	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345203	B. WING		01/20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	
LIFE CAR	E CENTER OF BANNER	ELK		185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 253 SS=E	483.15(h)(2) HOUSE MAINTENANCE SEF		F 25	3	3/21/17
		ide housekeeping and s necessary to maintain a comfortable interior.			
	by: Based on observation facility failed to label a items and store them 2 bath basins in resid 2 of 4 resident hallway prevention doors on t with broken and splin the lower edges of the hallways), failed to re- room and to the door on the 300 hall with b laminate and wood of doors, failed to repair resident rooms (room #305, #310 and #312 laminate and wood of doors (on 3 of 4 resid repair a loose toilet w of the toilet in the bat #310, failed to repair resident room #311 a molding in resident root therapy department a The findings included 1. a. Observations on	n the lower edges of the bathroom doors in 7 #108, #211, #213, #303, with broken and splintered in the lower edges of the ent hallways), failed to ith a broken bolt at the base hroom of resident room an edge guard on a wall in nd failed to repair base boom #305 and between the and entrance to the 100 hall.		 How will this deficiency be corrected feeach resident found to be affected by the deficient practice? On 1/20/17, the Director of Nursing removed and disposed of the bath bas from resident rooms #213 and #312 the were stored on the floor and were not labeled. They were disposed of in housekeeping garbage for discard. On 2/2/17, The Director of Maintenance placed an order for a contract vendor the replace the smoke prevention doors or the 200 and 400 hallways, doors to the main dining room, the door of the dayroom/dining room on the 300 hall, a resident bathroom doors in resident rooms #108, #211, #213, #303, #305, #310 and #312. They will be replaced and installed by 3/21/17. The Director of Maintenance repaired to loose toilet with the broken bolt at the base of the toilet and related grout in the bathroom of resident room #310 on 1/20/17. 	he ins at e o n e and
	sitting on the floor un	evealed a bath basin was der a sink in the room. The a plastic bag and there was		The Director of Maintenance replaced edge guard on the wall in resident roor	

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.

<u>CENTER</u>	<u>IS FOR MEDICARE &</u>	MEDICAID SERVICES			OMB NO	0. 0938-039
	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION	(X3) DATE COMF	SURVEY
		345203	B. WING _		01/	20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP	CODE	
				185 NORWOOD HOLLOW ROAD		
LIFE CAR	E CENTER OF BANNER	ELK		BANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN O (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	CTION SHOULD BE	(X5) COMPLETIOI DATE
F 253	Continued From page	e 1	F 2	53		
1 200			ΓZ			
	no resident name vis	19/17 at 9:00 AM in resident		#311 on 1/20/17.		
		a bath basin was sitting on		The Director of Maintenar	nce replaced the	
		in the room. The bath		base molding in resident	•	
		astic bag and there was no		1/20/17 and the base mol		
	resident name visible	-		the therapy department a	•	
	Observations on 01/2	20/17 at 11:18 AM in resident		the 100 hall on 2/2/17.		
	room #213 revealed	a bath basin was sitting on				
		in the room. The bath				
		astic bag and there was no		How will this deficiency be		
	resident name visible	on the basin.		each resident who would the deficient practice in th	2	
	b. Observations on 0	1/18/17 at 10:27 AM in				
		evealed a bath basin was		The Minimum Data Set (N	/IDS)	
	sitting on the floor un	der a sink in the room. The		Coordinators, The Discha		
	-	a plastic bag and there was		Nurse, Staff Developmen		
	no resident name vis	ible on the basin.		and Health Information M	anagement	
	Observations on 01/1	19/17 at 3:09 PM in resident		Director conducted a 100	% audit of	
	room #312 revealed	a bath basin was sitting on		resident rooms for proper	labeling and	
	the floor under a sink	in the room. The bath		storage of resident persor	nal care items on	
	basin was not in a pla	astic bag and there was no		1/20/17, and no other bat	h basins or	
	resident name visible			personal care items were	unlabeled or	
		20/17 at 11:26 AM in resident		improperly stored.		
		a bath basin was sitting on				
		in the room. The bath		The Director of Maintenar		
		astic bag and there was no		smoke prevention doors,		
	resident name visible			prevention doors, includin		
	During a tour and inte	enview on 01/20/17 at 11:40		bathroom doors, for disre and any/or all identified do		
		erview on 01/20/17 at 11:49 lursing (DON) she explained		repaired by 2/17/17 or we		
		ient was supposed to be		replacement and installati		
		lents name with included		3/21/17.		
		ited bath basins were not				
		ed on the floor in resident		The Maintenance Directo	r will review all	
		stored in the resident's		the toilets in the facility to		
		ur the DON verified the bath		no loose or cracked bolts		
	-	om #213 and #312 had no		edge guards on the walls		
		em and she was not sure why		rooms and base molding		
		them and they should not		rooms by 2/17/17 to ensu		

Facility ID: 923310

If continuation sheet Page 2 of 19

		ND HUMAN SERVICES MEDICAID SERVICES			PRINTED: 02 FORM API OMB NO. 09	PROVED
STATEMENT	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION	(X3) DATE SURV COMPLETE	
		345203	B. WING		01/20/2	017
NAME OF P	ROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, ZIP CODE	•	
	E CENTER OF BANNER			185 NORWOOD HOLLOW ROAD		
	E CENTER OF BANNER	ELR		BANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CON	(X5) MPLETION DATE
F 253	Continued From page	e 2	F 25	53		
	have been left on the			no further identified issues noted.		
	revealed the smoke p hall had broken and s edges of the lower ha rough to touch. Observations on 01/1 the smoke preventior broken and splintered the lower half of the o touch. Observations on 01/2 the smoke preventior broken and splintered	101/17/17 at 12:06 PM prevention doors on the 200 splintered laminate on the alf of the doors that were 18/17 at 10:50 AM revealed in doors on the 200 hall had d laminate on the edges of doors that were rough to 20/17 at 11:15 AM revealed in doors on the 200 hall had d laminate on the edges of doors that were rough to		What measures or systemic chan be made to ensure that this defici practice will not occur in the future The Director of Nursing, Staff Development Coordinator or desi completed educated from 2/7/17 with all housekeeping staff, thera and nursing staff on proper labelin storage of residents' personal car Any associates not educated by 2 will not work until this education is received and new staff will be trai	ent e? - 2/17/17 py staff ng and e items. 2/17/17	
	hall had broken and s edges of the lower had rough to touch. Observations on 01/1 the smoke prevention broken and splintered the lower half of the of touch. Observations on 01/2 the smoke prevention broken and splintered the lower half of the of touch. 3. a. Observations or revealed 2 doors to the broken and splintered	1/17/17 at 12:09 PM prevention doors on the 400 splintered laminate on the alf of the doors that were 18/17 at 10:55 AM revealed a doors on the 400 hall had d laminate on the edges of doors that were rough to 20/17 at 11:30 AM revealed a doors on the 400 hall had d laminate on the edges of doors that were rough to 10/18/17 at 11:16 AM he main dining room with d laminate on the edges of doors that were rough to		 during orientation. The Director of Nursing or design conduct an inspection of 5 randor resident rooms weekly to observe proper labeling and storage of peitems. Any items found to be out compliance will be corrected at the The Director of Maintenance or d will educate all facility staff on the order process by 2/17/17. Any as not educated by 2/17/17 will rece training before returning to work. associates in those departments receive this education during orie The Director of Maintenance or d will conduct an inspection of all si prevention doors, 5 random non-si prevention doors, 5 toilets, 5 edge and 5 base molding areas in the further of the sector of	n for rsonal of at time. esignee work sociates ive this New will intation. esignee moke smoke e guards iacility	

Facility ID: 923310

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			0/00 100 170-		OMB NO. 0938-03
	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		PLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345203	B. WING		01/20/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP	CODE
LIFE CAR	E CENTER OF BANNER	ELK		185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OI (EACH CORRECTIVE AC CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE COMPLETIC THE APPROPRIATE DATE
F 253	Continued From page	a 3	F 25	53	
	Observations on 01/1 doors to the main din splintered laminate of of the doors that were Observations on 01/2 doors to the main din	9/17 at 11:35 AM revealed 2 ing room had broken and n the edges of the lower half e rough to touch. 20/17 at 11:40 AM revealed 2 ing room had broken and n the edges of the lower half		they will be prioritized and copy of the completed wo given to the Executive Dir 3 months to ensure finding corrected or a plan is in pl correction.	rk order will be ector weekly for gs have been
	b. Observations on 0	1/17/17 at 12:02 PM m/dining door and the dining		How will the facility monitor to make sure that solution sustained?	
	of the doors that were Observations on 01/1 the day room/dining of door on the 300 hall f laminate on the edge doors that were rough	9/17 at 11:45 AM revealed door and the dining room nad broken and splintered s of the lower half of the		The Director of Maintenan of Nursing will present all Performance Improvemen monthly for 3 consecutive Performance Improvemen consisting of, but not limite Executive Director, Medic Director of Nursing, Busin	findings to the it Committee months. The it Committee ed to, the al Director,
	on the 300 hall had b laminate on the edge doors that were rough	s of the lower half of the h to touch.		Manager, Health Informat Management Director, Dir Environmental Services, I Maintenance, Director of S Director of Admissions, Di	ion ector of Director of Social Services, rector of Rehab
	revealed the bathroom #108 had broken and was rough to the touch half of the door.	n 01/17/17 at 12:37 PM m door in resident room I splintered laminate that ch on the edges of the lower		Services, Director of Food Infection Control Nurse, a Development Coordinator findings and make recomm develop plans of action if a	nd Staff will review the mendations and any areas are
	the bathroom door in broken and splintered the touch on the edge door.	8/17 at 10:28 AM revealed resident room #108 had d laminate that was rough to es of the lower half of the		noted to be non-compliant member of the Performan Committee is not present, reviewed upon return to w	ce Improvement findings will be
	the bathroom door in broken and splintered	9/17 at 12:32 PM revealed resident room #108 had d laminate that was rough to es of the lower half of the			

Facility ID: 923310

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		ID HUMAN SERVICES MEDICAID SERVICES				FORM	D: 02/13/2017 MAPPROVED D. 0938-0391
STATEMENT C	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	• •		E CONSTRUCTION	(X3) DATE	
		345203	B. WING			01/:	20/2017
NAME OF PF	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
LIFE CARI	E CENTER OF BANNER	ELK			85 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604		
0(0)15		ATEMENT OF DEFICIENCIES	10				(75)
(X4) ID PREFIX TAG	(EACH DEFICIENC)	Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	Continued From page door. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. b. Observations on 01 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. c. Observations on 01 revealed the bathroom #213 had broken and was rough to the touc half of the door. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/12 the bathroom door in broken and splintered the touch on the edge door.	e 4 0/17 at 11:12 AM revealed resident room #108 had I laminate that were rough to as of the lower half of the 1/17/17 at 3:10 PM revealed resident room #211 had I laminate that was rough to as of the lower half of the 9/17 at 9:20 AM revealed resident room #211 had I laminate that was rough to as of the lower half of the 0/17 at 11:18 AM revealed resident room #211 had I laminate that was rough to as of the lower half of the		253			
	the touch on the edge door.	es of the lower half of the					

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	MAPPROVED 0. 0938-0391
STATEMENT	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, í		CONSTRUCTION	(X3) DATE	
		345203	B. WING			01/	20/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u>, , , , , , , , , , , , , , , , , , , </u>	
LIFE CAR	E CENTER OF BANNER	ELK			85 NORWOOD HOLLOW ROAD ANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIZ TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 253	 d. Observations on 0° the bathroom door in broken and splintered the touch on the edge door. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. e. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. e. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/12 the bathroom door in broken and splintered the touch on the edge door. Observations on 01/2 the bathroom door in broken and splintered the touch on the edge door. f. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. f. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. g. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. f. Observations on 01/1 the bathroom door in broken and splintered the touch on the edge door. 	 a 5 1/18/17 at 9:59 AM revealed resident room #303 had I laminate that was rough to as of the lower half of the 9/17 at 9:25 AM revealed resident room #303 had I laminate that was rough to as of the lower half of the 0/17 at 11:23 AM revealed resident room #303 had I laminate that was rough to as of the lower half of the 0/17 at 11:23 AM revealed resident room #303 had I laminate that was rough to as of the lower half of the 1/18/17 at 9:45 AM revealed resident room #305 had I laminate that was rough to as of the lower half of the 9/17 at 9:30 AM revealed resident room #305 had I laminate that was rough to as of the lower half of the 0/17 at 11:24 AM revealed resident room #305 had I laminate that was rough to as of the lower half of the 1/17/17 at 2:35 PM revealed resident room #310 had I laminate that was rough to as of the lower half of the 1/17/17 at 2:35 PM revealed resident room #310 had I laminate that was rough to as of the lower half of the 1/17/17 at 2:35 PM revealed resident room #310 had I laminate that was rough to as of the lower half of the 	F	253			

If continuation sheet Page 6 of 19

		ID HUMAN SERVICES			FORI	D: 02/13/2017 M APPROVED
	S FOR MEDICARE &	MEDICAID SERVICES				D. 0938-0391
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			· /	E SURVEY PLETED
		345203	B. WING		01	/20/2017
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		
				185 NORWOOD HOLLOW ROAD		
	E CENTER OF BANNER	ELK		BANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 253	Continued From page	- 6	F 25	3		
1 200			1 25	5		
		d laminate that was rough to es of the lower half of the				
	door.					
		20/17 at 11:28 AM revealed				
	the bathroom door in	resident room #310 had				
	broken and splintered	l laminate that was rough to				
	the touch on the edge	es of the lower half of the				
	door.					
	a Observations on 0	1/10/17 at 10:07 AM				
	g. Observations on 0	m door in resident room				
		splintered laminate that				
		ch on the edges of the lower				
	half of the door.	in on the edges of the lower				
		9/17 at 9:37 AM revealed				
	the bathroom door in	resident room #312 had				
	broken and splintered	l laminate that was rough to				
	the touch on the edge	es of the lower half of the				
	door.					
		20/17 at 11:26 AM revealed				
		resident room #312 had				
	-	d laminate that was rough to es of the lower half of the				
	door.					
	5. Observations on 0	1/17/17 at 02:35 PM in the				
	bathroom of resident	room #310 revealed a large				
	white vinyl base plate	e for the toilet had shifted				
		er the base of the toilet and				
		he toilet was broken and the				
	0	e of the toilet was cracked.				
		8/17 at 9:56 AM in the				
		room #310 revealed a large				
		e for the toilet had shifted				
		er the base of the toilet and				
		he toilet was broken and the e of the toilet was cracked.				
		9/17 at 9:36 AM in the				
		room #310 revealed a large				

CENTER STATEMENT	S FOR MEDICARE & I	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MUL	TIPL	E CONSTRUCTION	FORM OMB NC (X3) DATE	
AND PLAN OF	- CORRECTION	IDENTIFICATION NUMBER:	A. BUILD	ING _		COMP	LETED
		345203	B. WING			01/	20/2017
NAME OF P	ROVIDER OR SUPPLIER		•	Ś	STREET ADDRESS, CITY, STATE, ZIP CODE	-	
	E CENTER OF BANNER			·	185 NORWOOD HOLLOW ROAD		
	E CENTER OF DANNER	ELK		1	BANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREF TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 253	white vinyl base plate partially out from under a bolt at the base of the grout around the base Observations on 01/2 bathroom of resident white vinyl base plate partially out from under a bolt at the base of the grout around the base 6. Observations on 0 resident room #311 re- protect edges of a war on the edge of a corner was broken off from the wall with rough edges Observations on 01/1 room #311 revealed at edges of a wall from co- edge of a corner wall broken off from the to with rough edges to the Observations on 01/2 room #311 revealed at edges of a wall from co- edge of a corner wall broken off from the to with rough edges to the Observations on 01/2 room #311 revealed at edges of a wall from co- edge of a corner wall broken off from the to with rough edges to the 7. a. Observations on revealed in resident re- molding was missing bathroom. Observations on 01/1 resident room #305 at was missing at a corner Observations on 01/2	for the toilet had shifted er the base of the toilet and he toilet was broken and the e of the toilet was cracked. 0/17 at 11:28 AM in the room #310 revealed a large for the toilet had shifted er the base of the toilet and he toilet was broken and the e of the toilet was cracked. 1/18/17 at 1:40 PM in evealed a clear guard to ill from damage was located er wall at the bathroom but he top partially down the s to the touch. 9/17 at 9:38 AM in resident a clear guard to protect damage was located on the at the bathroom but was p partially down the wall he touch. 0/17 at 11:25 AM in resident a clear guard to protect damage was located on the at the bathroom but was p partially down the wall he touch.	F	253	3		

Facility ID: 923310

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	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT (DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345203	B. WING			01/	20/2017
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
LIFE CAR	E CENTER OF BANNER	ELK			85 NORWOOD HOLLOW ROAD		
				В	ANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI, DEFICIENCY)		(X5) COMPLETION DATE
F 253	b. Observations on 0 [°] between the therapy	er next to the bathroom. 1/18/17 at 10:49 AM department and the	F	253			
	entrance to the 100 h floor on a corner was and was slit open. Observations on 01/1 the therapy departme 100 hall the vinyl mol- was pulled apart from Observations on 01/2 the therapy departme 100 hall the vinyl mol- was pulled apart from During an interview a 01/20/17 at 11:59 AM Director he explained order system and the	all the vinyl molding at the pulled apart from the wall 9/17 at 9:40 AM between nt and the entrance to the ding at the floor on a corner the wall and was slit open. 0/17 at 11:11 AM between nt and the entrance to the ding at the floor on a corner the wall and was slit open. In denvironmental tour on with the Maintenance the facility utilized a work re was a clipboard in stations to write things down le stated he had an					
	items off when the rep further stated he or hi 24 hours a day, 7 day for staff to report ever He explained he did of employees and orient system and showed t clipboard was located replaced all resident r year but were not doin time with repairs to ot confirmed the smoke and 400 halls, doors in dining room doors ha	ted them to the work order hem where the work order I. He stated they had room doors within the last ng anything at the present her doors in the facility. He prevention doors on the 200 n resident bathrooms and					

Facility ID: 923310

If continuation sheet Page 9 of 19

		MEDICAID SERVICES			OMB NO. 0938-03
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345203	B. WING		01/20/2017
NAME OF PI	ROVIDER OR SUPPLIER	•	•	STREET ADDRESS, CITY, STATE, ZIP COI	DE
IFE CAR	E CENTER OF BANNER	R ELK		185 NORWOOD HOLLOW ROAD	
				BANNER ELK, NC 28604	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE COMPLETIN E APPROPRIATE DATE
F 253	Continued From pag	e 9	F 25	3	
		oom #305 had not been	. 20		
		he had not noticed the			
		molding between the therapy			
		entrance to the 100 hall. He			
		had not been made aware of			
	the damage to the co	orner guard on the edge of			
	the bathroom wall in	resident room #311. He			
	stated the toilet in the	e bathroom of resident room			
	#310 looked as if it h	ad been kicked loose and			
	confirmed the base p	plate that was supposed to be			
	under the base of the	e toilet was partially out from			
	under the toilet and l	oolt flange was broken on the			
	base on the right sid	e of toilet and the toilet was			
	loose at the floor and	had not been reported to			
	him.				
	•	and tour on 01/20/17 at 12:38			
	PM with the Adminis				
	maintenance staff ha				
		t log for staff to document			
		mething that needed repair.			
		enance staff checked the log			
		ney brought requests to her			
		ses were involved. She			
	-	ectation for staff to report			
		ed damage to doors, toilets,			
		s and base molding to the			
	maintenance staff ar				
E 494		complete the repairs.	F 43		2/17/17
F 431	483.60(b), (d), (e) DI	IGS & BIOLOGICALS	F 43	''	2/1////
SS=D	LADEL/STURE DRU				
	The facility must em	ploy or obtain the services of			
	•	st who establishes a system			
	of records of receipt				
		ufficient detail to enable an			
		on; and determines that drug			

Facility ID: 923310

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CENTER STATEMENT (AND PLAN OF NAME OF PI	S FOR MEDICARE & I DF DEFICIENCIES CORRECTION ROVIDER OR SUPPLIER E CENTER OF BANNER SUMMARY ST/ (EACH DEFICIENCY	ID HUMAN SERVICES MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345203 ELK ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	, ,	S ⁻ 18 B	E CONSTRUCTION TREET ADDRESS, CITY, STATE, ZIP CODE 85 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604 PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI	FORM OMB NC (X3) DATE COMP 01/	2: 02/13/2017 APPROVED 0. 0938-0391 SURVEY LETED 20/2017 (X5) COMPLETION DATE
F 431	controlled drugs is ma reconciled. Drugs and biologicals labeled in accordance professional principles appropriate accessory instructions, and the e applicable. In accordance with St facility must store all o locked compartments controls, and permit o have access to the ke The facility must prov permanently affixed c controlled drugs listed Comprehensive Drug Control Act of 1976 an abuse, except when t package drug distribu	aintained and periodically a used in the facility must be with currently accepted s, and include the y and cautionary expiration date when tate and Federal laws, the drugs and biologicals in a under proper temperature only authorized personnel to eys. ide separately locked, compartments for storage of	F	431	DEFICIENCY)		
	by: Based on observation interviews the facility antiemetic suppositor 2 medication storage Findings included: A review of the facility	 is not met as evidenced n, record review, and staff failed to remove 10 expired ies (promethazine) from 1 of refrigerators. v policy entitled A Guide to Expiration Dates and was 			How will this deficiency be corrected f each resident found to be affected by t deficient practice? The Director of Nursing disposed of th 10 expired anti-emetic suppositories (promethazine) from the medication refrigerator on 1/20/17.	the	

Event ID: JY2S11

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	OF DEFICIENCIES	MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIF	PLE CONSTRUCTION		NO. 0938-039 TE SURVEY
	CORRECTION	IDENTIFICATION NUMBER:	. ,	G		MPLETED
		345203	B. WING			01/20/2017
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZI	P CODE	
LIFE CAR	E CENTER OF BANNER	ELK		185 NORWOOD HOLLOW ROAD BANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN (EACH CORRECTIVE & CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETIOI DATE
F 431	Continued From page	e 11	F 43	31		
		ndicated drugs including				
		on carts as well as those in		How will this deficiency b	be corrected for	
		were to be checked monthly		each resident who could		
	for an expiration date	by nursing personnel. If the would be disposed of as per		the deficient practice in t	5	
	state and federal laws			The Director of Nursing	and the RN	
				Supervisor completed a		
		27 AM 5 Promethazine 12.5		1/20/17 to identify any of		
		sitories with an expiration		expired or improperly sto		
		5 Promethazine 12.5 mg		No other areas of deficie	ency were	
		expiration date of 10/2016		identified.		
		f 2 medication refrigerators				
		ock bag with an expiration				
		utside of the bag as 12/2017.		What measures or syste be made to ensure that t	-	
	On 01/20/16 at 8:30 /	AM an interview was		practice will not occur in		
	conducted with Nurse					
		ng suppositories had expired		The Director of Nursing	or designee will	
	on 07/2016 and 5 Pro	•		educate all licensed nurs		
	suppositories had exp	pired on 10/2016 and were		medication storage and	security in the	
	in the medication refr	igerator ready for resident		facility policy to ensure e	expired	
		liately removed the 10		medications are immedia	ately removed	
	-	e suppositories from the		from and are not stored		
	medication refrigerate	or.		refrigerators by 2/17/17.		
	On 01/20/2017 at 0:0	1 AM on interview was		nurses who have not rec	•	
		1 AM an interview was		by 2/17/17 will not be all		
	who verified that 5 Pr	irector of Nursing (DON)		such training is received associates will be given		
		xpired on 07/2016 and 5		during orientation.		
		ng suppositories were				
		ind were in the medication		Effective 1/20/17, the Dir	rector of Nursina	
	· ·	resident use. The DON		or designee will audit the	-	
		oonsibility of the treatment		refrigerator daily for 12 v		
		edication refrigerator 3 days		expired or improperly sto		
		er expectation that the		immediately removed fro	om stock, locked	
		d have removed the expired		in the medication room in		
		sitories from the medication		area, and disposed of ac	-	
	refrigerator. The DON			procedure for medication		
	expectation that the r	nursing staff would check for		re-ordered from the phar	rmacy if a current	

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	S FOR MEDICARE &				OMB NO. 0938-03	
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	(X2) MULTIPLE CONSTRUCTION A. BUILDING		
		345203	B. WING		01/20/2017	
NAME OF P	ROVIDER OR SUPPLIER		ST	IREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIFE CAR	E CENTER OF BANNER	ELK		35 NORWOOD HOLLOW ROAD ANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE	
F 431	Continued From pag	e 12	F 431			
	expired medication p	rior to administering any sident. The DON stated		order exists.		
	moving forward the r be checked on a dail	nedication refrigerator would ly basis and individual the refrigerator would be		Upon completion of the 12-week daily audit, the Director of Nursing or design will audit the medication refrigerators monthly for any expired or improperly stored items. Any expired or improper		
	conducted with the A expectation was that would have been res expired medications	13 AM an interview was dministrator who stated her the DON or her designee sponsible to assure that were not available in the or ready for resident use.		stored items will be immediately remove from stock, locked in the medication ro- in a segregated area, and disposed of according to procedure for medication destruction and re-ordered from the pharmacy if a current order exists.	ved om	
	The Administrator sta individual medication labeled with an expir	ated moving forward that any stored in a plastic bag and ation date on the outside of ecked by nursing to assure		How will the facility monitor the measu to make sure that solutions are sustained?	res	
	conducted with Nurs responsible to check for expired medication checked the medication	28 AM an interview was e #2 who stated she was the medication refrigerator on. Nurse #2 stated she tion refrigerator this month ed the expired Promethazine		Effective 1/20/17, the medication room refrigerator will be audited by the Direc of Nursing or designee daily for 12 wea Results will be reported to the Performance Improvement Committee months.	etor eks.	
				Upon completion of the 12-week daily audit, the Director of Nursing or design will audit the medication refrigerators monthly for any expired or improperly stored items. Any expired or improper stored items will be immediately remove from stock, locked in the medication ro- in a segregated area, and disposed of according to procedure for medication destruction and re-ordered from the pharmacy if a current order exists.	ly red om	
F 520	483.75(o)(1) QAA		F 520		3/21/17	

	-	ID HUMAN SERVICES MEDICAID SERVICES				FORM	APPROVED 0. 0938-0391
STATEMENT	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE	
		345203	B. WING			01/	20/2017
NAME OF P	ROVIDER OR SUPPLIER			ST	REET ADDRESS, CITY, STATE, ZIP CODE	•	
LIFE CAR	E CENTER OF BANNER	ELK			5 NORWOOD HOLLOW ROAD ANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	ĸ	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 520 SS=E	COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 5	520			
	assurance committee nursing services; a pl	in a quality assessment and consisting of the director of hysician designated by the other members of the					
	issues with respect to and assurance activit develops and implem	ent and assurance east quarterly to identify which quality assessment ies are necessary; and ents appropriate plans of tified quality deficiencies.					
		rds of such committee h disclosure is related to the ommittee with the					
		y the committee to identify ficiencies will not be used as					
	by: Based on observatio facilities Quality Asse Committee failed to n procedures and moni the committee put int This was for one recit originally cited in Dec	tor these interventions that o place in January of 2016. ted deficiency which were ember of 2015 on a o and subsequently recited			How will this deficiency be corrected f each resident found to be affected by t deficient practice? On 1/20/17, the Director of Nursing removed and disposed of the bath bas from resident rooms #213 and #312 th were stored on the floor and were not labeled. They were disposed of in	he ins	

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				LE CONSTRUCTION	OMB NO. 0938-
	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	(X3) DATE SURVEY COMPLETED	
		345203	B. WING		01/20/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP C	CODE
LIFE CARE CENTER OF BANNER ELK					
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENC	TION SHOULD BE COMPLE
F 520	Continued From page	e 14	F 52	0	
		area of housekeeping and s. The continued failure of		housekeeping garbage for	discard.
		federal surveys of record		On 2/2/17, The Director of	
	-	e facilities inability to sustain		placed an order for a contr	
	an effective Quality A	Assurance Program.		the 200 and 400 hallways,	
	Findings included:			main dining room, the door	
	5			dayroom/dining room on th	
		rred to: F 253 Housekeeping		resident bathroom doors in	
	and Maintenance Se			rooms #108, #211, #213, #	
		ff interviews the facility failed rsonal care items and store		#310 and #312. They will and installed by 3/21/17.	be replaced
		ich included 2 bath basins in			
		and #312 (on 2 of 4 resident		The Director of Maintenand	ce repaired the
		epair smoke prevention doors		loose toilet with the broken	•
		nallways with broken and		base of the toilet and relate	0
		nd wood on the lower edges		bathroom of resident room	#310 on
		4 resident hallways), failed		1/20/17.	
	to repair doors to the main dining room and to the door of the day room/dining room on the 300 hall			The Director of Maintenand	re replaced the
	-	ntered laminate and wood on		edge guard on the wall in r	-
		e doors, failed to repair		#311 on 1/20/17.	
		resident rooms (room #108,			
		805, #310 and #312) with		The Director of Maintenand	-
		d laminate and wood on the		base molding in resident ro	
		oors (on 3 of 4 resident epair a loose toilet with a		1/20/17 and the base mold the therapy department an	•
	broken bolt at the bas			the 100 hall on 2/2/17.	
		room #310, failed to repair			
		wall in resident room #311		The Executive Director (ED)) will educate
		ase molding in resident room		the Performance Improven	
		he therapy department and		Committee on the facility P	
	entrance to the 100 h	1aii.		Improvement Program Pol	-
	During the recertifica	tion survey of 12/04/15 the		requirement for this commi substantial compliance with	
	-	ailure to repair resident		regulations to include main	
	-	d splintered laminate and		implemented procedures a	-
	wood on 13 of 59 res	sident doors (Resident room		these interventions that the	e committee
	#101 #104 #105 #1	106, #108, #109, #110, #111,		puts into place. The policy	includes the

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PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION) TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	ROAD 04 S PLAN OF CORRECTION (X5)
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, ST LIFE CARE CENTER OF BANNER ELK BANNER ELK, NC 2860 (X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG	ATE, ZIP CODE ROAD 04 S PLAN OF CORRECTION (X5)
LIFE CARE CENTER OF BANNER ELK (X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) 185 NORWOOD HOLLOW BANNER ELK, NC 2860 PREFIX (EACH CORREC (EACH COR	ATE, ZIP CODE ROAD 04 S PLAN OF CORRECTION (X5)
LIFE CARE CENTER OF BANNER ELK (X4) ID PREFIX TAG TAG SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) BANNER ELK, NC 2860 PREFIX (EACH CORREC CROSS-REFERENCIES TAG CROSS-REFERENCIES	B PLAN OF CORRECTION (X5)
ID SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	S PLAN OF CORRECTION (X5)
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORREC TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCE	
F 520 Continued From page 15 F 520	CTIVE ACTION SHOULD BE COMPLETI NCED TO THE APPROPRIATE DATE DEFICIENCY)
#114, #208, #404, #406 and #415); failed to committee's respon	nsibility to monitor.
	re appropriate follow-up
laminate and wood in 3 of 59 resident rooms action. This will oc	cur by 2/17/17. The
	onsists of, but is not
	cutive Director, Medical
	of Nursing, Business
halls; failed to label and cover personal care Office Manager, He equipment in 2 resident bathrooms (Resident Management Direct	
rooms 310 and 313) on 300 hall and 2 resident Environmental Ser	
	ctor of Social Services,
	ions, Director of Rehab
clean on 400 hall (Residents #126 and #156). Services, Director	of Food Services,
Infection Control N	
	dinator will review the
	recommendations and
recertification survey the plan of correction for develop plans of ac environmental and maintenance issues was noted to be non-co	ction if any areas are
	formance Improvement
	bresent, findings will be
incorporate the environmental and maintenance reviewed upon retu	
concerns last year in the Quality Assurance and	
Assessment process but focused on damage to	
resident room doors and corrected them. She	
	ency be corrected for
	would be affected by
report damage to doors or other damage on a the deficient practice work order and she expected for maintenance to	
do repairs. She stated she did not feel there had The Minimum Data	set (MDS)
	Discharge Planning
	opment Coordinator
all of the environmental and maintenance and Health Informa	
problems fixed before the survey was conducted. Director conducted	a 100% audit of
	proper labeling and
	personal care items on
1/20/17, and no oth	
improperly stored.	s were unlabeled or
The Director of Ma	intenance reviewed all
M CMS-2567(02-99) Previous Versions Obsolete Event ID; JY2S11 Facility ID: 923310	

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DEPARTMENT OF HEALTH AN CENTERS FOR MEDICARE &				PRINTED: 02/13/2017 FORM APPROVED OMB NO. 0938-0391
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	. ,	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
	345203	B. WING		01/20/2017
NAME OF PROVIDER OR SUPPLIER	•	-	STREET ADDRESS, CITY, STATE, ZIP COD)E
LIFE CARE CENTER OF BANNER ELK			185 NORWOOD HOLLOW ROAD	
LIFE CARE CENTER OF BANNER ELK			BANNER ELK, NC 28604	
PREFIX (EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE COMPLETION E APPROPRIATE DATE
F 520 Continued From page	e 16	F 5	 20 smoke prevention doors, and prevention doors, for disrepair and any/or all identified doors repaired by 2/17/17 or were or replacement and installation a 3/21/17. The Maintenance Director will the toilets in the facility to ensine loose or cracked bolts or gedge guards on the walls in more rooms and base molding in reprosens by 2/17/17 to ensure the no further identified issues not what measures or systemic or be made to ensure that this depractice will not occur in the fact the Director of Nursing, Staff Development Coordinator or completed educated from 2/7 with all housekeeping staff, the and nursing staff on proper lastorage of residents' persona Any associates not educated will not work until this education. The Director of Nursing or deconduct an inspection of 5 ra resident rooms weekly to obs proper labeling and storage of items. Any items found to be compliance will be corrected 	esident on 1/23/17, a were ordered for no later than Il review all sure there are grout, all esident hat there are oted. changes will leficient duture? f designee /17 - 2/17/17 herapy staff abeling and I care items. by 2/17/17 on is e trained signee will ndom eerve for of personal o out of

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		ID HUMAN SERVICES MEDICAID SERVICES				PRINTED: 02/13/2 FORM APPRON OMB NO. 0938-03	VED
STATEMENT (DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,		CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345203	B. WING			01/20/2017	
NAME OF PI	ROVIDER OR SUPPLIER		•	S	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
LIFE CAR	LIFE CARE CENTER OF BANNER ELK				35 NORWOOD HOLLOW ROAD		
				B	ANNER ELK, NC 28604		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETI	ION
F 520	Continued From page	≥ 17	F	520	The Director of Maintenance or design will educate all facility staff on the worl order process by 2/17/17. Any associa not educated by 2/17/17 will receive the training before returning to work. New associates in those departments will receive this education during orientation. The Director of Maintenance or design will conduct an inspection of all smoke prevention doors, 5 random non-smoke prevention doors, 5 toilets, 5 edge gua and 5 base molding areas in the facilit weekly. As needed repairs are identifit they will be prioritized and scheduled. copy of the completed work order will given to the Executive Director weekly 3 months to ensure findings have been corrected or a plan is in place for correction. The Performance Improvement (PI) Committee will review the results of the audits and education will be provided the all survey findings bi-monthly for 3 mo to ensure substantial compliance is mo How will the facility monitor the measure to make sure that solutions are sustained? The Director of Maintenance and Direct of Nursing will present all findings to the Performance Improvement Committee monthly for 3 consecutive months. The Performance Improvement Committee monthly for 3 consecutive months. The Performance Improvement Committee consisting of, but not limited to, the	k ates ates ais / on. nee e ards y ied, A be for n e for n ths et. ares	
	7(02-99) Previous Versions Obs	alete Event ID: JY2S1			Executive Director, Medical Director,	uation sheet Page 18 (

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		ND HUMAN SERVICES MEDICAID SERVICES				FC	TED: 02/13/201 RM APPROVE NO. 0938-039		
	DF DEFICIENCIES	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDI		(X3) DATE SURVEY COMPLETED				
		345203	B. WING				01/20/2017		
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE					
			185 NORWOOD HOLLOW ROAD						
LIFE CARE CENTER OF BANNER ELK				BANNER ELK, NC 28604					
(X4) ID PREFIX TAG				ID PROVIDER'S PLAN OF C PREFIX (EACH CORRECTIVE ACTIV TAG CROSS-REFERENCED TO TH DEFICIENCY			(X5) COMPLETION DATE		
F 520	Continued From pag	je 18	F	520	Director of Nursing, Business Office Manager, Health Information Management Director, Director of Environmental Services, Director of Social Serv Director of Admissions, Director of R Services, Director of Food Services, Infection Control Nurse, and Staff Development Coordinator will review findings and make recommendations develop plans of action if any areas noted to be non-compliant. If any member of the Performance Improve Committee is not present, findings w reviewed upon return to work.	ehab the and are ement			

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