# STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

**Provider/Supplier/CLIA Identification Number:**

<table>
<thead>
<tr>
<th>ID</th>
<th>PREFIX</th>
<th>TAG</th>
</tr>
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<tbody>
<tr>
<td>345203</td>
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</table>

**Multiple Construction**

<table>
<thead>
<tr>
<th>A. Building</th>
<th>B. Wing</th>
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<tbody>
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</tbody>
</table>

**Date Survey Completed:** 01/29/2015

**Name of Provider or Supplier:**

LIFE CARE CENTER OF BANNER ELK

**Street Address, City, State, Zip Code:**

185 NORWOOD HOLLOW ROAD

BANNER ELK, NC  28604

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**Summary Statement of Deficiencies**

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**Initial Comments:**

No deficiencies were cited as a result of the re-certification survey, Event ID #T5VO11, Exit Date 012915.

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**Laboratory Director's or Provider/Supplier Representative's Signature**

Electronically Signed 02/05/2015

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**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.**

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**Event ID:** T5VO11  
**Facility ID:** 923310

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*FORM CMS-2567(02-99) Previous Versions Obsolete*