

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p> | <p>Reasonably accommodate the needs and preferences of each resident.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 41069</b></p> <p>Based on record review, observations, and resident and staff interviews, the facility failed to maximize residents' independence with transfers and bed mobility by not providing assist bars or side rails for 2 of 4 residents reviewed for accommodation of needs (Resident #43 and Resident #28).</p> <p>The findings included:</p> <p>1. Resident #43 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease, cervical and vertebral disc degeneration, spinal fusion, and generalized muscle weakness.</p> <p>The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated Resident #43 was cognitively intact, did not have range of motion impairment to either upper or lower extremities, and required supervision or touching assistance with rolling left and right, sitting to lying, lying to sitting on side of bed, sitting to standing position, and chair/bed-to-chair transferring.</p> <p>A physical device evaluation dated 2/6/25 indicated Resident #43 had assist bars that were both up in his bed. The assist bars were assessed as enabler and the following reasons were listed for the device use: repositioning/support, enable/increase bed mobility, enhance mobility, enable/increase independence, improve physical status, and enable resident to reposition self. The evaluation further indicated that Resident #43 was at low risk for entrapment related to the device use.</p> <p>Resident #43's care plan revised on 3/20/25 indicated Resident #43 had a functional ability deficit and required assistance with self-care and mobility. He required assistive devices. Interventions included to encourage participation in therapy, and encourage to participate in self-care as much as able, provide positive reinforcement for all activities attempted, and praise resident for all efforts and accomplishments.</p> <p>A physical device evaluation dated 5/8/25 indicated Resident #43 did not use bed/side rails and assist bars.</p> <p>(continued on next page)</p> |

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:<br><br>345438  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>An observation and interview with Resident #43 on 5/12/25 at 11:31 AM revealed him sitting on his wheelchair which was right next to his bed. He did not have any side rails or assist bars in his bed. Resident #43 stated he used to have an assist bar on his bed before the nursing staff took it out and said the state made them take out all the side rails and assist bars. Resident #43 stated that he talked to the Administrator who told him that there was some way they could put the assist bar in his bed through a therapist evaluation. He further stated that he talked to the therapist, but she told him that she didn't know anything about putting an assist bar back in his bed. Resident #43 shared that he used to use his assist bar to get up from his bed and to get back in it because he was able to transfer himself without assistance from staff. He said it was easier instead of trying to hang on to his wheelchair which he kept positioned right by his bed so he could have something to hold onto whenever he was moving to or from the bed.</p> <p>An interview with the Rehabilitation Services Director (RSD) on 5/13/25 at 1:30 PM revealed physical therapy was currently working with Resident #43 on ambulation and transfers. The RSD stated that they originally worked with Resident #43 when he was first admitted to the facility, and they worked on trying to get him to a position to where he could manage at home, but he could not physically master toileting and effectively cleaning himself up independently. After they had finished working with him the first time, Resident #43 was able to transfer himself independently. The RSD further stated that Resident #43 had mentioned to him about requesting for an assist bar because he had difficulty rolling himself in bed without having something to hold onto. The RSD stated that he passed it on to nursing during clinical meetings but there wasn't much of a response. He further shared that as far as he knew, it was company facility that the use of assist bars and side rails had to meet a certain criteria before they would allow their use. The RSD said that Resident #43 would benefit from the use of an assist bar in increasing his independence with bed mobility and transferring.</p> <p>A second observation and interview with Resident #43 on 5/13/25 at 1:15 PM revealed he mentioned the issue about an assist bar to the Unit Manager, and she told him that she was just following what her boss told her. Resident #43 was observed transferring himself from his wheelchair to his bed while holding on to the wheelchair armrest. Resident #43 voiced difficulty in maneuvering around without the support of an assist bar. He stated that it would make it easier for him to transfer himself from the bed to his wheelchair or vice versa if he had an assist bar in his bed.</p> <p>A joint interview with the Unit Manager and the Director of Nursing (DON) on 5/15/25 at 10:17 AM revealed all residents received a physical device assessment to make sure their devices were appropriate for them, and these included the use of assist bars. The DON stated that this was a gradual process which they started a couple of weeks ago because they were trying to decrease the use of side rails or assist bars and discourage their long term use. The DON further stated that they only wanted to use them when necessary. She shared that this was based on direction from their corporate who felt that the less devices they used, the better it would be for safety reasons. The DON stated that Resident #43 never slept in the bed, always slept in a recliner, rarely transferred himself independently, and staff was needed to help him pivot when transferring.</p> <p>(continued on next page)</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>A follow-up observation and interview with Resident #43 on 5/15/25 at 10:47 AM revealed there was no recliner in Resident #43's room and Resident #43 stated he had always slept in his bed, and never had a recliner in his room. Resident #43 further stated that the DON did not know enough about him because she never came into his room, and that it made him so mad when they took off his assist bar because he wanted to maintain his independence with bed mobility and transfers. He also shared that the Unit Manager did not assess and observe him using the assist bar but instead all she did was look at the device and told him that they would have to take it out due to a corporate decision.</p> <p>An interview with Nurse Aide #1 on 5/15/25 at 10:51 AM revealed he never had to assist Resident #43 in transferring himself, and that Resident #43 was able to do it independently.</p> <p>A joint interview was conducted with the DON and the Administrator on 5/15/25 at 3:51 PM. The DON stated that most of her interaction with Resident #43 was when he was on the rehabilitation hall, so she hadn't seen his current room. The DON stated that they were given a directive from corporate to lessen device use, but they did not consult with therapy prior to discontinuing Resident #43's assist bar because he was not on their caseload at that time. The Administrator stated that she met with Resident #43 at least five times since she started working at the facility and he had not mentioned his concern regarding the assist bar. The Administrator added that she had seen Resident #43 holding on to his bed with the head of the bed raised up while transferring himself, and she did not think he had difficulty doing it.</p> <p>51464</p> <p>2. Resident #28 was admitted to the facility on [DATE] with diagnoses that included chronic kidney disease, cervical disc degeneration and generalized weakness.</p> <p>The significant change Minimum Data Set (MDS) dated [DATE] indicated Resident #28 was cognitively intact, did not have range of motion impairment to either upper or lower extremities, and was independent with rolling left and right in bed.</p> <p>A physical device evaluation dated 2/6/25 indicated Resident #28 had both 1/2 side rails up on her bed. The 1/2 side rails were assessed as an enabler and the following reasons were listed for the device use: repositioning/support, enable/increase bed mobility, enhance mobility, enable/increase independence, and improve physical status. The evaluation further indicated Resident #28 was at low risk for entrapment related to the device use.</p> <p>Resident #28's care plan dated 3/26/25 indicated she had a functional ability deficit, required assistance with self-care and mobility and required assistive devices. Interventions included to encourage participation in therapy and encourage to participate in self-care as much as able.</p> <p>A physical device evaluation dated 5/07/25 indicated Resident #28 did not use bed/side rails and assist bars. The evaluation was completed by the Unit Manager and the documentation did not include a risk assessment, or the observation Resident #28 was not able to follow directions consistently and was deemed unsafe for bed rails.</p> <p>(continued on next page)</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0558</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>An observation and interview with Resident #28 on 5/12/25 2:01 PM revealed her lying in bed with the head of her bed raised. Resident #28 indicated her side rails were taken off about three weeks ago and she had been using them to turn over and pull herself around in bed and would like to get her side rails back. She stated she would like to be able to position herself when she wants as she did before without having to ask staff for help. Resident #28 shared staff now had to assist her by pushing her to roll from side to side in bed.</p> <p>A follow-up observation and interview with Resident #28 on 5/15/25 at 11:28 AM revealed a staff member came into her room about three weeks ago and removed her side rails, and she did not recall a side rail assessment being done with her at that time. She further indicated Nurse Aides now have to push her to roll left or right in bed when she could do it before by herself. Resident #28 shared she uses her bedside nightstand to assist her with rolling over in bed when she can reach it.</p> <p>An interview on 5/13/25 at 2:05 PM with the Physical Therapist (PT) revealed Resident #28 would have a much easier time with bed mobility if side rails were in place. The PT indicated therapy was currently working with Resident #28 to increase independence with bed mobility and get her to be modified independent (taking more time to perform a task but able to do it independently with an assistive device) with bed mobility. She revealed Resident #28 would definitely benefit from having side rails for her bed mobility.</p> <p>An interview on 5/15/25 at 8:51 AM with Nurse Aide (NA) #2 revealed Resident #28 had been mostly independent with rolling from side to side in bed using her side rails and had required just a little assistance now and then. She indicated Resident #28 currently moves around in bed but not quite as well as when she had side rails and needed more assistance to roll over now.</p> <p>A joint interview with the Unit Manager and the Director of Nursing (DON) on 5/15/25 at 10:23 AM revealed every resident received a physical device assessment to ensure any devices used were appropriate and safe for them to use. The Unit Manager indicated when she performed the physical device assessment on 5/07/25, Resident #28 was not able to follow directions consistently and was deemed unsafe for side rails. The DON shared their corporate office directive was to use the least restrictive interventions possible for resident safety.</p> <p>A joint interview with the DON and Administrator on 5/15/25 at 3:51 PM revealed they would communicate with the therapy department regarding Resident #28 and have her reevaluated for side rail safety. The Administrator shared they were given a directive from their corporate office to remove side rails and use the least restrictive option available for residents.</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0584</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely.</p> <p>51464</p> <p>Based on observation and staff interviews the facility failed to maintain the shower room tile floor in good repair when missing and broken tiles were observed for 1 of 1 shower rooms reviewed for a safe, clean, comfortable and homelike environment.</p> <p>The findings included:</p> <p>An observation of the shower room conducted on 05/14/25 at 3:06 PM with the Unit Manager revealed missing and broken floor tiles at the front of the shower area. The damaged space on the floor comprised of 22 missing square tiles with tiles in the space loose and not attached to the floor. Each tile was approximately 2 inches by 2 inches. Two tiles were loose from the floor in the damaged space, four attached tiles were loose in the damaged space and one loose tile was broken into two pieces and loose in the damaged space. The entire damaged area was approximately one foot by one foot in an irregular shape and could be a tripping hazard based on the loose, irregular shaped tiles. While in a shower chair a resident's feet could come in contact with the damaged area and broken tiles.</p> <p>During an interview with the Unit Manager conducted immediately after the shower room observation on 5/21/25 at 3:11 PM she indicated the damage must have just happened and she would alert the Maintenance Director to get it fixed. The Unit Manager stated not all residents received a shower or bath in the shower room but a shower had just been completed before we entered the room as the shower area was still wet. She voiced the Maintenance Director was in the process of redoing all the floors including the shower room floor and once the other floors were done, he would start replacing the shower room floor.</p> <p>An interview with Nurse Aide #2 on 05/15/25 at 8:51 AM revealed the tiles in the shower room had been damaged for about six weeks but she had no problem rolling a shower chair occupied by a resident over the damaged area when using the shower room.</p> <p>On 05/14/25 at 3:56 PM an observation of the shower room conducted with the Maintenance Director revealed the shower room floor would be replaced in about a month, after the other flooring replacement was completed in other parts of the building. He indicated the missing and loose tiles had been there a couple of months but there was nothing that could be done to fix the damaged area as anything that was put into place would just pop up again when the water hit it.</p> <p>An interview with the Administrator on 05/15/25 at 4:15 PM revealed she was aware of the damage and had put it on the list to be fixed as soon as possible. She indicated the shower room was not being used by residents as all residents received a shower in their own bathroom. The Administrator was informed during the interview the shower room was being used for resident showers per observations and staff interviews and she had no response.</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Provide care and assistance to perform activities of daily living for any resident who is unable.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 45272</p> <p>Based on observations, record review, resident and staff interviews, the facility failed to perform fingernail care for 1 of 2 residents reviewed for (ADL) care (Resident #8).</p> <p>The findings included</p> <p>Resident #8 was admitted to the facility on [DATE] with diagnoses that included dementia, Parkinson's Disease, type 2 diabetes, and osteoarthritis.</p> <p>Resident #8 was care planned for functional ability deficit and required assistance with self-care and mobility and frequently refusing showers revised on 1/30/25. Interventions included to document and report to a nurse as needed for any changes in functional ability, potential for improvement, and reasons for inability to perform activities of daily living. An additional intervention included to reapproach the resident later with another staff if he refuses care.</p> <p>A review of Resident #8's quarterly Minimum Data Set (MDS) assessment dated [DATE] coded him as cognitively intact. He required maximum assistance with toileting and setup or clean up assistance with personal hygiene.</p> <p>A review of the facility's bathing schedule revealed Resident #8 was scheduled to be bathed on Monday and Thursday.</p> <p>On 5/12/25 at 2:48 PM an in-room observation and interview revealed all of Resident #8's fingernails on both hands to be approximately 1/2 inch past the tip of his fingers. The fingernails contained black substance underneath his nails. Resident #8 stated during the observation that it had been a couple of months since his fingernails were last cut or cleaned by a nurse aide or nurse. The resident stated he was told by a nurse aide that a nurse would have to cut his nails because he had diabetes. Resident #8 said he would like to have all his nails on both hands cut and cleaned, and he had not tried to cut or clean his nails.</p> <p>On 5/15/25 at 11:28 AM an in-room observation and interview revealed Resident #8's nails remained unchanged. The resident stated he had not had a bath or shower during the current week.</p> <p>Resident #8's assigned Nurse Aide (NA) #1 was interviewed on 5/15/25 at 12:55 PM. NA #1 stated Resident #8 was scheduled to be showered or bathed 2 days each week on Monday and Thursdays. The NA stated around 9:00 AM on 5/15/25 he asked Resident #8 if he wanted a shower and the resident refused. NA #1 stated he did not notice Resident #8's fingernails and was unaware how long they were or that they needed to be cleaned when he was with the resident earlier. He also stated he had not noticed Resident #8's fingernails while providing care to him the previous day (5/14/25). The NA went on to say cleaning fingernails and trimming fingernails was part of the shower routine, but he was not allowed to trim resident nails who had diabetes. NA #1 said he would tell his nurse when a diabetic resident needed to have their nails trimmed and he had not notified his nurse regarding Resident #8's fingernails</p> <p>(continued on next page)</p> |  |  |

|   |  |  |  |
|---|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION                | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438 | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |
|--|---|
| <p>F 0677</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p> | <p>On 5/15/25 at 1:11 PM a follow-up observation and interview with Resident #8 revealed his fingernails remained unchanged. The resident stated he was offered a shower Monday evening (5/12/25) and he declined the shower, and he was not asked if he wanted his fingernails cleaned or cut. Resident #8 also stated he was not offered a shower during the current morning (5/15/25).</p> <p>Resident #8's assigned Nurse #1 for 5/15/25 was interviewed on 5/15/25 at 1:17 PM. She stated NA #1 had reported to her a few minutes prior that Resident #8 had refused his shower today (5/15/25) and she was writing a nurse's progress note that documented the refusal. Nurse #1 stated Resident #8 did have a history of refusing showers and baths and she had not personally tried to cut his fingernails. Nurse #1 stated it was the nurse's responsibility trim the fingernails of a diabetic resident, and she was not aware Resident #8's nails were 1/2 inch longer than his fingers or that there was a black substance noted under the nails. Furthermore, the nurse stated the NAs should have communicated to her Resident #8's fingernails needed to be trimmed and cleaned, and she would ask the resident if she could trim his nails.</p> <p>On 5/15/25 at 2:01 PM Nurse #1 stated she had trimmed Resident #8's nails. Resident #8 had not refused the nail care today and she had soaked his nails in water, cleaned and filed them down.</p> <p>On 5/15/25 at 4:02 PM the Director of Nursing (DON) stated Resident #8 did have a history of refusing care. The DON stated nail care was completed as part of showers or baths and long nails of a diabetic resident needed to be reported to a nurse. The nurse would have been able to trim and clean Resident #8's fingernails.</p> |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0759</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>Ensure medication error rates are not 5 percent or greater.</p> <p><b>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY**</b> 41069</p> <p>Based on record review, observations and staff interviews, the facility failed to maintain a medication error rate of less than 5% as evidenced by a medication omission and administration of wrong dosage (2 medication errors out of 31 opportunities), resulting in a medication error rate of 6.45% for 1 of 3 residents (Resident #28) observed during medication pass.</p> <p>The findings included:</p> <p>Resident #28 was admitted to the facility on [DATE] with diagnoses that included chronic obstructive pulmonary disease (COPD), and anemia.</p> <p>a. The Physician's Orders in Resident #28's electronic medical record indicated an active order dated 11/26/24 for Cyanocobalamin (Vitamin B12) tablet 1000 micrograms (mcg) - give 1 tablet by mouth one time a day.</p> <p>On 5/14/25 at 8:48 AM, Nurse #1 was observed as she prepared and administered Resident #28's medications. Nurse #1 did not administer a Cyanocobalamin tablet to Resident #28.</p> <p>An interview with Nurse #1 on 5/14/25 at 10:42 AM revealed she missed giving the Cyanocobalamin tablet to Resident #28 and it wasn't included in the pills she administered to Resident #28.</p> <p>b. The Physician's Orders in Resident #28's electronic medical record indicated an active order dated 3/18/25 for Guaifenesin (expectorant medication) extended release 12 hour 600 milligrams (mg) - give 1 tablet by mouth every 12 hours for COPD.</p> <p>On 5/14/25 at 8:48 AM, Nurse #1 was observed as she administered Resident #28's medications. Nurse #1 administered Guaifenesin 400 mg tablet to Resident #28.</p> <p>An interview with Nurse #1 on 5/14/25 at 10:42 AM revealed she didn't realize that she gave the wrong dose of Guaifenesin to Resident #28. Nurse #1 stated that she took the medication out of a stock bottle and what was available was 400 mg tablets on the label, and they did not have 600 mg tablets of Guaifenesin available.</p> <p>An interview with the Director of Nursing (DON) on 5/14/25 at 10:54 AM revealed Guaifenesin was normally a stock medication at the facility, and it came in different strengths. The DON stated that if the dosage ordered for Resident #28 was different from what they had available, then they could order them from the pharmacy. The DON stated that this was Nurse #1's first time working on the medication cart after several weeks of orientation, and she should have followed the five rights of medication administration by verifying the medication cards against the orders.</p> |  |  |

|  |  |  |  |
|--|--|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438   | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |  | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)  |  |  |
| <p>F 0812</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>                    | <p>Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards.</p> <p>45272</p> <p>Based on observations and interviews with staff, the facility failed to date leftover food stored for use in the walk-in refrigerator. The facility also failed to maintain the walk-in refrigerator cooling unit pipe from dripping water onto the wall and floor and maintain the cooling unit pipe and walls of the walk-in refrigerator free from substance build-up. This was for 1 of 2 walk-in refrigerators observed (walk-in refrigerator #2).</p> <p>Findings included</p> <p>An observation made in the kitchen's walk-in refrigerator #2 on 5/12/25 at 10:37 AM with the [NAME] revealed 2 opened and undated bags of shredded cheese located on the second shelf of the food storage rack. A pipe located behind the cooling unit was slowly dripping water onto the floor of the refrigerator. The pipe went from the back of the cooling unit and into the wall and contained a white and fuzzy in appearance substance spread across the duration of the pipe. Each wall of the walk-in refrigerator contained areas of the white fuzzy substance.</p> <p>The [NAME] was interviewed on 5/12/25 at 10:37 AM during the observation and stated the cheese was used earlier in the day and should have been dated for use within 7 days before storing it in the walk-in refrigerator. The [NAME] immediately dated the cheese. Additionally, the [NAME] said she did not know the cooling unit's pipe was dripping water and did not know the last time the walk-in refrigerator had been cleaned.</p> <p>On 5/15/25 at 1:59 PM an observation of the walk-in refrigerator #2 with the Maintenance Director revealed the cooling unit pipe to be dripping water. The Maintenance Director stated he was not aware the water was dripping and would contact a refrigerator repair company to look at it.</p> <p>The temporary Dietary Manager was interviewed on 5/15/25 at 2:30 PM. She stated the shredded cheese should have been dated before storing in the refrigerator. She also stated she was unaware of the dripping pipe from the cooling unit and the walk-in refrigerators should be deep cleaned on a quarterly basis, and did not know the last time they were deep cleaned.</p> <p>The Administrator was interviewed on 5/15/25 at 4:02 PM. She stated food stored in the walk-in refrigerator's should be dated when stored. The Administrator stated the dripping pipe from the cooling unit should be repaired to prevent water from dripping in the refrigerator. She also stated the walk-in refrigerators should be cleaned routinely and as needed.</p> |  |  |

|  |   |  |  |
|--|---|--|--|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION   | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:<br><br>345438  | (X2) MULTIPLE CONSTRUCTION<br>A. Building<br>B. Wing                                   | (X3) DATE SURVEY COMPLETED<br><br>05/15/2025 |
| NAME OF PROVIDER OR SUPPLIER<br><br>The Laurels of Summit Ridge  |   | STREET ADDRESS, CITY, STATE, ZIP CODE<br><br>100 Riceville Road<br>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<br>(Each deficiency must be preceded by full regulatory or LSC identifying information)   |  |  |
| <p>F 0880</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>                     | <p>45272</p> <p>Provide and implement an infection prevention and control program.</p> <p>Based on observations, record review, and staff interviews, the facility failed to follow their infection control policy when the Floor Technician entered a resident's room (Resident #46) on Enhanced Droplet Precautions without donning an N95 mask, gown, or eye protection. This was for 1 of 6 staff members observed for infection control practices (Floor Technician).</p> <p>Findings included</p> <p>The facility's policy titled Multi Route Transmission Based Precautions was last updated on 11/22/22. The droplet precautions policy stated that staff should wear an N 95 mask, gown, gloves, and eye protection.</p> <p>Resident #46 was diagnosed with COVID on 5/5/25.</p> <p>A physician order dated 5/5/25 for Contact and Droplet Isolation (Transmission Based Precautions) related to COVID-19 every shift and all care to be provided in room.</p> <p>On 5/12/25, at 1:41 PM Floor Technician was observed entering Resident #46's room. Adjacent to Resident #46's door was observed to have an Enhanced Droplet precaution sign that stated staff were to wear gown, an N95 mask, gloves and either face shield or goggles. Outside of Resident #46's door was a small 3 drawer container next to the room with masks, gowns, gloves, and eye covering. The Floor Technician entered the room wearing a surgical mask and gloves and proceeded to check the trash can in the resident's room. The trash can was located approximately 4 feet from the foot of the resident's bed. The Floor Technician was in the room for approximately 10 seconds. When the Floor Technician left Resident # 46's room, he removed his gloves and sanitized his hands with sanitizer that was available on the wall in the hallway.</p> <p>On 5/12/25 at 1:42 PM the Floor Technician was interviewed. He confirmed he entered Resident #46's room without wearing the required personal protective equipment (PPE). The Floor Technician stated he normally did not go into resident rooms and that he did not realize he needed to wear the PPE. The Floor Technician acknowledged the signage beside the resident's door was for enhanced droplet precautions, and he was supposed to do what the sign said before entering the room. The Floor Technician also said he had received infection control training recently.</p> <p>On 5/14/25 at 11:55 AM the Infection Preventionist (IP) was interviewed. She stated Resident #46 was on enhanced droplet precaution for a positive COVID test on 5/5/25. The IP stated all facility staff were expected to wear the PPE indicated on the signage for enhanced droplet precautions which included a KN95 mask, gown, gloves, and face shield when entering a room on enhanced droplet barrier precautions.</p> <p>ON 5/15/25 at 4:02 PM the Director of Nursing stated the Floor Technician was not typically assigned as a housekeeper; he was filling in for a housekeeper on 5/12/25. The Floor Technician was not accustomed to going into resident rooms and had received infection prevention training. The DON stated he should have followed the enhanced droplet precautions before entering the room.</p> |  |  |