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	07/02/2026

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 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. Based on observation and staff interviews, the facility failed to remove expired leftover food and label and date leftover opened foods stored for use in 1 of 1 walk-in refrigerator. The facility failed to discard expired food items stored in 1 of 1 nourishment refrigerator (200 hall). These practices had the potential to affect food served to residents. Findings included: a. During an observation and interview on 6/29/26 at 9:08 AM with the [NAME] in the walk-in refrigerator, there was a 1/2 of an approximately 3 pound (lb) fully cooked turkey breast dated 6/04/26. The [NAME] was unable to state if this was the date the turkey breast had been opened or date expired but stated it was expired either way. The observation and interview continued in the walk-in refrigerator with 2 packs of opened undated American cheese with about 4 slices each remaining and an opened undated package of 2 lbs of bologna. b. An observation on 7/01/26 at 8:30 AM with the Corporate Interim Dietary Manager of the nourishment refrigerator on the 200 hall revealed an 8-ounce container of cole slaw with a use by date of 6/15/26, 1 lb plastic container of fresh strawberries which appeared shriveled with pale fuzz growing on them with a handwritten date of 2/28/26, and 1/2 gallon of milk with the sell by date of 6/16/26. An interview on 7/01/26 at 3:22 PM with the Corporate Interim Dietary Manager revealed it was her first day at the facility. She was unaware of the expired food items in the walk-in refrigerator and nourishment refrigerator, and stated expired food should be discarded. The Corporate Interim Dietary Manager stated the kitchen refrigerators and nourishment room refrigerator was supposed to be checked daily by the kitchen staff for expired food items. An interview on 7/02/26 at 9:20 AM with the Administrator revealed the kitchen staff should label food items when opened and discard expired food items and she was unable to state why these practices had not been followed.

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

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, observations, and interviews with resident and staff the facility failed to honor a residents choice to receive a shower instead of a bed bath for 1 of 3 residents reviewed for choices (Resident #28).The findings included:Resident #28 was admitted to the facility on [DATE] with a diagnosis of wedge compression (fracture in front of spinal vertebra) fracture of the T19-T10 vertebrae (T is the thoracic or middle of spinal column). The admission Minimum Data Set (MDS) assessment dated [DATE] revealed that Resident #28 was cognitively intact. For bathing and showers, she needed substantial/maximal assistance.The 6/25/26 care plan had a focus area that stated Resident #28 had a functional ability deficit and required assistance with self-care and mobility related to muscle wasting, atrophy and lack of coordination. The approaches were to transfer with a mechanical lift, substantial to maximal assistance with shower and encourage to participate in selfcare as much as possible, provide positive reinforcement for all activities, explain procedures and tasks before starting. report refusals of Activity of Daily Living (ADL) care, personal hygiene, bathing or showers to nurse.A review of Resident #28's medical record indicated she was scheduled to have a shower on Tuesday and Thursday.On 6/29/26 at 11:55 AM an interview was held with Resident #28 who stated that she would like a shower, but the shower stretcher was broken and the one they had was not safe. Resident #28 stated she only received bed baths and had not had a shower since being admitted .On 6/30/26 at 2:24 PM an interview was held with Nurse #1 who was working the 100 Hall where Resident #28 resided. Nurse #1 stated that every room on the 100 Hall had a shower stall in it but if a resident needed a shower with the use of a stretcher they would need to go upstairs to the shower room on the 200 Hall. On 7/1/26 at 10:58 AM an observation was made of the shower room on the 200 Hall and the shower stretcher was observed and was in working condition. On 7/1/26 at 10:58 AM an interview was held with a Nurse Aide #1 (NA). NA #1 stated that if a resident on the 100 Hall needed to use the shower stretcher the resident would be brought upstairs and given their shower. There was not a shower room on the 100 Hall. NA #1 had not heard anything about the shower stretcher being broken. On 7/1/26 at 2:46 PM an interview was held with NA #2. NA #2 stated that he usually worked the 100 hall. NA #2 stated that he gave Resident #28 a bed bath or got her out of bed into her wheelchair and washed her up with soap and water. NA #2 stated he had not ever given Resident #28 a shower because it was a lot of work. NA #2 stated that Resident #28 required a mechanical lift for transfers and he would need to use either a shower chair or shower stretcher and bring her upstairs to the shower room. NA #2 stated that he understood that Resident #28 wanted a shower, but he could not do it. He then stated he would need another staff person to help and sometimes there were no staff to help him. On 7/1/26 at 2:51 PM an interview was conducted with the 100 hall Unit Manager. She stated that she had just gone through showers sheets for the 100 hall and she saw that Resident #28 had 1 shower since her admission. The Unit Manager stated that Resident #28 was assigned to get a shower on Tuesday and Thursday if she wanted one. The Unit Manager stated that all that needed to happen would be the NA assigned to the 100 Hall would need to come and ask for help and she or other staff would help. The Unit Manger was not aware that Resident #28 was not getting showers. On 7/2/26 at 9:56 AM an interview was held with the Therapy Director. The Therapy Director stated that Resident #28 has had multiple back surgeries and was receiving physical and occupational therapy, but she was still unable to stand on her own. The Therapy Director stated that Resident #28 currently required a mechanical lift for transfers and would require a mechanical lift to be lifted into a shower chair or shower stretcher to receive a shower. The Therapy Director could not think of any medical reason why Resident #28 could not receive a shower and stated the staff were trained on using the mechanical lift and could ask the therapy department questions if they had any concerns. On 7/2/26 at 10:10 AM a follow up interview was held with (continued on next page)

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Resident #28. Resident #28 was observed sitting up in her wheelchair and stated that NA #2 gave her a bed bath and washed her hair earlier that morning. Resident #28 stated she had told NA #2 that she would like a shower but NA #2 stated that it was a lot of work because he would need to take her upstairs. Resident #28 stated she did not reply back to NA #2. Resident #28 stated that even though she was cleaned up and had her hair washed she would prefer to have a shower. On 7/2/26 at 10:25 AM an interview was held with the Director of Nursing (DON). She had a document showing that NA #2 had given Resident #28 a shower on 6/17/26. That was the only shower sheet she had. The DON stated that she would expect a resident to receive a shower if they wanted one. On 7/2/26 at 10:37 AM an interview was held with the Administrator. She stated that she would expect that a resident would receive a shower and it would not matter how much work was involved.