

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 08/21/2024
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	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Honor the resident's right to organize and participate in resident/family groups in the facility.</p> <p>50045</p> <p>Based on record review, and resident and staff interviews, the facility failed to provide a resolution of Resident Council grievances for 1 of 1 monthly Resident Council Meetings (June 2024). The Resident Council had reported they would like to have transportation to go on group outings.</p> <p>The findings included:</p> <p>A review of the Grievance Program policy dated 5/6/2019 stated the facility should make prompt efforts to resolve a grievance and should actively work toward a solution of a complaint/grievance. The facility should follow up with the resident to communicate resolution or explanation and ensure that the issue was handled to the resident's satisfaction.</p> <p>A review of the Resident Council minutes from 6/24/2024 revealed residents requested to take day trips and were advised that the facility had contacted companies regarding party buses for transportation and the prices were too expensive. The Activities Director (AD) had called local rafting companies that had large buses, and none were handicap accessible. The AD was to contact the local transportation agency.</p> <p>A review of a grievance filed on 6/24/2024 by the Activities Director (AD) revealed residents had requested the facility to find transportation to ride around and get lunch. The AD advised residents that she had contacted local rafting companies to see if their bus was handicap accessible and was told they were not. The AD advised the residents that she would contact the local transportation company. The grievance form indicated the facility was not able to resolve the concern at the time it was shared. The Administrator was assigned the grievance. The investigation steps stated, at this time staffing restraints are hindering resident outings. Documented actions taken to resolve/respond to the concerns stated, will continue to try to hire a driver and will also consider ordering special meals in for the residents upon request. There was no documented date, time, findings, or action plan for when the information was shared with the concerned party and the concerned party's response to the action plan/outcome was disappointed. The grievance was signed by the Administrator on 6/27/2024.</p> <p>(continued on next page)</p>

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.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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<p>F 0565</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>An interview was conducted on 8/19/2024 at 10:41 am with the AD. The AD stated the resident council met once a month and had requested to go on day trips. The AD stated day trips were not possible at the time because the facility did not have a van driver. The AD stated that she had called the local transportation company in the past and was told that there was a charge for transportation if the reason for transport was not for a medical need. The AD was unsure of when she had reached out to the local transportation agency and stated that when they had used them for a non-medical appointment in the past, it was very expensive.</p> <p>An interview was conducted on 8/20/2024 at 12:33 pm with the Social Services Director. The Social Services Director stated the Grievance Official was the Administrator and that a grievance could be filled out by anyone in the facility. The Social Services Director stated she received all grievances, made a copy of the grievance and wrote the information from the grievance on the grievance log. She stated she gave the grievance to the appropriate department manager and once the grievance was resolved, or if the facility was not able to come to a resolution, the grievance was discussed with the person who filed the grievance, and the Administrator signed the grievance as completed. The Social Services Director stated she was aware members of the Resident's Council had expressed wanting to go on group outings. The Social Services Director stated any interventions, or resolution should have been documented on the grievance form and stated she did not think any interventions or resolutions had been agreed upon.</p> <p>An interview was conducted on 8/20/2024 at 1:18 pm with the Administrator. The Administrator stated anyone at the facility could complete a grievance. The Administrator stated she was the Grievance Official and the Social Services Director was responsible for keeping a log of the grievances and distributed the grievances to the appropriate department manager. The Administrator stated after a grievance was completed, the staff discussed the status of grievances in their morning meetings until the grievance was resolved. The Administrator stated she was under the impression that the residents knew that outings were not feasible at this time due to the facility not having a van/bus driver. The Administrator stated she knew a few months ago the AD had reached out to the local transportation agency and at the time it was too expensive for non-medical trips and the agency did not have a lot of availability. The Administrator stated she had not contacted the local transportation agency or tried to arrange transportation for outings recently, however the facility had advertised for a van/bus driver. The Administrator stated that she should have made sure the residents knew that the grievance could not be resolved, and that the facility would continue to work on hiring a van/bus driver to take the residents on group outings.</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>Provide activities to meet all resident's needs.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 50045</p> <p>Based on record reviews, facility activity calendars, and resident and staff interviews, the facility failed to ensure group activities were planned for outside of the facility to meet the needs of residents who expressed that it was important to them to attend group activities outside of the facility for 4 of 5 residents reviewed for activities (Resident #7, #22, #28, #21).</p> <p>The findings included:</p> <p>A review of the Resident Council Minutes from July 2023 through July 2024 revealed the following:</p> <p>-July 2023 the residents had discussed trips that might be fun when activities were able to provide group trips. Residents #22 and Resident #7 were in attendance.</p> <p>-September 2023 the residents had discussed wanting to take short trips on the Parkway to see the leaves change. Residents #7, #22, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing.</p> <p>-October 2023 the residents had discussed wanting to take short trips on the Parkway to see the leaves change. Residents #7, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing.</p> <p>-March 2024 the resident had discussed they would like to go on short trips, to the store or Subway, on the van. Activities was going to looking to the dynamics of the van and transportation rules and would report back to Resident Council. Residents #7, #22, #28, #21 were all in attendance. There was no documented response to the residents requests for a group outing.</p> <p>-April 2024 the residents were informed that the Activities Assistant had left his position and that short trips on the van would not be possible until a driver was hired. Residents #7, #22, and #28 were all in attendance. There was no documented response to the residents request for a group outing.</p> <p>-May 2024 residents had discussed they were still wanting to go on day trips and would like for activities to look into renting a party bus so many residents could attend. Resident #7, #22, #28, #21 were all in attendance. There was no documented response to the residents request for a group outing.</p> <p>-June 2024 residents were advised that the facility had looked into party buses and their prices were just too expensive and had called local rafting companies that have large buses, but none were handicap accessible. The residents were informed the Activities Director (AD) had inquired about renting a party bus and the prices were too expensive. The AD had also contacted local rafting companies that had larger buses and none of the buses were handicap accessible. The AD was going to contact the local transportation agency. Residents #22 and Resident #7 were in attendance. There was no documented response to the residents request for a group outing.</p> <p>-July 2024 there was no documented response to the residents request for a group outing.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>A Resident Council meeting was conducted on 8/21/2024 at 9:59 am with Residents #7, #22, #28, and #21 in attendance. The residents expressed that they had been asking about going on a group outing repeatedly during their Resident Council meetings. The facility staff had responded to the residents that there was no transportation, van/bus driver, and not enough staff to go on group outings at this time. During the Resident Council meeting Resident #7 stated she would like to go to the dollar store and had not been in a store in several years. Resident #22 stated the residents had been told they did not have transportation for group outings. Resident #22 stated not being able to go on group outings felt like being in prison. Resident #21 stated she would love to get out of the facility and go to a store because she wanted to be able to pick out her own stuff, but it with her own money, and feel like an addition to society.</p> <p>An observation was conducted on 8/20/2024 at 12:00 pm revealed the facility was within driving distance of local restaurants (0.8 miles), local stores (6.4 miles), and a park (2.8 miles).</p> <p>a. Resident #7 was admitted to the facility on [DATE].</p> <p>A review of an annual Minimum Data Set (MDS) dated [DATE] revealed Resident #7 was cognitively intact, and it was very important to do things with groups of people and to go outside to get fresh air when the weather is good.</p> <p>An interview was conducted on 8/19/2024 at 9:22 am with Resident #7. Resident #7 stated she regularly attended Resident Council and activities at the facility. Resident #7 stated that since she had been admitted, she had never been on an outing and wanted to go. Resident #7 stated the residents had been told there was no transportation to be able to take them on outings. Resident #7 stated she would love to go to a store and stated that not being able to go on outings felt kind of like being in jail.</p> <p>b. Resident #22 was admitted to the facility on [DATE].</p> <p>A review of a change in condition Minimum Data Set (MDS) dated [DATE] revealed Resident #22 was cognitively intact, and it was very important to do things with groups of people and to go outside to get fresh air when the weather is good.</p> <p>An interview was conducted on 8/18/2024 at 3:49 pm with Resident #22. Resident #22 stated she had been at the facility for a couple of years and was the Resident Council President. Resident #22 stated the residents had not been on a group outing since she was admitted to the facility. Resident #22 stated the residents had expressed wanting to go on group outings just go get out. Resident #22 stated not being able to go on outings really bothered the residents.</p> <p>c. Resident #28 was admitted to the facility on [DATE].</p> <p>A review of an annual Minimum Data Set (MDS) dated [DATE] revealed Resident #28 was cognitively intact, and it was very important to do things with groups of people and to go outside to get fresh air when the weather is good.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 8/19/2024 at 9:28 am with Resident #28. Resident #28 stated he had been at the facility for six years, had regularly attended Resident Council and activities, and had never been on a group outing. Resident #28 stated it made him feel terrible to not be able to go on group outings. Resident #28 stated his family was not able to take him out of the facility and he would just like to go out to a restaurant to eat.</p> <p>d. Resident #21 was admitted to the facility on [DATE].</p> <p>A review of an annual Minimum Data Set (MDS) dated [DATE] revealed Resident #21 was cognitively intact, and it was very important to do things with groups of people and to go outside to get fresh air when the weather is good.</p> <p>An interview was conducted on 8/19/2024 at 9:31 am with Resident #21. Resident #21 stated she had been at the facility for four years and had never been on a group outing. Resident #21 stated the only time she had left the facility was to go to doctor appointments. Resident #21 stated the residents had been told the facility did not have a transportation van that was big enough or enough staff to be able to help.</p> <p>An interview was conducted on 8/19/2024 at 10:41 am with the Activities Director (AD). The AD stated she had worked at the facility for four and a half years and transferred to the Activities Director position about a year and a half ago. The AD stated the residents had mentioned wanting to take day trips that were unrealistic because the facility did not have a driver for the van. The AD stated the residents had not been on a group outing since before Coronavirus. The AD stated the facility did not have transportation large enough to support the amount of residents that would want to go, and there was not enough staff to take them. The AD stated most of the residents would require assistance with transfers and toileting, which would require one staff member to one resident for safety purposes. The AD stated she had called local rafting companies about transporting residents on their vans/buses but was told the vans/buses were not handicap accessible. The AD stated she had also reached out to a local transportation agency and stated they would charge if the transportation was not for a medical necessity. The AD stated if she was not able to go out on outings she would feel land locked. The AD stated she did not feel comfortable driving the van in the event something bad happened. The AD stated the van could hold approximately 2 residents in wheelchairs. The AD stated she would have felt bad if she took only 2 out at a time because that would make other residents feel like they were left out and would not be fair.</p> <p>An interview was conducted on 8/19/2024 at 11:18 am with the Administrator. The Administrator stated several of the residents had mentioned wanting to go on group outings but stated that transportation was a huge issue in their county along with the fact that everyone wanted to go. The Administrator stated the facility took the residents outside when the weather was good and provided a variety of entertainment groups. The Administrator stated they started the Resident Council Store which gave the residents an opportunity to feel like they were shopping at a real store. The Administrator stated the AD had made efforts to try to find transportation but that between the lack of a van driver and not having enough staff, it was not feasible to go on outings at this time. The Administrator stated the bus would hold a couple of wheelchairs and several ambulatory residents. The Administrator stated she did not feel comfortable driving the van or bus and being responsible for the residents while they were on an outing if something bad were to happen.</p> <p>(continued on next page)</p>		

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<p>F 0679</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Some</p>	<p>An interview was conducted on 8/20/2024 at 9:23 am with the Maintenance Director. The Maintenance Director stated the facility had a transportation van and a bus. He stated the van would hold approximately 2 residents and the bus could hold approximately 3 wheelchairs and several other residents that were ambulatory. The Maintenance Director stated that anyone with a driver's license could drive the van, or the bus and no special credentials were needed. The Maintenance Director stated he occasionally went to the hospital to pick up residents in the van, but primarily was only responsible for maintenance duties in the facility.</p>

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37280</p> <p>Based on observations, record reviews and staff interviews, the facility failed to complete bed rail assessments to determine the need for bed rails for 2 of 9 residents reviewed for accidents (Resident #3 and Resident #45).</p> <p>Findings Included:</p> <p>1. Resident #3 was admitted to the facility 10/06/22 with diagnoses that included history of repeated falls, status post fracture of the superior rim of the left pubis (a bone of the pelvis) and dementia.</p> <p>The annual Minimum Data Set (MDS) assessment dated [DATE] assessed Resident #3 with short and long term memory problems. The MDS also indicated she had functional range of motion impairment on one side of her lower extremity and required substantial to maximal assistance from staff to roll from left to right. The MDS revealed bed rails were not used as a restraint.</p> <p>A review of Resident #3's electronic medical record revealed there had not been a bed rail assessment completed since her admission on 10/06/22.</p> <p>An observation of Resident #3 on 08/18/24 at 4:00 PM revealed she was lying in her bed on her back sleeping with the bilateral quarter bed rails in the up position.</p> <p>During an interview with Nurse Aide (NA) #1 on 08/18/24 at 4:11 PM, the NA explained that Resident #3 had a fall from her bed a while back that fractured some of the bones in her pelvis. The NA stated the Resident was total care with the assistance of two staff but she would attempt to feed herself when sitting up.</p> <p>On 08/19/24 at 2:19 PM an observation was made of Resident #3 lying on her back in her bed with the bilateral quarter bed rails in the up position.</p> <p>During an interview with NA #2 on 08/19/24 at 4:10 PM the NA explained that Resident #3 had a fall from her bed several months ago that broke a bone around her pelvis and since then she seemed to decline. The NA stated Resident #3 required two staff assist to turn in the bed but would hold the bed rail if her hand was put in that position.</p> <p>An interview conducted with Nurse #1 on 08/20/24 at 2:09 PM revealed Resident #3 had declined since she fractured her pelvic bones from a fall. The Nurse explained that the Resident required two staff assist with most of her activities of daily living including rolling from side to side in the bed. She indicated Resident #3 could hold the side rail if you put her hand in that position but could not actively roll herself. Nurse #3 continued that bed rail assessments were completed quarterly but when she reviewed the Resident's electronic medical record for the last assessment, she stated there was no bed rail assessment in the medical record.</p> <p>(continued on next page)</p>		

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<p>F 0700</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>During an interview with the Director of Nursing (DON) on 08/20/21 at 3:40 PM the DON explained that the bed rail assessments were supposed to be done quarterly along with the MDS assessments. She stated they discovered a glitch in the system that prevented the bed rail assessments from automatically popping up to be completed.</p> <p>50045</p> <p>2. Resident #45 was admitted to the facility on [DATE] with diagnoses which included Alzheimer's disease and dementia.</p> <p>A review of Resident #45's Medical Record revealed an Evaluation for Use of Bed Rails form dated 6/8/2021 which revealed bed rails were not indicated at that time. The Medical Record did not contain a signed consent for the use of bed rails.</p> <p>A review of a quarterly Minimum Data Set (MDS) dated [DATE] revealed Resident #45 was severely cognitively impaired and had no behaviors. Bed rails were coded as not used for Resident #45.</p> <p>An observation was conducted on 8/20/2024 at 8:18 am of Resident #45. Resident #45 was observed lying in bed with bilateral upper quarter bed rails raised.</p> <p>An interview was conducted on 8/20/2024 at 8:48 am with Nurse #2. Nurse #2 stated an evaluation for the use of bedrails was performed on admission. Nurse #2 stated bedrails were utilized for mobility purposes or at the request of the resident or resident's family. Nurse #2 stated if a resident required bedrails, there was a quarterly bed rail assessment that had to be completed. Nurse #2 stated there was no evaluation for bed rails in the medical record that indicated Resident #45 needed bed rails, there was no quarterly bed rail assessment, and there was no mention of bed rails in the care plan. Nurse #2 was unsure why there were quarter bed rails used on Resident #45's bed and stated there should not have been.</p> <p>An interview was conducted on 8/20/2024 at 3:42 pm with the Director of Nursing (DON). The DON stated when a resident was admitted to the facility there was an initial assessment for the use of bed rails that was completed by the nurse. The DON stated some residents and/or resident families would request the use of bed rails and signed consent for use. The DON stated if bed rails were used for a resident there should have also been a quarterly assessment for bed rails completed. The DON was unsure why Resident #45 had quarter bed rails on his bed and stated he should not have had bed rails.</p>		