

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 09/13/2021
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345203	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/19/2021
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	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments	E 000		
F 000	A recertification survey was conducted on 8/16/2021 through 8/19/2021. The facility was found in compliance with CFR 483.73, Emergency Preparedness. Event ID # Y4IJ11. INITIAL COMMENTS	F 000		
F 690 SS=D	An unannounced recertification and complaint investigation survey was completed 08/16/21 through 08/19/21. There were 5 allegations investigated and they were unsubstantiated. Event ID # Y4IJ11, Bowel/Bladder Incontinence, Catheter, UTI CFR(s): 483.25(e)(1)-(3) §483.25(e) Incontinence. §483.25(e)(1) The facility must ensure that resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain. §483.25(e)(2) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that- (i) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; (ii) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary; and (iii) A resident who is incontinent of bladder	F 690		9/10/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Electronically Signed

09/10/2021

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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F 690	<p>Continued From page 1</p> <p>receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.</p> <p>§483.25(e)(3) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on record review, observations and staff interviews, the facility failed to prevent a urinary catheter tubing and bag from touching the floor for 1 of 2 residents (Resident #45) reviewed for urinary catheters.</p> <p>The findings included:</p> <p>Resident #45 was admitted to the facility on 7/12/21 with diagnoses that included urinary retention and urinary tract infection (UTI).</p> <p>Resident #45's care plan revised on 7/15/21 indicated Resident #45 had an indwelling catheter due to urinary retention. Interventions included catheter care every shift, position catheter bag and tubing below the level of the bladder, check tubing for kinks each shift, may use leg strap or catheter securement device to help hold tubing in place, ensure leg strap or catheter securement device was on and tubing was not placed under leg and check each shift for proper positioning.</p> <p>The admission Minimum Data Set (MDS) assessment dated 7/19/21 indicated Resident #45 was moderately cognitively impaired, did not</p>	F 690	<p>Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice?</p> <p>Resident # 45 was affected by this practice. On 8/19/21, resident #45's Foley catheter bag was noted to be touching the floor upon investigation. Resident noted to have a low chair that therapy identified was needed for mobility purposes. The Director of Nursing (DON) and Infection Prevention nurse (IPN) removed drainage bag from the side of the chair and attached to a higher area of the chair but also below the level of the bladder to ensure that bag and tubing cleared the floor during that time. Staff assigned to resident #45 was alerted to the change immediately. Staff did state that resident frequently attempts to transfer himself and often places his catheter bag on the floor or on his bed. Nursing IDT was alerted to this behavior and the behavior was added to resident's personalized Care Plan on 8/19/21 by the RN MDS Coordinator.</p>		

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F 690	<p>Continued From page 2</p> <p>exhibit rejection of care behaviors and had an indwelling catheter.</p> <p>Resident #45's Medication Administration Record for August 2021 indicated he received Ciprofloxacin 250 mg (milligrams) 1 tablet by mouth one time a day for 5 days for UTI from 8/9/21 to 8/13/21.</p> <p>An observation was made on 8/16/21 at 11:35 AM of Resident #45 while he was sitting at the bedside in his wheelchair. Resident #45 had a urinary catheter with the tubing and the urinary catheter bag touching the floor.</p> <p>Another observation of Resident #45 on 8/18/21 at 12:11 PM revealed his urinary catheter bag laying flat on the floor while Resident #45 was lying on his bed.</p> <p>An interview with Nurse Aide (NA) #1 on 8/18/21 at 12:19 PM revealed Resident #45's urinary catheter bag was not supposed to be left laying flat on the floor. During the interview, NA #1 picked up Resident #45's catheter bag and hung it on the bed frame off the floor. NA #1 stated she last saw Resident #45 before 11:00 AM and he was sitting up in his wheelchair with his urinary catheter bag secured on his wheelchair. NA #1 further stated she was not sure if Resident #45 took himself to bed or if another staff member helped him back to bed.</p> <p>An interview with Nurse #2 on 8/18/21 at 12:26 PM revealed he had helped Resident #45 back to bed around 11:00 AM and he hung Resident #45's urinary catheter bag to the metal railing on his bed. Nurse #2 stated the catheter bag might have come unhooked and ended up on the floor.</p>	F 690	<p>Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice? Facility audit was conducted on 8/19/21 by the Director of Nursing of all Foley Catheter in house to identify any further issues. None noted.</p> <p>Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur. Education was provided to all nursing staff by the Staff Development Coordinator (SDC) or DON to address care of residents with a Foley Catheter to include proper placement of drainage bag and tubing, etc. The education began on 8/19/21 with nursing staff on duty and continued until completed on 9/8/21. The same topics will be addressed during orientation for new nurses. An audit will be conducted by the DON, ADON, nurse supervisor or SDC beginning 9/13/21 to include all residents with a Foley Catheter at a frequency of 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks bringing the documented audit results to monthly QAPI meeting. Any omission identified in the audit, the DON, ADON and/or SDC will re-educate on non-compliance. The ADON, SDC or nurse supervisor will conduct a weekly audit which will be turned in to the DON on-going.</p> <p>Criterion # 4 <input type="checkbox"/> How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur?</p>		

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F 690	Continued From page 3 Nurse #2 also stated it was not acceptable for Resident #45's catheter bag to be on the floor. An interview with the Infection Preventionist (IP) on 8/19/21 at 9:31 AM revealed she was familiar with Resident #45 and knew that he had just completed antibiotic therapy for UTI. The IP stated Resident #45's urinary catheter bag and tubing should have been positioned off the floor when he was in his wheelchair or his bed. An interview with the Director of Nursing (DON) on 8/19/21 at 11:11 AM revealed she was alerted by the IP regarding concerns related to Resident #45's urinary catheter and they found out that Resident #45's wheelchair was lower than the regular wheelchairs. The DON confirmed that they noted Resident #45's urinary catheter bag and tubing were right against the floor whenever he was sitting in his wheelchair and both should be positioned higher up in his wheelchair. The DON stated Resident #45 also often attempted to transfer himself from wheelchair to bed and would take his urinary catheter bag off the wheelchair and either lay it on the floor or on the bed.	F 690	The Director of Nursing (DON), Assistant Director or Nursing (ADON), and/or Staff Development Coordinator (SDC) will present monthly for three (3) months, the results of the audits and education as indicated to the facility Quality Assurance/ Performance Improvement (QAPI) Committee. The QAPI Committee will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.		
F 761 SS=D	Label/Store Drugs and Biologicals CFR(s): 483.45(g)(h)(1)(2) §483.45(g) Labeling of Drugs and Biologicals Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. §483.45(h) Storage of Drugs and Biologicals	F 761		9/10/21	

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F 761	<p>Continued From page 4</p> <p>§483.45(h)(1) In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys.</p> <p>§483.45(h)(2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews, the facility failed to store undated and unopened eye drop bottles according to manufacturer's instructions on 2 of 4 medication carts (300 hall medication cart and 400 hall medication cart).</p> <p>The findings included:</p> <ol style="list-style-type: none"> 1. An observation of the 300 hall medication cart on 8/19/21 at 10:03 AM with Nurse #3 revealed an undated and unopened bottle of Latanoprost 0.005% eye drops, a medication used to treat glaucoma and ocular hypertension. The bottle was labeled with a sticker that read "refrigerate until opened; discard 6 weeks after opening." The undated and unopened bottle of Latanoprost belonged to Resident #61. <p>An interview with Nurse #3 on 8/19/21 at 10:05 AM revealed the unopened bottle of Latanoprost was filled by the pharmacy and delivered to the</p>	F 761	<p>Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? Residents # 41 and # 61 were identified as affected by this practice. On 8/19/21, resident #41 and resident #61 both were noted to have unopened bottles of Latanoprost 0.005% eye drops in the medication cart with labels stating to remain refrigerated until opened. Eye drops were removed from both carts immediately and reordered from pharmacy.</p> <p>Criterion # 2 - How will the facility identify other residents having the potential to be affected by the same practice? On 08/19/21, the other remaining medication carts were audited by the Director of Nursing for improperly stored medications. No further issues were</p>		

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F 761	<p>Continued From page 5</p> <p>facility on 8/16/21 and must have been placed directly on the medication cart after it was delivered. Nurse #3 stated the Latanoprost bottle should have been stored in the refrigerator until it was ready to be opened and used.</p> <p>An interview with the Director of Nursing (DON) on 8/19/21 at 10:23 AM revealed she remembered Nurse #2 telling her that he was going to put the Latanoprost bottle on the 300 hall medication cart the day before, after it was delivered from the pharmacy. The DON stated Nurse #2 must have forgotten to throw away the old bottle and open the new bottle of Latanoprost and date it.</p> <p>2. An observation of the 400 hall medication cart on 8/19/21 at 10:14 AM with Nurse #4 revealed an undated and unopened bottle of Latanoprost 0.005% eye drops that belonged to Resident #41. The bottle was labeled with a sticker that read "refrigerate until opened; discard 6 weeks after opening." The bottle also had a pharmacy label that it was filled on 8/6/21.</p> <p>An interview with Nurse #4 on 8/19/21 at 10:15 AM revealed the unopened and undated bottle of Latanoprost should have been kept in the refrigerator until opened because it only lasted for 6 weeks after being taken out of refrigeration. Nurse #4 stated she did not notice the unopened Latanoprost bottle because it was due to be given only at night.</p> <p>An interview with the Director of Nursing (DON) on 8/19/21 at 11:11 AM revealed the nurses were supposed to be checking the medication carts weekly for undated medications. The DON stated</p>	F 761	<p>identified.</p> <p>Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur.</p> <p>All medication carts will be audited for improperly stored medications beginning on 9/13/21 by the DON, ADON, nurse supervisor or SDC at a frequency of 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks bringing the documented audit results to monthly QAPI meeting. Any omission identified in the audit, the DON, ADON and/or SDC will re-educate on non-compliance.</p> <p>Education was provided to all licensed nurses by the Staff Development Coordinator (SDC) or DON to address medication storage. This education was started immediately on 8/19/21 for nurses on duty and continued through 9/8/21 until all nurses were educated. The same topics will be addressed during orientation for new nurses. On-going/routine monitoring of medication carts will continue with facility weekly red-zone audit schedule.</p> <p>Criterion # 4 <input type="checkbox"/> How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur? The Director of Nursing (DON), Assistant Director or Nursing (ADON), and/or Staff Development Coordinator (SDC) will present monthly for three (3) months, the results of the audits and education as indicated to the facility Quality Assurance/ Performance Improvement (QAPI) Committee. The QAPI Committee will</p>		

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F 761	Continued From page 6 she was going to call the pharmacy to verify if the Latanoprost eye drop bottles were supposed to be refrigerated until they were opened and to check if any of the Latanoprost eye drop bottles were still good to be used even though they had not been refrigerated since being sent from the pharmacy.	F 761	review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.		
F 812 SS=D	Food Procurement,Store/Prepare/Serve-Sanitary CFR(s): 483.60(i)(1)(2) §483.60(i) Food safety requirements. The facility must - §483.60(i)(1) - Procure food from sources approved or considered satisfactory by federal, state or local authorities. (i) This may include food items obtained directly from local producers, subject to applicable State and local laws or regulations. (ii) This provision does not prohibit or prevent facilities from using produce grown in facility gardens, subject to compliance with applicable safe growing and food-handling practices. (iii) This provision does not preclude residents from consuming foods not procured by the facility. §483.60(i)(2) - Store, prepare, distribute and serve food in accordance with professional standards for food service safety. This REQUIREMENT is not met as evidenced by: Based on observations and staff interviews the facility failed to dispose of expired perishable food items in 1 of 2 nourishment room refrigerators (Nourishment room # 1). The findings included:	F 812	Criterion #1 - How will the corrective action be accomplished for those residents found to have been affected by the deficient practice? No residents were cited in this practice. Criterion # 2 - How will the facility identify other residents having the potential to be	9/10/21	

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F 812	<p>Continued From page 7</p> <p>Observation of the resident nourishment room # 1 refrigerator was completed with the Dietary Manager (DM) on 8/18/2021 at 3:40 PM. The observation revealed the following:</p> <p>- 14 containers of yogurt with expiration dates of 8/17/2021</p> <p>An interview with the DM on 8/18/2021 at 3:41 PM revealed dietary staff were assigned daily to verify expiration dates in resident refrigerators. All outdated / expired items were to be discarded. The DM stated she believed the person who checked it on 8/18/2021 must have forgotten the date. The DM verified items in the refrigerator were available for resident consumption.</p> <p>The Director of Nursing (DON) was interviewed on 8/19/2021 at 11:12 AM. The DON stated checking expiration dates in refrigerators was the responsibility of the dietary department. She revealed her expectation was for expired items not to be available for consumption by residents.</p> <p>The facility Administrator was interviewed on 8/19/2021 at 12:11 PM. The Administrator stated her expectation of dietary staff was to maintain foods ready for distribution to residents within manufacturers expiration dates.</p>	F 812	<p>affected by the same practice? Residents who reside in the facility have the potential to be affected by this practice. The Director of Food and Nutrition Services audited 100% of nourishment storage areas on 08/18/2021 and no other issues were identified.</p> <p>Criterion #3 - What measures will be put in place or systematic changes made to ensure the deficient practice will not reoccur. Education was provided by The Director of Food and Nutrition Services (CDM) to all dietary employees starting on 08/18/2021 regarding Food Safety including Nourishment Storage Areas. This education addressed proper food and beverage labeling and storage processes as well as checking for any expired items as nourishment areas are re-stocked. Education was completed on 09/10/2021 and the same topics will be addressed during orientation for new dietary employees. The Registered Dietician (RD) will perform a monthly observation audit for 3 months observing for food/beverage items being labeled/stored properly and not past expiration dates in all nourishment storage areas and will report results to the CDM and Executive Director(ED) monthly for a minimum of 3 months. The Director of Food Services (CDM), RN, LPN, Cook, or SDC will audit nourishment storage areas for proper food storage/labels and expiration dates and document on an audit form. This audit began on 09/06/2021 at a frequency</p>		

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F 812	Continued From page 8	F 812	<p>of 5 times a week for 5 weeks, then 3 times a week for 4 weeks then 1 time a week for 4 weeks. Any omission identified in the audit, the CDM and/or ED will re-educate on non-compliance.</p> <p>Criterion # 4 <input type="checkbox"/> How will the facility monitor the corrective plan to ensure the deficient practice was corrected and not reoccur? The Director of Food and Nutrition Services (CDM) and/or Executive Director will present monthly for three (3) months, the results of the audits and education as indicated to the facility Quality Assurance/ Performance Improvement (QAPI) Committee. The QAPI Committee will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.</p>		