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 ______	05/02/2019

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LIFE CARE CENTER OF BANNER ELK	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 A recertification survey was conducted on 04/29/19 through 05/02/19 by the Division of Health Service Regulation, Nursing Home Section. The facility was in compliance with the requirements of CFR 483.73, Emergency Preparedness. Event ID #CYCV11.	E 000		
F 658 SS=D	Services Provided Meet Professional Standards CFR(s): 483.21(b)(3)(i) §483.21(b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (i) Meet professional standards of quality. This REQUIREMENT is not met as evidenced by: Based on record review, physician, and staff interviews the facility failed to follow physician orders to withhold blood pressure medication as directed by parameters for 1 of 5 residents reviewed for unnecessary medications (Resident #17). Findings included: Resident #17 was admitted to the facility 11/16/18 with diagnoses which included primary hypertension and non-Alzheimer's dementia. A review of the quarterly Minimum Data Set (MDS) dated 02/09/19 assessed Resident #17's cognition as being severely impaired. A review of the physician orders dated 03/29/19 for Resident #17 revealed nurses were to administer 12.5 milligrams (mg) of Atenolol (a medication used to treat high blood pressure) by	F 658	Services Provided Meet Professional Standards 1. How corrective action will be accomplished for those residents found to be affected by the deficient practice. Resident # 17 was identified as the affected resident. Resident # 17's physician and responsible party were notified of this deficiency on 05/01/19 by the Director of Nursing. Blood pressures and medications were discussed with the physician and the medication was deemed no longer necessary as her blood pressure readings resulted in the medication being held often. The medication was discontinued on 05/01/19 per physician order. A medication error event was entered into the clinical documentation system. The nurse	5/24/19

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
Electronically Signed		05/22/2019

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 658	Continued From page 1 mouth one time a day related to the diagnosis of primary hypertension. Included in the order were parameters to hold Atenolol if systolic blood pressure (the amount of pressure in the arteries during the contraction of the heart muscle) was less than 100. Review of Resident #17's April 2019 Medication Administration Record (MAR) revealed on 04/20/19 at 10:00 AM Nurse #1 documented Resident #17's systolic blood pressure reading as 94 and initialed she administered Atenolol 12.5 mg. Review of Resident #17's April 2019 MAR revealed on: 04/20/19 at 10:00 AM a blood pressure reading of 94/58, 04/21/19 at 10:00 AM a blood pressure reading of 104/62, 04/22/19 at 10:00 AM a blood pressure reading of 90/61. Nurse #1 documented on the MAR she withheld Atenolol using code #3 which read vitals outside of parameters of administration. Review of the nurses' notes for Resident #17 revealed no documentation was entered on 04/20/19. The next documented nurse note revealed on 04/22/19 Nurse #1 withheld Atenolol for a systolic blood pressure reading less than 100. During an interview on 05/01/19 at 3:37 PM the Medical Doctor (MD) revealed parameters were written to guide the nurses to withhold Atenolol when systolic blood pressure readings were less than 100. He was unaware Resident #17's Atenolol medication was administered outside of the parameter. The MD stated if notified he	F 658	identified in the deficient practice received 1:1 education by the Director of Nursing on 05/01/19 regarding holding medication if required based on parameters in the physician order. 2. How the facility will identify other residents having the potential to be affected by the same deficient practice. Residents on cardiac medication with parameters to hold based on blood pressure/heart rate readings have the potential to be affected. On 05/03/19, the Director of Nursing completed a 100% audit of physician orders, vital signs and medication administration records (MARS) for the past 30 days to identify any other medication errors. Any issues noted were addressed and corrected immediately. 3. What measures will be put into place or systemic changes made to ensure that the deficient practice will not recur. The Director of Nursing and/or Staff Development Coordinator will provide education to licensed nurses on the Medication Administration Policy including following physician orders for cardiac medications with "hold parameters" and proper documentation for held medications by 05/24/19. Newly hired licensed nurses will be educated on these same processes during orientation. 4. How the facility plans to monitor it's performance to make sure that solutions	

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F 658	Continued From page 2 would've directed the nurse to monitor Resident #17 for negative side effects from the medication and possibly discontinue the medication. During an interview on 05/01/19 at 3:49 PM Nurse #1 confirmed on 04/20/19 she initialed Atenolol was administered to Resident #17 on the MAR on 04/20/19. Nurse #1 revealed her routine was to obtain and record the blood pressure reading on the MAR. She then would administer and document the medication was given. Nurse #1 explained on the MAR a code was used to identify when medications were withheld for vital signs outside of parameters and if she withheld a medication she notified her Nurse Supervisor. Nurse #1 couldn't say why she administered Atenolol when the systolic blood pressure was 94. There were other times when this occurred, and she withheld the Atenolol and documented the reasons. She stated when she signed the MAR this meant she had given the medication. She was unable to give a reason why the Atenolol was administered on 04/20/19 and wasn't sure if she did or did not give it that day but was aware the MAR indicated she had. During an interview on 05/01/19 at 4:24 PM the Nurse Supervisor (NS) revealed the computer MAR prompted the nurses to document the reason a medication was held. The NS reviewed Resident #17's MAR which revealed Atenolol was given on 4/20/19 with a systolic blood pressure of 94. She didn't recall being notified Atenolol was administered outside of parameters for Resident #17. She revealed the nurses obtained vital signs prior to administering a medication with parameters. The NS explained it was her expectation if blood pressure medication was administered outside set parameters the nurse	F 658	are sustained. The Director of Nursing, Staff Development Coordinator and/or RN Supervisor will conduct a medication administration record, vital signs and physician orders review audit for any residents on cardiac medications with parameters to ensure physician orders are followed properly with appropriate documentation. This audit will be conducted 5 times a week for 4 weeks, then 3 times a week for 4 weeks, then 1 time a week for 4 weeks. Any deficient practice identified in the audits will be addressed immediately and the Director of Nursing, Staff Development Coordinator and/or RN supervisor will re-educate on non-compliance with following physician orders. The Director of Nursing and/or Staff Development Coordinator 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 committee consisting of the Executive Director, Director of Nursing, Medical Director, Director of Food and Nutrition Services, Director of Social Services, Business Office Manager, Director of Admissions, and the Director of Activities will review the findings and make recommendations and develop plans of action if any areas are noted to be non-compliant.	

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F 658	Continued From page 3 would notify her, so she could contact the MD for guidance. The NS revealed it was her expectation the nurse notify her if blood pressures were consistently outside of parameters, so she could notify the MD for guidance and or direction to discontinue the medication. During an interview on 05/01/19 at 4:49 PM the Director of Nursing (DON) revealed it was her expectation physician orders with parameters were followed. After the DON reviewed Resident #17's MAR she confirmed on 04/20/19 there was no documentation showing the Atenolol was withheld. The DON was unaware the Atenolol was administered when parameters directed the nurse to withhold. The DON expected the nurse to notify her after administering the Atenolol outside of those parameters, so the MD and the family could be notified.	F 658		