the order and changed the code status in the EHR. She stated they double checked those forms in the book. There were no checks in between. They reviewed code status in care plan meetings. The Unit Managers were supposed to audit the forms and keep them up to date when there were changes.

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Coordinate assessments with the pre-admission screening and resident review program; and referring for services as needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48945 Based on record review and staff interviews, the facility failed to ensure a Level II Preadmission Screening and Resident Review (PASRR) was completed for a resident with a new mental health diagnosis for 1 of 3 residents reviewed for PASRR (Resident #36). The findings include: Resident #36 was admitted to the facility on [DATE]. Diagnoses included adjustment disorder, unspecified mood disorder, generalized anxiety and major depressive disorder. Review of Resident #36's records revealed she had a halted Level II PASRR dated [DATE]. The notification letter stated the resident did not meet criteria for a mental illness. Review of Resident #36's diagnoses revealed a primary diagnosis of bipolar disorder was listed on [DATE]. Review of Resident #36's medical records revealed no new PASRR Level II had been completed. Review of physician's order revealed Resident #36 was started on Valproic Acid Sprinkles Extended Release 125 milligrams three times a day for mood disorder on [DATE]. Review of Resident #36's annual Minimum Data Set (MDS) dated [DATE] revealed she was not considered by the state Level II PASRR to have serious mental illness. During an interview on [DATE] at 2:23 pm, the Social Worker (SW) revealed she started her job in [DATE] and did not have PASRR training. She stated the Admission Coordinator was completing the PASRR referrals. During an interview on [DATE] at 2:28 pm, the Admission Coordinator stated she was only helping with the PASRR because they did not have a trained SW. She stated she only dealt with residents that had Level II PASRR. She listed the residents' names on the erase board to keep track of who needed an update. She stated the Business Office was working with the Regional Office to complete submission requirements for residents' PASRR. During an interview on [DATE] at 3:05 pm, the Administrator stated the Business Office Manager was assigned to work with the Regional Manager to ensure compliance with PASRR. He revealed the facility checked on the resident's PASRR on admission. If a PASRR was due, the facility prepared the needed information to submit through the North Carolina web portal. If a resident got flagged for Level II PASRR, then a referral got submitted. He stated certain diagnoses or certain difficult behaviors were instances for submission for a Level II PASRR. (continued on next page)

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F 0644 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on [DATE] at 10:54 am, the Regional Business Office Manager stated she followed up on the expired PASRR only. She stated if a resident needed a PASRR, that was between nursing and social work. The facility reviewed the previous screening and looked at the resident's electronic health record for changes or additional diagnoses. The Regional Business Office Manager entered the required information into the NC MUST (North Carolina Medicaid Uniform Screening Tool - web portal for PASRR). The NC MUST office reviewed the resident's information and determined the PASRR level and length of time. If a resident was a Level II, the NC MUST staff set up a visit with the resident through the SW. She stated she got the decision regarding the resident's PASRR via email from NC MUST. The facility received the official letters through the mail. The Regional Business Office Manager stated Resident #36 had a halted PASRR in the NC MUST on [DATE]. She stated the previous SW processed it. She stated the MDS nurse, and the current SW were new when Resident #36 had a diagnosis added on [DATE]. She stated neither she nor the business office manager were notified when the resident's primary diagnosis changed. She stated she would immediately complete a new PASRR if she was notified. During a follow up interview on [DATE] at 12:08 pm, the Administrator stated Resident #36 had behaviors since admission, but the facility was not paying too close attention to her diagnoses. The business office should have been notified when there were changes in the resident's diagnoses. He stated the management discussed it and would have a plan of correction.

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F 0758 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Implement gradual dose reductions(GDR) and non-pharmacological interventions, unless contraindicated, prior to initiating or instead of continuing psychotropic medication; and PRN orders for psychotropic medications are only used when the medication is necessary and PRN use is limited. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on record review, staff and Medical Director (MD) interviews the facility failed to follow a physician's order to discontinue a psychotropic medication that resulted in the resident continuing to receive the medication for 1 of 5 residents (Resident #39) reviewed for unnecessary medications. Findings include Resident #39 was admitted to the facility on [DATE] with diagnoses including insomnia and anxiety. A review of the Resident #39's physician orders found trazadone 25 milligrams (mg) once daily dated ordered on 5/11/23. The annual Minimum Data Set (MDS) dated [DATE] revealed Resident #39 was cognitively intact and was coded for receiving psychotropic medication all 7 days during the lookback period. A review of Resident #39's care plan for pain dated 3/18/24 revealed she had an alteration in sleeping pattern related to diagnoses of insomnia with an intervention that included administering trazadone off label as a sleep aide. A review of monthly pharmacy recommendation dated 12/23/23 for Resident #39 was completed. The pharmacy recommendation read in part, the resident had received trazadone 25 mg since 5/11/23, please attempt a gradual dose reduction (GDR) to 12.5 mg. The physician's written response read to change trazadone 25 mg to as needed (PRN) for 2 weeks then discontinue the medication. The physician signed the order on 1/8/24. A review of Resident #39's December 2023 through March 2024 medication administration record (MAR) revealed trazadone 25 mg was administered daily for insomnia. The DON was interviewed on 3/20/24 at 2:40 PM. She stated the pharmacist sent her monthly pharmacy recommendations and she provided all recommendations to the physician to review and respond. The DON then received the response from the physician and was responsible for placing the physician order onto a resident's MAR. The DON stated she had overlooked the physician's order dated 1/8/24 for Resident # 39, and the medication was not changed. The MD was interviewed on 3/21/24 at 12:01 PM and stated his orders should be followed and the missed GDR order for trazadone did not cause harm for Resident #39.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 45272 Based on observations and interview with the Dietary Manager (DM) the facility failed to remove expired thickened liquids from 2 of 3 nourishment room refrigerators (the 100 Unit and 300 Unit nourishment rooms). The practice had the potential to affect all residents receiving thickened liquids. The Findings Included: a. An observation of the 100-unit nourishment room refrigerator with the DM on [DATE] at 10:28 AM found 3 unopened 4 oz thickened liquid containers with an expiration date of [DATE]. The DM immediately disposed of the thickened liquids. b. An observation of the 300-unit nourishment room refrigerator on [DATE] at 10:38 AM with the DM found 3 unopened 4 oz thickened liquid containers with expiration date of [DATE] and one unopened 4 oz thickened liquid container with expiration date of [DATE]. The DM stated during the observation he was responsible for checking each nourishment room refrigerator daily for expired items and to replenish the nourishment rooms when needed. He stated he had overlooked the expired thickened liquids. The Administrator stated on [DATE] at 12:46 PM thickened liquids should be removed and discarded when expired. The nourishment room refrigerators should not contain any expired items.

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F 0814 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Dispose of garbage and refuse properly. 45272 Based on an observation and staff interviews the facility failed to ensure all trash was disposed of inside the dumpster for 1 of 1 dumpster. This practice had the potential to attract pests and mice. The findings included: An observation of the outside dumpster area on 3/20/24 at 10:41 AM with the Dietary Manager (DM) revealed two full and tied trash bags laying on the ground beside a dumpster. The DM stated during the observation he did not know how long the trash bags had been there. He stated the kitchen, housekeeping and nursing staff dispose of trash into the dumpsters and were responsible for putting their trash into the dumpster. The DM said the dumpsters were emptied on Monday and Friday and that the dumpsters were not full. The Administrator stated on 3/21/24 at 12:46 PM that trash should be disposed of in the dumpsters and not left lying on the ground in the dumpster area. He stated it was the responsibility of everyone to dispose trash into the dumpster and not leave it on the ground.

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F 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. 48945 Based on observations, record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions the committee put into place following the complaint survey conducted on 10/1/21. This was for a repeat deficiency that was originally cited during the complaint survey on 10/1/21 for infection control and recited during the recertification and complaint investigation survey completed on 3/21/24. The continued failure of the facility during a two federal survey of record shows a pattern of the facility's inability to sustain an effective QAA program. The findings included: This tag is cross referenced to: F880 - Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for laundry services when 1 of 1 staff member (Laundry Staff) failed to follow standard precautions during the infection control observation. During the complaint survey on 10/1/21, the facility failed to implement their infection control policies and procedures when a staff member failed to sanitize her hands after depositing linen in the soiled laundry bin and before assisting a resident in her wheelchair to her room and when another staff member failed to bag a resident's urinals prior to placing them in the bathroom for 2 of 2 residents reviewed for infection control. During the interview on 3/21/24 at 12:46 pm, the Administrator stated Infection Control was a huge area of focus the facility looks at daily. They provided education and training to all staff. The infection control issue in the laundry room was an oversight from an individual worker and they would provide more education and training in laundry on infection control.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. 48945 Based on record reviews, observations and staff interviews, the facility failed to implement their infection control policies for laundry services when 1 of 1 staff member (Laundry Staff) failed to follow standard precautions during the infection control observation. The findings included: The facility's policy on Laundry Services dated October 17, 2023, stated All staff will use standard precautions in handling linen; therefore, all linen is handled in the same manner. Dirty linen should be moved from the dirtiest to the cleanest areas as it is being processed. Dirty linen should be clearly separated from areas where clean linen is handled. Laundry personnel should remove protective barriers and wash their hands before going into the clean linen area. On 3/19/24 at 10:04 am, the Laundry Staff was observed transporting a yellow soiled linen bin into the laundry room. She was wearing short white rubber gloves while pushing the soiled linen bin. Three clean resident shirts on clothes hangers were observed hanging at waist level on a white cart handle partially blocking the passageway. The shirts were observed rubbing on the side of the soiled linen bin as the Laundry Staff passed through. She set the soiled linen bin in front of the sink and dryer and took off her gloves. The Laundry Staff did not wash her hands. She walked over to the folding table and leaned on it with her hands. She tapped a stack of washcloths that were on the folding table. The Laundry Supervisor came in and handed the Laundry Staff a clear plastic bag containing soiled laundry. The Laundry Staff opened the soiled linen bin and dropped the bag of soiled laundry inside. The Laundry Staff did not wash her hands after touching the soiled laundry bin with her bare hands. She opened the dryer and pulled out dried mop heads and placed them in clean mop head bucket. During the interview on 3/19/24 at 10:06 am, the Laundry Staff stated she was trained to wear gloves when handling soiled linens. She stated the laundry room was small and did not have enough workspace. The Laundry Staff stated the shirts hanging on the white cart had been washed. She used the white cart to transport the residents' clothes that were washed. She did not wash bed linens or towels. She only washed the washcloths, the residents' clothes, and the mop heads. During an interview on 3/19/24 at 10:09 am, the Housekeeping/Laundry Supervisor stated the laundry staff should wear gloves when sorting out soiled linens. She stated the Laundry Staff should have washed her hands with soap and water for hand hygiene when taking gloves off and when handling contaminated items. The clean residents' clothes were usually hung on the rod over the folding table. During an interview on 3/21/24 at 8:49 am, the Infection Preventionist stated all staff were trained with infection control practices during orientation. The staff were expected to follow the standard precautions and wash their hands after taking off protective equipment. She stated she would follow up with the Laundry Staff. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	During an interview on 3/21/24 at 9:34 am, the Director of Nursing stated she would follow up with the Infection Preventionist and discuss a plan of action.