STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	346203	A. BUILDING _____ B. WING _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD PO BOX 2199 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
F 323 SS=E	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observations and resident and staff interviews, the facility failed to monitor and maintain water temperatures within safe parameters on four (4) of four (4) resident halls. The findings are: On 6/6/11 at 4:24 PM water temperatures from the sink in resident rooms felt hot to touch. Water temperatures were immediately checked with the surveyor's calibrated thermometer in a cup with running water in three room sinks on the 400 hall in which three ambulatory residents with cognitive impairment resided. Temperatures revealed the water from the sinks in resident rooms were: Room 402 registered 122 degrees Fahrenheit (F); Room 408 registered 125 degrees F; Room 411 registered 124 degrees F. Other rooms checked by other surveyors starting at 4:25 PM revealed temperatures in resident room sinks and central bath showers using a cup and running water as follows:	F 323	**Plan of Correction for Survey 06/09/2011** This plan of correction in response to the Statement of Deficiencies demonstrates our good faith and desire to improve the quality of care and services rendered to our residents. By submitting this plan of correction, the facility does not, however, admit that any deficiency actually existed at the time of the survey. This plan of correction constitutes a written allegation of substantial compliance. **F323 483.25 (L) Free of Accidents Hazards / Supervision / Devices** **A. Resident found to be affected by alleged deficient practice:** No residents were affected **B. Resident having potential to be affected:** All residents have the potential to be affected by hot water temperatures. **C. Systematic changes to assure alleged deficient practices will not occur:** All maintenance staff have been re-educated by the Executive Director on the procedure to follow if water temperatures are out of range. If temperature ranges are below 105° or above 116° they are to notify the ED, AED, or DON and a new form was created to document this information. After water temps have been adjusted, water temps will be re-checked every hour until water temps are in range. Once temperatures are in range they are then to check the temperatures every hour for three hours. Education was completed on 6-21-11	6/29/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
CNHA	Senior Executive Director	6-30-11

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 323	Continued From page 1 Room 104 registered 121.7 degrees F; 100 hall central bath shower registered 121 degrees F; Room 204 registered 117.8 degrees F; 200 hall central bath shower registered 121 degrees F; Room 305 registered 124 degrees F; Room 310 registered 120 degrees F; 300 hall central bath shower registered 120 degrees F. On 6/6/11 at 5:07 PM the Maintenance Director stated that once a week, usually on Fridays, he or his staff went to two (2) random resident rooms on each hall with a cup and check water temperatures with a digital thermometer which is calibrated prior to the start of water temperature checks. He stated that the goal was to keep the water temperatures around 115 degrees F. He further stated that he did not check central bath water temperatures. He stated that there usually was not much varying of the temperatures from room to room. He stated that last week the temperatures were adjusted (turned down) because they registered 116 degrees F. He further described that there were two boilers across from the 400 hall nursing station that feed water to all the resident rooms and central showers. These boilers both ran through the same mixing valve and recirculation pump. He did not recall any concerns or complaints about water temperatures from residents or staff. He stated that he had not checked or made adjustments on this date. On 6/6/11 at 5:20 PM with the Maintenance Director using his thermometer, which he calibrated at this time, observations revealed	F 323	**D. Monitoring process:** Logs and forms will be monitored weekly to ensure the temperature ranges are between 105° to 116° by Executive Director, AED and Maintenance Director. Beginning on 6/24/11. Findings of this audit will be brought to the Continuous Quality Improvement Committee monthly for three months. The next meeting is scheduled for 7/20/2011.	

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F 323	Continued From page 2 resident room sink temperatures in the following room: Room 408 registered 125 degrees F; Room 411 registered 124 degrees F; Room 402 registered 120 degrees F. He stated that he had never seen the water temperatures range this high before. Observations of the temperature gauge on the mixing valve at 5:50 PM in the boiler room revealed the water temperature was set at 122 degrees F. Per maintenance it is kept at this temperature to allow the water to cool off when it reaches resident areas. He could not explain why the water temperatures in the resident areas were so high. On 6/6/11 at 5:45 PM a phone conversation was held with the maintenance assistant who most recently checked the water temperatures. The maintenance assistant stated that he noticed the water temperatures seemed high when he checked them with his hands in the morning, last Saturday. Upon checking them with a thermometer, he noted the water temperatures were 120 degrees F so he lowered the water temperature on the mixing valve. He stated that he thought the mixing valve was set at 120 degrees F before he lowered it. He stated that he did not write the high temperatures down in the water temperature log but wrote the temperatures that he got when he rechecked the temperatures in the afternoon. He verified the temperatures that are recorded in the log book are after the adjustment. He stated that he did not report finding the high water temperatures or that he had to adjust the mixing valve to anyone. He further stated that he worked again on Sunday but did not check the water temperatures.	F 323		

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LIFE CARE CENTER OF BANNER ELK	105 NORWOOD HOLLOW ROAD PO BOX 2199 BANNER ELK, NC 28604

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F 323	Continued From page 3 Review of the last six months of water temperature logs revealed water temperatures were well controlled and within acceptable parameters except one day. On 5/6/11 the temperatures ranged from 115 degrees F to 120 degrees F. There were no notations regarding what changes if any were made on this date. Review of the water logs revealed the last time the water temperatures were recorded was on Saturday 6/4/11 which ranged from 112 to 115 degrees F. Follow up interview with the Maintenance Director on 6/6/11 at 6:00 PM revealed that he remembered talking to the maintenance assistant about the water temperatures last Thursday or Friday. They looked at the thermometer in the boiler room above the mixing valve. If that thermometer reads between 119-121 degrees F, he stated they don't necessarily go to resident rooms to check. He stated that his monitoring of the water temperatures included checking the thermometer at the mixing valve to make sure it was between 119 - 121 degrees F. He stated the thermometer at the mixing valve in the mechanical room normally read 122 degrees F and would not be of any concern. He stated that each season they need to "tweak" the temperatures but never was the water temperatures this high. He could not recall the temperatures of 5/6/11. On 6/9/11 at 1:57 PM interview with the administrator revealed that he expected the water temperatures in areas used by residents would be between 110 - 116 degrees F. He would expect maintenance staff to inform either his	F 323		

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F 323	Continued From page 4 assistant or himself if and when adjustments needed to be made. He further stated that once an adjustment was made to change the water temperature to areas used by residents, a plan should be implemented to determine what follow up would be established to ensure the water temperatures were with in an acceptable range. Interviews with resident and staff revealed only one alert and oriented resident who stated on 6/6/11 at 4:28 PM that sometimes the water was a little too warm. She had never reported this to anyone.	F 323		
F 329 SS=D	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs.	F 329	**F329 483.25(1) Drug Regimen is Free From Unnecessary Drugs** **A. Resident found to be affected by alleged deficient practice:** Resident #28 had a clarification order obtained on 6/9/11 from attending physician for Lasix 40mg po daily and Micronase 2.5 mg po daily. The Medication Administration Record reflects the clarification order. Re-education was completed with the nurse involved in the recapitulation process for resident #28. **B. Residents have the potential to be affected:** All residents have the potential to have order changes during the month to be checked in the monthly recapitulation process.	6/30/11

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F 329	Continued From page 5 This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to reduce the dosage of two medications as ordered by the physician for one (1) of twelve (12) residents reviewed for unnecessary medications resulting in Resident #28 receiving an excessive dose. The findings are: Resident #28 was re-admitted to the facility 09/12/06 with diagnoses which included including Hypertension and Diabetes. Review of the current Physician Orders Sheet for Resident #28 dated 06/01/11 revealed an order for Micronase 2.5mg (milligrams) daily and Lasix 40mg daily. Review of the June 2011 Medication Administration Record (MAR) revealed both of these medications were being given twice a day from June 1st through June 8th, 2011. During an interview on 06/09/11 at 10:45 AM, the Director of Nursing (DON) stated this was a transcription error. The DON further stated that every month the new MARs were sent out from pharmacy and were recapitulated by facility staff to ensure the physician order sheets were correct. The nurse who performed the recapitulation process caught the error and had made the correction on the physician order sheet	F 329	**C. Systematic changes to assure alleged deficient practices will not occur:** All nurses involved in the recapitulation process have been re-educated on the monthly recapitulation procedure by the Director of Nursing to ensure accuracy. Re-education completed 6/29/11. **D. Monitoring process:** The recapitulation process will be observed/monitored by the Director of Nursing, Assistant Director of Nursing, or the Staff Development Coordinator to ensure that the process is consistent and accurate and that all residents records are reviewed to ensure all recap orders and Medication Administration Records are accurate. This will be monitored monthly during the monthly recapitulation process beginning 6/29/11. Copies of the corrections on the physician orders will be sent back to the pharmacy for the pharmacy to correct in the resident profiles and then they will return the copy stating the corrections have been made for us to audit. Findings of this audit will be brought to the Continuous Quality Improvement Committee meeting monthly for three months. The next meeting is scheduled for 7/20/2011.	

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F 329	Continued From page 6 but this had not been corrected on the June 2011 MAR. The DON stated Resident #28 had an outpatient procedure done on 05/16/11 and had returned to the facility on 05/17/11 with orders from the surgeon for these medications to be given daily. The DON stated the resident had been on them twice a day prior to the procedure. During a telephone interview on 06/09/11 at 11:30 AM the resident's physician stated he did not think there would be any adverse effects and had ordered the facility to go back to daily doses of the Lasix and Micronase. No lab work was ordered and the physician stated the facility would continue with routine FSBS (finger stick blood sugar) monitoring one time a week. Review of the FSBS for June 2nd and June 9th was 182 and 124 respectively. Interview with the ADON (Assistant DON) on 06/09/11 at 1:30 PM revealed she had verified the medications on 05/30/11 for the new physician's order sheet for June and the discrepancy had been found and corrected on the physician's order sheet. No explanation was given for not being corrected on the MAR.	F 329		
F 333 SS=D	483.25(m)(2) RESIDENTS FREE OF SIGNIFICANT MED ERRORS The facility must ensure that residents are free of any significant medication errors. This REQUIREMENT is not met as evidenced by: Based on observations, review of the medical record and medication manufacturer packet insert, and interviews the facility failed to adhere	F 333	**F333 483.25 (m) (2) ADL Residents Free of Significant Med Errors** **A. Residents found to be affected by alleged deficient practice:** Resident #80 had a clarification order obtained on 6/9/11 from attending physician for Potassium liquid 20MEQ po every Monday, Wednesday, and Friday for treatment of CHF. The Medication Administration Record reflects the clarification order.	7/7/11

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F 333	Continued From page 7 to instructions not to crush a sustained release medication for one (1) or eleven (11) sampled residents observed for medication administration. (Resident #80). The findings are: The manufacturer package insert, Revised 1208, for Klor-Com M20 20 mEq (Milliequivalent) read in part: "Klor-Con M is a tablet formulated to provide an extended rate of release of microencapsulated potassium chloride and thus to minimize the possibility of a high local concentration of potassium near the gastrointestinal wall." Precautions noted in the insert included: "Take each dose without crushing, chewing or sucking the tablets." Resident #80 was admitted to the facility 08/22/2007 with diagnoses including Congestive Heart Failure (CHF) and Stomach Function Disorder. The June 2011 Physician's Orders and Medication Administration Record (MAR) for Resident #80 revealed a physician's order, dated 01/14/2011, for Klor-Con M20 20 mEq SR (sustained release) to be administered by mouth every Monday, Wednesday, and Friday for treatment of CHF. Additional instructions for administration on the MAR included "DO NOT CRUSH OR CHEW" per precautions noted in the manufacturer packet insert. During observations of medication administration, 06/08/2011 at 09:02 AM, Licensed Nurse (LN) #2 prepared Resident #80's medications for administration. The pharmacy label on the	F 333	Re-education was completed on 6/9/11 with Licensed Nurse (LN) #2 regarding following manufacturer package insert, the additional instructions on the pharmacy label on the medication unit dose dispensing card, and the additional instructions on the Medication Administration Record. Education completed by ADON. **B. Residents having the potential to be affected:** All residents have the potential to be have an order obtained for Potassium tablets. **C. Systematic changes to assure alleged deficient practice will not occur:** All nurses have been re-educated on Medication crushing- General Guidelines for All medications to include Potassium. Completed by DON on 6/24/11. All Potassium orders were reviewed to ensure appropriate consistency for specific residents initiated 6/14/11 through 7/6/11. On 7/6/11 all Potassium orders with a tablet consistency were changed to either a capsule or liquid consistency. **D. Monitoring Process:** All new Potassium orders will be reviewed/audited in the morning meeting to ensure appropriate consistency initiated on 6/14/11.	

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F 333	Continued From page 8 medication unit dose dispensing card read in part: Klor-Con M20 20 mEq SR take 1 tablet by mouth every Monday, Wednesday, and Friday. Addition instructions for administration included "DO NOT CRUSH OR CHEW." LN #2 removed one tablet from the dispensing card placing it in a cup. LN #2 prepared additional medications, added them to the cup containing the Klor-Con SR, and proceeded to crush all the medications. LN #2 confirmed all prepared medications were crushed in preparation for administration to Resident #80 During a follow-up interview, 06/09/2011 at 10:45 AM, LN #2 reviewed Resident #80's MAR and the Klor-Con unit dose pharmacy label and confirmed administration instructions included "do not crush." LN #2 reported she was thinking about being observed and did not place the Klor-Con in a separate cup to avoid crushing. LN #2 stated the Klor-Con should not have been crushed due to the risk of increasing the absorption rate of the medication. During an interview, 06/09/2011 at 2:15 PM, the Director of Nursing (DON) stated LN staff were responsible for reviewing instructions on the MAR and medication pharmacy label and administering medications accordingly. The DON confirmed Resident #80's Klor-Con should not have been crushed.	F 333	All new Potassium orders will be reviewed/audited in the morning meeting to ensure Potassium consistency is capsule or liquid form effective 7/7/11. We will do a med pass audit to ensure the Potassium's are given appropriately twice a week for three months. Findings of this audit will be brought to the Continuous Quality Improvement Committee meeting monthly for three months. The next meeting is scheduled for 7/20/2011.	
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.	F 441	**F441 483.65 Infection Control, Prevent Spread, Linens** **A. Resident found to be affected by alleged deficient practice:** No residents were affected.	7/5/11

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F 441	Continued From page 9 (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: Based on observation, staff interview and facility policy review the facility failed to follow infection control practices during medication administration and meals. One (1) Licensed Nurse (LN) failed	F 441	**B. Residents having the potential of being affected:** All residents have the potential to be affected. **C. Systematic changes to assure alleged deficient practice will not occur:** Re-education was completed on 6/8/11 with LN #3 on the hand washing/hand sanitizing protocol. Completed by ADON. Re-education was started on 6/6/11 for all nurses and C.N.A.'s on hand washing/ hand sanitizing protocol and was completed on 6/24/11 by the Staff Development Coordinator. **D. Monitoring Process:** Monitoring infection control practices during Medication Administration three times a week for three months by DON, ADON, SDC or other designee on 6/29/11. Monitoring infection control practices during meal times three times per week for three months by DON, ADON, SDC, or designee. Monitoring began on 6/14/11. Findings of this audit will be brought to the Continuous Quality Improvement Committee meeting monthly for three months. The next scheduled meeting is 7/20/2011.	

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

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F 441	Continued From page 10 to perform hand hygiene after wiping a spill from the floor and three (3) Nurse Aides (NA) in two (2) dining areas were observed assisting multiple residents without sanitizing or washing their hands. The findings are: Review of the facility's Hand Hygiene Policy, last revised 5/21/04, documented when hands were contaminated with proteinaceous material, a waterless alcohol based rub could be used but if hands were visibly soiled, they should be washed with soap and water. 1. During a medication administration observation on 06/08/11 at 9:15 a.m., LN #3 prepared to administer a nutritional supplement. LN #3 took the carton of supplement from the medication cart and shook the carton vigorously. The lid of the supplement carton was not secure resulting in a moderate amount of the supplement being spilled on the med cart and floor. LN #3 grabbed some Kleenex tissues from the med cart and wiped the spill from the floor and from the med cart. LN #3 then proceeded to picked up supplement carton again, with unwashed hands and secured the lid before washing or using hand sanitizer. The LN placed the carton of supplement back on the med cart for use. Interview at this time revealed she was in a hurry to clean up mess and did not think about cleaning her hands before securing the lid. During an Interview with the Infection Control Nurse at 10:55 AM on 06/08/11 she stated she would expect all staff to wash their hands after cleaning a spill from the floor before touching	F 441		

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LIFE CARE CENTER OF BANNER ELK	185 NORWOOD HOLLOW ROAD PO BOX 2199 BANNER ELK, NC 28604

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F 441	Continued From page 11 items on the medication cart. 2. The noon meal was observed on 06/06/11 in the skilled dining room between 100 and 200 halls. a. NA #2 was observed at 12:05 PM, feeding two residents simultaneously. NA #2 gave one resident a bite of food, wiped the resident's mouth and nose with the resident's napkin then turned to the other resident and did the same without using hand sanitizer or washing between residents. NA #2 went back and forth between the two residents the entire meal, wiping their faces and/or noses without washing or sanitizing between the residents. During an interview on 06/06/11 at 1:35 PM, NA #2 stated she forgot to take her hand sanitizer into the dining room and "just did not think about it today", going back and forth between residents while feeding because she "was just so busy". NA #2 stated she should have used hand sanitizer or washed after wiping one resident's nose/mouth because "he has such bad allergies." b. NA #3 was observed at 12:10 PM, feeding two residents simultaneously. NA #3 gave one resident a bite of food, wiped the resident's mouth a napkin then turned to the other resident and did the same without using hand sanitizer or washing between residents. NA #3 went back and forth between the two residents the entire meal, wiping their faces without washing or sanitizing between the residents. During an interview on 06/06/11 at 1:30 PM, NA #3 stated "we wash or use hand sanitizer before	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345203	A. BUILDING _____ B. WING _____	06/09/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 441	Continued From page 12 feeding residents". NA # 3 stated she did not remember if she had any specific training regarding feeding two residents at a time. NA #3 stated that she should have used hand sanitizer or washed after wiping the resident's mouth but "just did not think about it." During an interview with the Infection Control Nurse (ICN) at 10:55 AM, on 06/08/11 she stated she expected NAs to use hand sanitizer or wash after wiping a resident's mouth before feeding another resident and staff were trained to wash or use hand sanitizer before feeding a resident. The ICN stated she had not done any specific training regarding feeding two residents simultaneously. 3. On 6/6/11 at 12:29 PM, Nurse aide (NA) #1 was observed assisting residents throughout the meal. AT 12:32 PM, NA #1 scooped up spilled food and paper debris which was in front of a resident into her hand. With the food and paper debris in her hand, she assisted two other residents by exchanging bowls of food from which they were eating. Throughout this process, with the debris in her hand, she held resident spoons, uncovered fresh bowls of food and wiped up food from a resident's shirt. With the debris still in her hand and no hand washing or sanitizer used, NA #1 patted a female resident on her back, and fed her a bite of pie. At 12:43 PM, NA #1 placed the debris of paper and food and left it on the table where two residents were still eating. NA #1 did not wash her hands or use sanitizer after placing the debris on the table before wiping her neck, assisted a resident drink from a cup and set up more food for a resident. Then she gathered a soiled lunch tray, scraped bowls into the trash, and then without handwashing or using sanitizer,	F 441		

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

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F 441	Continued From page 13 sat with a resident and assisted feeding her. At 1:00 PM in the middle of gathering trash and scraping food from soiled trashed, NA #1 went over to a resident and wiped food off of her nose. It was after this contact that she got a hand sanitizer cloth and wiped her hands for the first time since scraping paper and food debris into her hand. On 6/6/11 at 1:27 PM NA #1 was interviewed. She stated that she was taught to wash her hands when entering a residents room and when exiting a residents room after care was provided. She stated that in the dining room there is no handwashing between residents. She then stated that nurse aides use sanitizer in the dining room. When asked if she had some sanitizer to use today she replied no. She confirmed it was available for staff. She stated she did not wash or use sanitizer because she was nervous being observed in the dining room. On 6/8/11 at 10:55 AM, the infection control nurse was interviewed. She stated that nurse aides are taught to use standard precautions. Training is provided during orientation and annually. Her expectation was that hand sanitizer should be used during dining when staff reposition a resident or clean someone's mouth and if they clear dirty trays they should sanitize hands prior to assisting residents. She further stated that she has never been specific during training of what to do when feeding multiple residents. She further stated that she will observe staff provide care and watch for handwashing techniques but has not watched for proper handwashing in the dining rooms this year.	F 441		