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	08/06/2025

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

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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. (continued on next page)

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

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	08/06/2025

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

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)
F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to secure an indwelling urinary catheter tubing to prevent tension or trauma for 1 of 2 residents reviewed for urinary catheter (Resident #62).The findings include:Resident #62 was admitted to the facility on [DATE] with diagnoses that included benign prostatic hyperplasia with urinary obstruction.Review of Resident #62's physician orders dated 02/20/25 revealed an order to secure the catheter tubing with an anchoring device to prevent pulling or trauma.Review of Resident #62's care plan dated 02/20/25 addressed the use of an indwelling urinary catheter related to benign prostatic hyperplasia with obstruction. The goal that he would have no complications due to the urinary catheter would be attained by utilizing interventions that include encouraging the use of a leg strap to reduce pulling and trauma.The quarterly Minimum Data Set assessment dated [DATE] revealed Resident #62's cognition was intact, and he had an indwelling urinary catheter.Review of Resident #62's physician orders dated 07/22/25 revealed an order for a urinary catheter to straight drain for obstructive uropathy.On 08/03/25 at 12:49 PM an observation and interview were conducted with Resident #62. The Resident explained that he has had his urinary catheter since he has been in the facility. The Resident was asked if he had an anchoring device on his catheter tubing and Resident #62 stated he did not and pulled back the sheet and revealed there was no anchoring device on his leg for the catheter tubing. The Resident remarked that sometime the catheter tubing was pulled during care, but he tolerated the pulling.On 08/04/25 at 10:20 AM an observation was made of Nurse Aide (NA) #1 and NA #2 providing catheter care to Resident #62 who did not have an anchoring device for his catheter tubing. Near the completion of the task NA #1 explained that the Resident should have an anchoring device on his thigh to prevent pulling and tugging of the catheter tubing and she informed Nurse #1 yesterday (08/02/25) that Resident #62 did not have an anchoring device for his catheter. NA #1 stated it was the nurses' responsibility to apply the anchoring devices on the residents for their catheters.At 11:10 AM on 08/04/25 an interview was conducted with Nurse #1 who confirmed that she worked with Resident #62 on 08/03/25. The Nurse explained that she removed the anchoring device from Resident #62's catheter tubing on 08/02/25 due to soilage and could not find another one to replace it. The Nurse stated she reported it to Nurse #2 that Resident #62 needed an anchoring device for his catheter tubing. Nurse #1 stated that she did not recall NA #1 informing her that Resident #62 did not have an anchoring device for his catheter tubing.On 08/04/25 at 2:30 PM an interview was conducted with Nurse #2. The Nurse confirmed that she took care of Resident #62 on 08/03/25 7:00 PM to 7:00 AM. Nurse #2 explained that residents who have indwelling urinary catheters should have anchoring devices to prevent from pulling and trauma. The Nurse stated she did not know that Resident #62 did not have an anchor device in place on her shift and Nurse #1 did not inform her that the Resident needed one. During an interview with Nurse #3 on 08/04/25 at 1:10 PM, the Nurse, who was assigned to Resident #62, explained that he had put an anchoring device on Resident #62 after NA reported to him that there was not an anchoring device on Resident #62. An interview was conducted with the Unit Manager on 08/05/25 at 1:44 PM. The Unit Manager explained that all residents with urinary catheters should have anchoring devices in place to prevent them from pulling and trauma unless there was a specific reason why they should not have them. The Unit Manager stated that if that were the case then it should be care planned.On 08/06/25 at 9:00 AM an interview was conducted with the Director of Nursing (DON) who explained that residents with urinary catheters should have an anchor device in place to prevent for pulling and trauma. She stated the hall where Resident #62 resided on was a hectic hall but that was no excuse. The DON indicated that the anchor devices should be made accessible for nurse aides to apply them. [NAME], [NAME] (62) pearson, [NAME] (37280) - RESIDENT NOTE No Notes

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	08/06/2025

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

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)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observations, record review, and resident and staff interviews, the facility failed to ensure medications were under direct observation by the administering nurse who left medications unattended at the bedside of 1 of 1 resident reviewed for medication storage (Resident #56).Findings included:Resident #56 was admitted to the facility 05/05/23 with diagnoses including diabetes with polyneuropathy (damage of multiple nerves), hypertension (high blood pressure), and depression. Partial review of Resident #56's Physician orders revealed the following:Metformin ER (diabetes medication) 1,000 (milligrams) mg twice a day for diabetes ordered 05/16/23Cholecalciferol (Vitamin D) 2,000 units once a day for supplement ordered 10/26/23Pregabalin (neuropathy medication) 75 mg twice a day for diabetic polyneuropathy ordered 07/23/24Sertraline (antidepressant) 100 mg once a day for depression ordered 09/10/24Empagliflozin (diabetes medication) 25 mg once a day for diabetes ordered 12/24/24Amlodipine (high blood pressure medication) 10 mg once a day for hypertension ordered 04/03/25The quarterly Minimum Data Set (MDS) assessment dated [DATE] indicated he was moderately cognitively impaired and received antidepressant and hypoglycemic (medications that lower blood sugar) medications during the 7-day look back period. An observation of Resident #56's overbed table on 08/03/25 at 12:11 PM revealed a medication cup containing 6 pills of various shapes and sizes. An interview with Resident #56 on 08/03/25 at 12:11 PM revealed he wasn't sure what the pills in the cup were or why they were there. An interview with Nurse #1 on 08/03/25 at 12:13 PM revealed she was caring for Resident #56. She stated the medications in the cup in Resident #56's overbed table were Pregabalin, Sertraline, Vitamin D, Amlodipine, Metformin, and Jardiance. Nurse #1 stated she took the pills to Resident #56 around 9:45 AM and got distracted by the resident's roommate and did not realize Resident #56 did not swallow the medications while she was in the room. She stated she usually stayed with a resident until they swallowed their medication or removed the medication from the room if the resident did not want to take the medication at that time. Nurse #1 stated she had just left Resident #56's room after watching him take all the medications in the cup. An interview with the Director of Nursing (DON) on 08/06/25 at 10:50 AM revealed she expected nurses to stay with residents until all medications were taken or remove them from the room if the resident did not want to take them at the time they were scheduled. She stated Nurse #1 got distracted on 08/03/25 and that was why medications were left unattended in Resident #56's room. An interview with the Administrator on 08/06/25 at 10:55 AM revealed she expected nurses to stay with residents until they completed taking their medication or remove it from the room if the resident did not want to take the medication at the scheduled time.

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	08/06/2025

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

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. (continued on next page)

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	08/06/2025

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

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)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Based on observation, record review, and staff interviews, the facility failed to implement their infection control policy when Nurse Aide (NA) #2 and the Treatment Nurse did not don (put on) a gown while providing wound care to Resident #47 who required enhanced barrier precautions (EBP) due to the presence of a pressure ulcer (sore). This deficient practice occurred for 2 of 7 staff members observed for infection control practices (Treatment Nurse and NA #2).Findings included:Review of the facility's Enhanced Barrier Precautions policy last revised 03/21/2024 read in part as follows: Policy:The facility should use Enhanced Barrier Precautions (EBP) as an additional MDRO [multi-drug resistant organisms] mitigation [prevention] strategy for residents that meet the following criteria, during high-contact resident care activities; wounds even if the resident is not known to be infected with a MDRO. Wounds generally include chronic wounds. Examples of chronic wounds include pressure ulcers. EBP should be used for any residents who meet the criteria.Definitions:Enhanced Barrier Precautions (EBP)-refer to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high contact resident care activities. Personal Protective Equipment (PPE)-refers to protective items or garments worn to protect the body or clothing from hazards that can cause injury and protect residents from cross-transmission.Procedure:The facility should develop a process to communicate which residents require the use of EBP for all high-contact resident care activities. The facility may choose to post signage on the door or wall outside of the resident room indicating the resident is on Enhanced Barrier Precautions. Examples of high-contact resident care activities requiring gown and glove use include: wound care and changing linens.Review of Resident #47's medical record revealed a nurse's note written by the Director of Nursing (DON) on 07/14/25. The note read in part as follows: Resident noted with unstageable pressure area to sacrum [the triangular bone at the base of the spine]. Measurements 1.5 [centimeters] x 1.7 [centimeters] x 1 [centimeter]. Resident denies pain in area. New orders for treatments in use at this time.An observation of Resident #47's door on 08/04/25 at 8:54 AM revealed no signage indicating he was on EBP, and no shelf or container was present outside the room containing gowns or gloves. A continuous observation of the Treatment Nurse and NA #2 on 08/04/25 from 8:56 AM though 9:02 AM revealed they entered Resident #47's, performed hand hygiene with alcohol-based hand rub (abhr), donned (put on) gloves, and assisted Resident #47 with turning on his left side. NA #2 assisted Resident #47 with staying on his left side and the Treatment Nurse pulled back the brief, removed the dressing from Resident #47's sacrum and placed it in the trash, removed her gloves and placed them in the trash, performed hand hygiene, donned clean gloves, cleaned the wound with wound cleanser, removed her gloves and placed them in the trash, performed hand hygiene, donned clean gloves, measured the wound with a paper tape measure, removed her gloves and placed them in the trash, performed hand hygiene, donned clean gloves, applied medical grade honey gel with a cotton-tipped applicator to the wound bed, covered the wound with a bordered gauze, removed her gloves and placed them in the trash, and performed hand hygiene. The Treatment Nurse and NA #2 did not don gowns while performing wound care for Resident #47.In an interview with the Treatment Nurse on 08/05/25 at 12:12 PM she confirmed on 08/04/25 there was no sign indicating Resident #47 was on EBP and she did not wear a gown while providing wound care. She stated she thought that since the wound did not have a large amount of drainage that Resident #47 did not need EBP. In an interview with NA #2 on 08/05/25 at 2:42 PM she confirmed she did not wear a gown when assisting the Treatment Nurse with positioning Resident #47 for wound care on 08/04/25. She stated since there was no sign indicating Resident #47 was on EBP, she assumed he was not on EBP. An interview with the Infection Preventionist (IP) on 08/06/25 at 10:31 AM revealed Resident #47 should have been placed on EBP when his pressure ulcer was identified. She stated that a miscommunication between herself and the Treatment Nurse was the reason Resident #47 was not on EBP. The IP stated she should have followed up to ensure Resident #47 was placed on EBP and she did not. She stated that placing Resident #47 on EBP fell through the cracks. An interview with the DON on 08/06/25 at 10:42 AM revealed when it was determined that Resident #47 had a pressure ulcer, it was unclear if the wound was open or not. She stated once she determined the pressure ulcer was open, EBP was put in place. The DON stated Resident #47 should have been placed on EBP when the pressure ulcer was identified. An interview with the Administrator on 08/06/25 revealed she thought the reason Resident #47 was not placed on EBP for his pressure ulcer was due to a miscommunication between the IP and Treatment Nurse.