PRINTED: 05/30/2017 FORM APPROVED OMB NO. 0938-0391

		IDENTIFICATION NUMBER:	A. BUILDII	NG _		COMP	SURVEY PLETED
		345193	B. WING_			05/	04/2017
NAME OF PROVIDER  MOUNTAIN VIEW		NG CE	·	41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 BUCKNER BRANCH ROAD RYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
(i)(2) Innecess comformation This Figure 1. Obstantial The file of the sire which unlabed sink control to the ite stated labele. An interest at 10:5 items contain 2. Obstantial to 1. Obstantial 2. Obstantial to 1. Obstantial to	Housekeeping a sary to maintaintable interior; EQUIREMENT of on observation failed to label ems and person that bathrooms of the observations and tootheled.  Between with the observations of the observation	ACEPING & MAINTENANCE  and maintenance services in a sanitary, orderly, and  T is not met as evidenced  ans and staff interview the and properly store personal anal hygiene products in 3 an 2 of 4 halls of the facility.  It:  Be bathroom shared by 2 ande on 05/01/17 at at 11:00 AM, 05/04/17 at at 11:00 AM, 05/04/17 at at 11:00 AM, os/04/17 at at 10:50 AM revealed an aug sitting on the right side of attribution of the side of the attribution of Nursing (DON)  AM in Room 142 revealed as noted above. The DON and in Room 142 revealed as noted above. The DON be personal hygiene items to be alabeled container.  The Aide (NA) #3 on 05/04/17 at residents' personal care and and/or stored in a labeled  Be bathroom shared by 2 and and on 05/02/17 at 7:59	F2	253	On May 4, 2017, the ceramic mug, emesis basin, and denture cup in room 142 were labeled by a CNA with the resident sname. The toothbrush was discarded and replaced with a new toothbrush in a toothbrush holder that was labeled by a CNA  On May 4, 2017 the wash basins and be pan in room 123 were discarded by a CNA. New wash basins were labeled be CNA with the residents names and placed in the residents room. The new basins were stored separately, not stacked. The bedpan was not replaced because the affected resident no longe used it.  On May 4, 2017 the bedpan in room 13 was discarded by a CNA. It was replaced with a new bedpan, labeled by a CNA withe resident sname and stored in a plastic bag on the back of the commode. An audit of resident rooms, including bathrooms, was done by the ADON on May 5, 2017 for improper storage of was basins and bedpans. Any wash basins found nesting or without names were discarded and replaced with properly labeled and stored wash basins by a CNA. Any bedpans found without names	ed y a w r s1 ed with e.	6/1/17
		SUPPLIER REPRESENTATIVE'S SIGNATURI	<u> </u>		TITLE		(X6) DATE

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

05/26/2017

**Electronically Signed** 

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.

Facility ID: 923363

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	IPLE CONSTRUCTION		E SURVEY IPLETED
		345193	B. WING _		0,	5/04/2017
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZI	•	
		ania a=		410 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NUR	SING CE		BRYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIE	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN ( (EACH CORRECTIVE A CROSS-REFERENCED T DEFICIE	ACTION SHOULD BE TO THE APPROPRIATE	(X5) COMPLETION DATE
F 253	Continued From p	age 1	F 2	253		
F 253	AM, 05/02/17 at 4: AM, on 05/03/17 at 8:41 AM and on 08 unlabeled wash ba floor and nesting in An interview on 05 Aide (NA) #1 revea should be labeled stored separately or resident's closet. bedpans should no floor.  An interview with to on 05/04/17 at 10: the items remained stated she expecte and stored in each 3. Observations of residents in Room AM, 05/02/17 at 4: 05/03/17 at 10:08 revealed 2 unlabel bathroom floor and Also, stored on the unlabeled, unbagg An interview on 05 Aide (NA) #1 revea should be labeled stored on the shelf stated bedpans sh the back of the cor NA #1 stated wash	and 3 PM, on 05/03/17 at 8:07 at 10:07 AM, on 05/04/17 at 5/04/17 at 10:45 AM revealed 2 asins stored on the bathroom anside each other.  3/03/17 at 10:17 AM with Nurse aled residents' wash basins with resident's name and on the shelf in the appropriate NA #1 stated wash basins and ever be stored on the bathroom  The Director of Nursing (DON)  45 AM in Room 123 revealed as noted above. The DON ed wash basins to be labeled aresident's closet.  The bathroom shared by 2  131 made on 05/02/17 at 8:02  105 PM, 05/03/17 at 8:08 AM, AM and 05/04/17 at 8:41 AM led wash basins stored on the day and on the da	F2	or improperly stored wer replaced by properly labe bedpans by a CNA.  An audit of resident room bathrooms, was done by May 5, 2017 to make suitems were labeled with name. Any personal item labels were labeled by the On May 30, 2017 all CNA inserviced by the DON of storage and labeling of with bedpans and the correct personal items. Make-up provided by June 1, 2011 leave will be required to inservice prior to return the CNAs will be oriented or storage and labeling of with bedpans, and personal items was placed in the flow sheet books by the on May 26, 2017.  The DON, ADON, or the will do random audits for labeled or stored wash be and personal items week longer until substantial coachieved and maintained by the QA Committee. A	eled and stored  ns, including the ADON on re all personal the resident □s ns found without ne CNA.  As will be on the proper vash basins and tabeling of o inservices will be or. Any CNA on make-up the or duty. All new or the correct vash basins, tems.  store wash her personal care front of all CNA DON and ADON  RN Supervisor or improperly tasins, bedpans, kly for 4 weeks or ompliance is d as determined or the ADON discrepancies	
		n the bathroom floor.  he Director of Nursing (DON)		identified during audit wi corrective action by nurs directed by the auditor. A	ing staff as	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		05/04/2017
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIC (EACH CORRECTIVE ACTION SHOULI CROSS-REFERENCED TO THE APPROP DEFICIENCY)	O BE COMPLETION
F 278 SS=D	on 05/04/17 at 10:47 the wash basins had floor; however, the b above on the bathrod she expected bedpain a plastic bag on the An interview on 05/0 revealed bedpans sha plastic bag on the 483.20(g)-(j) ASSES ACCURACY/COORI  (g) Accuracy of Assemust accurately reflection (h) Coordination A registered nurse meach assessment wiparticipation of health (i) Certification (1) A registered nurse the assessment is considered in the	AM in Room 131 revealed been removed from the edpan remained as noted om floor. The DON stated ins to be labeled and stored be back of the commode.  4/17 at 10:48 AM with NA #2 hould be labeled and stored in back of the commode.  SMENT DINATION/CERTIFIED  Essments. The assessment ext the resident's status.  Inust conduct or coordinate the threappropriate in professionals.  The must sign and certify that completed.  In who completes a portion of the grand certify the accuracy of sessment.  The accuracy of the accuracy of sessment.  The accuracy of the accuracy of the accuracy of the grand Medicaid, an individual exingly-  all and false statement in a tries subject to a civil money.	F 27	practices will be documented and corrected immediately.  The Administrator will monitor for compliance. Any deficient practice w documented and reported to the QA Committee and corrective action will taken.	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	· /	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		05/04/2017
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSI	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES  Y MUST BE PRECEDED BY FULL  LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE COMPLETION
F 278	and false statement is subject to a civil mon \$5,000 for each assect (2) Clinical disagreer material and false states This REQUIREMENT by: Based on record revision facility failed to accurresidents utilizing the to reflect dialysis (Resampled residents for (Resident #31).  Findings included:  1. a. Resident #51 woon 06/27/16 with diag disease (ESRD).  A review of the physical dated 09/28/16 to 10. #51 was to receive disease wednesday, and Frical The annual Minimum assessment dated 10. #51 had not been controlled.	ndividual to certify a material in a resident assessment is ey penalty or not more than issment.  Inent does not constitute a atement.  It is not met as evidenced iew and staff interviews the rately code 1 of 1 sampled is Minimum Data Set (MDS) is ident #51) and 1 of 1 in death to reflect prognosis.  It is readmitted to the facility gnosis of end stage renal is signed monthly orders /31/16 indicated Resident is inlysis every Monday, day.	F 278	,	as  of e flect nitted May  of DS
	On 05/03/17 at 9:23 aconducted with the M she had completed S Treatments, Procedu	care. AM an interview was IDS Coordinator who stated		resident ☐s dialysis order. The modification MDS was successfully submitted by the MDS Coordinator to CMS on May 3,  On May 2, 2017, the MDS on resident #31, section J1400, Prognosis, was modified by the MDS Coordinator to	the 2017.

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:					
		345193	B. WING			0.5/	04/2047
NAME OF PI	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 05/	04/2017
				4	10 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURS	ING CE		В	RYSON CITY, NC 28713		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	,		PREFI				COMPLETION DATE
F 278	Continued From pag	ge 4	F	278			
					reflect a life expectancy of less than 6		
					months. The modified MDS was		
					successfully submitted by the MDS		
	annual MDS assess	ment. The MDS Coordinator			Coordinator to CMS on May 2, 2017.		
	stated she would im	DIDER OR SUPPLIER    SUMMARY STATELEINT OF DEFICIENCIES   SUMMARY STATELEINT OF DEFICIENCIES   SUMMARY STATELEINT OF DEFICIENCIES   BRYSON CITY, NC. 23713					
					TOMPLETED  05/04/20  STREET ADDRESS, CITY, STATE, ZIP CODE  110 BUCKNER BRANCH ROAD  BRYSON CITY, NC 28713  PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  Teflect a life expectancy of less than 6 months. The modified MDS was successfully submitted by the MDS Coordinator to CMS on May 2, 2017.  An audit of section J1400 on the MDS was done by the MDS Coordinator on all hospice residents in the past 6 months for correct MDS coding. For any deficient practice found, the MDS was modified and submitted by the MDS Coordinator to CMS on May 3, 2017.  An audit of section O on the MDS was done by the MDS Coordinator for special treatments. For any deficient practice found, the MDS was modified and sent by the MDS Coordinator to CMS on May 2, 2017.  Prior to coding, the MDS Coordinator will check physician orders and review resident status for hospice and dialysis services.  MDS Coordinator/ADON will do random audits of the MDS for deficient practices weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action. For any deficient practice found, the MDS will be modified and sent to CMS by the MDS Coordinator.  The Administrator will monitor the audits for compliance. Any deficient practice will		
	IDENTIFICATION NUMBER:  345193  B. WING  WINDER OR SUPPLIER  WINDER OR SUPPLIER  WINDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEPECIENCY MUST BE PRECEDED BY PULL REGULATORY OR I.SC IDENTIFYING INFORMATION)  Continued From page 4  eceiving dialysis. The MDS Coordinator stated Resident #51 had been receiving dialysis for a on or Special Treatments, Procedures, and Programs as receiving dialysis read under Section O for Special Treatments, Procedures, and Programs and stated Resident #51 had been receiving dialysis read or a long time and was missed for coding on the part of the physician's signed monthly orders lated 221/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday, Wednesday, and Friday.  A review of the physician's signed monthly orders lated 221/1/6 to 01/31/17 indicated Resident #51 was for exceive dialysis every Monday.  A review of the physician's signed monthly orders lated 221/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday.  A review of the physician's signed monthly orders lated 223/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday.  A review of the physician's signed monthly orders lated 223/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday.  A review of the physician's signed monthly orders lated 223/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday.  A review of the physician's signed monthly orders lated 223/1/6 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday.  A review of the physician's signed monthly orders lated 23/1/6 to 01/31/17 indicated Resident #51 was readmitted to the facility on the MDS was done by the MDS Coordinator for special treatments. For any deficient practice found, the MDS was modified and sent by the MDS Coordinator for special treatments. For any deficient practice found, the MDS was modified and sent by the MDS Coordinator will check physician orders and review resident status for hospice and dialysis						
R lc a st tc 11 b O d d d d # W	<u> </u>					for	
		<u> </u>					
	_	osis of end stage renal				. 4 -	
					_	r to	
					An audit of agation O on the MDC was		
						ial	
		· · · · · · · · · · · · · · · · · · ·			_ ·	ıaı	
	vveunesday, and i n	luay.				. hv	
	The quarterly MDS a	assessment dated 01/13/17				-	
					_	-,	
					Prior to coding, the MDS Coordinator v	vill	
	care.				_		
					resident status for hospice and dialysis	i	
					services.		
The quarte indicated Funder Sec Procedure care.  On 05/03/2 conducted (ADON) which is indicated in the conduction of the							
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					-	hd	
	_						
					_		
		•					
	assessment dated 0				-		
	care.				The Administrator will monitor the audi	ts	
	c. Resident #51 was	readmitted to the facility on			for compliance. Any deficient practice	vill	
	06/27/16 with diagno	osis of end stage renal			be documented and reported to the QA	١	

Facility ID: 923363

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
		345193	B. WING _			05/	04/2017
	ROVIDER OR SUPPLIER	IG CE	•	41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 BUCKNER BRANCH ROAD RYSON CITY, NC 28713		
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F 278	dated 03/29/17 to 04/ #51 was to receive di Wednesday, and Frice The quarterly MDS as indicated Resident #5 under Section O for S Procedures, and Procedures, and Procedures, and Procedures, and Procedures, and Procedures, and Procedures and Proce	cian's signed monthly orders 30/17 indicated Resident alysis every Monday, lay.  Sesessment dated 04/14/17 of had not been coded opecial Treatments, grams as receiving dialysis  AM an interview was DS Coordinator who stated ection O for Special res, and Programs and should have been coded as a MDS Coordinator stated en receiving dialysis for a seed for coding on the sment. The MDS are would immediately submit ent #51's quarterly MDS 1/14/17 to reflect dialysis  AM an interview was irrector of Nursing (DON) etation was that the annual ted 10/19/16, quarterly MDS 1/13/17, and the quarterly end 04/14/17 would have lay to reflect Resident #51 is. The DON stated Resident ysis since admission to the	F 2	78	Committee and corrective action will be taken.		
	stated her expectatio	ed for coding. The DON n was that a correction for Resident #51's annual					

STATEMENT OF AND PLAN OF C		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		05/04/2017
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING O		NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	,
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLETION
Maaaan Cooleaaaaa AAF aa tu 200 fi AA iii th AA Oo oo oo aa Ei ii soo oo oo aa Ei ii soo oo oo aa Ei ii soo oo	assessment dated 0 assessment dated 0 assessment dated 0 assessment dated 1 conducted with the A expectation was that assessment dated 1 assessment dated 0 assessment dated 0 assessment dated 0 accurately coded to Administrator stated Resident #51's annual assessments would to reflect dialysis care. A review of a physicial and 6 months related than 6 months related and 6 months related feet of less than 6 month congestive heart failly a review of Resident 4 review 6 review of Resident 4 review of Resident 4 review of Resident 4	ated 10/19/16, quarterly MDS 1/13/17, and quarterly MDS 4/14/17 and submitted to  PM an interview was administrator who stated his a Resident #51's annual MDS 0/19/16, quarterly MDS 1/13/17, and quarterly MDS 1/13/17, and quarterly MDS 4/14/17 would have been reflect dialysis. The his expectation was that all and quarterly MDS be corrected and submitted received and submitted received and submitted received and submitted received and a prognosis of less and to diagnosis of congestive related to diagno	F 278	3	

	IDENTIFICATION NUMBER:	IT OF DEFICIENCIES OF CORRECTION
345193 B. WING 05/04/20 <sup>-</sup>	345193	
STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	<b>=</b>	F PROVIDER OR SUPPLIER FAIN VIEW MANOR NURSIN
BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMP	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL SENTIFYING INFORMATION)	( (EACH DEFICIENC
rognosis and stated een coded as having n 6 months. The MDS ed reading the ee progress note d Resident #31 had a nths related to nt failure. The MDS d immediately submit 's admission MDS to reflect a life onths.  Interview was of Nursing (DON) was that Resident isment dated iccurately coded to fe expectancy of less ated her expectation for would have ler and hospice note ng Resident #31's t. The DON stated admission MDS would be corrected ident #31 had a life onths.  Interview was rator who stated his	pice progress note  Ited Resident #31 had a nonths related to eart failure. The MDS ould immediately submit 31's admission MDS 17 to reflect a life months.  In interview was or of Nursing (DON) In was that Resident ressment dated In accurately coded to a life expectancy of less stated her expectation nator would have order and hospice note ding Resident #31's ent. The DON stated he admission MDS 17 would be corrected esident #31 had a life months.  an interview was istrator who stated his	Resident #31 should a life expectancy of le Coordinator stated shiphysician's order and dated 01/05/17 that in prognosis of less than diagnosis of congestic Coordinator stated share correction to Reside assessment dated 01 expectancy of less the Conducted with the Down of the Who stated her expectancy of less than 6 months. The Expectance was that the MDS Coreviewed the physicial dated 01/05/17 prior admission MDS assessment dated 01 and submitted to reflect expectancy of less the Con 05/02/17 at 3:52
ssment dated accurately coded to fe expectancy of less ated her expectation for would have ler and hospice note fing Resident #31's fit. The DON stated fix admission MDS fix would be corrected fident #31 had a life fonths.  interview was frator who stated his mission MDS	dessment dated in accurately coded to italife expectancy of less stated her expectation inator would have order and hospice note ding Resident #31's ent. The DON stated he admission MDS 17 would be corrected esident #31 had a life months.  an interview was istrator who stated his admission MDS	#31's admission MDS 01/10/17 would have reflect Resident #31 than 6 months. The D was that the MDS Coreviewed the physicial dated 01/05/17 prior admission MDS assenter expectation was assessment dated 01 and submitted to reflee expectancy of less the On 05/02/17 at 3:52 conducted with the A expectation was that assessment dated 01

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		05/04/2017
	ROVIDER OR SUPPLIER  N VIEW MANOR NUR	SING CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPF DEFICIENCY)	OULD BE COMPLETION
F 278 F 282 SS=D	(b)(3) Comprehens The services provide as outlined by the of must-  (ii) Be provided by accordance with eacare. This REQUIREME by: Based on observatinterviews the facility for 2 of 14 resident dependent on staff The findings include 1. Resident #94 wt 11/21/16 with diagramon-Alzheimer's de Minimum Data Set indicated Resident assistance with tra and toileting. The #94 was occasiona MDS further indica plan including apprincentinence that in least every 2 hours  During a continuou on 05/04/17 from 9	RVICES BY QUALIFIED ARE PLAN sive Care Plans ded or arranged by the facility, comprehensive care plan, qualified persons in ach resident's written plan of NT is not met as evidenced tions, record review, and staff ty failed to follow the care plan is (Resident #94 and #2) for incontinence care.	F 276		48 pm ed for eds  s 06 pm necked utlined in  A #2 ut lents. enducted r eed of s as ssues

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′		CONSTRUCTION		ATE SURVEY OMPLETED
		345193	B. WING _			(	05/04/2017
NAME OF P	ROVIDER OR SUPPLIER		<u> </u>	ST	TREET ADDRESS, CITY, STATE, ZIP CODE	•	
MOUNTAI	N VIEW MANOR NURSIN	NG CE			IO BUCKNER BRANCH ROAD RYSON CITY, NC 28713		
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F 282	observed in the dinin if he wanted to go do #94 responded "no" a NA #1 left the room. checked for urinary ir offered assistance wi  On 05/04/17 at 9:46 walking up to Reside helped him to his roo be seated in a chair. checked for urinary ir offered assistance wi  On 05/04/17 at 10:07 observed using his carepeatedly.  On 05/04/17 at 10:09 walking into the room if he needed somethi unable to tell NA #2 word the rolling wal side and pulled up the the beverage that was to Resident #94. Resident #94. Resident #94. Resident walking into the room assistance with incom	AM, Nurse Aide (NA) #1 was g room asking Resident #94 wn to his room. Resident and NA #1 said "all right" and Resident #94 was not incontinence and he was not the incontinence care.  AM, NA #2 was observed and #94 in the hallway and m where he was assisted to Resident #94 was not incontinence and he was not incontinence and he was not the incontinence care.  AM, Resident #94 was all light and calling out "hello"  AM, NA #2 was observed and fresident #94 was what he needed. NA #2 liker of Resident #94 to the ebedside table and offered is sitting on the bedside table sident #94 was not checked ce and he was not offered	F 2	282	On May 30, 2017, the DON will inservall CNAs on incontinence care and curesidents for toileting as outlined in the care plan. Make-up inservices will be provided by June 1, 2017. Any CNA of leave will be required to make-up the inservice prior to return to duty.  All newly hired CNAs will be oriented of incontinence care and following the care plan by RN Supervisor. Incontinence and following the care plan has been added to the skills check list for new had been added to the skills be oriented to the sk	eing eir  n  on are care ires.  r ct e cies ctive  scal	
	Resident #94 and ma television (TV) and a	ade reference to the show that was on.			The DON will monitor for compliance a report results to the QA Committee. The QA Committee will review audit finding	ne js	
	observed walking into	AM, the housekeeper was the room of Resident #94. ok the trash out of the room.			and monitor for any trends or patterns The QA Committee will direct and inst corrective action with supervision from	itute	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	PLE CONSTRUCTION	' '	TE SURVEY MPLETED
		345193	B. WING		,	05/04/2017
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CO 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	•	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE
F 282	On 05/04/17 at 10:30 observed walking into The housekeeper swalking into The housekeeper swalking an interview of #2 stated Resident #every 2 hours but this because she had to whirlpool bath off the 35 minutes. NA #2 so Resident #94 with in knew it should have  During an interview of #1 stated she had astransfers, dressing ast 7:15 AM. NA #1 so Resident #94 about Resident #94 denied bathroom. NA #1 alstried to check all the she had gotten busy Resident #94 since as On 05/04/17 at 12:00 assisted Resident #8 Resident #94 was no was visibly wet with was also noted to haskin across his lower evidence of skin bread to check on the for incontinence care expectations were for	6 AM, the housekeeper was to the room of Resident #94. Wept and mopped the room.  20 05/04/17 at 11:53 AM, NA #94 was usually checked is had been a crazy day take another resident for a equit and was gone for about stated she had not assisted continence care but she been done.  20 05/04/17 at 12:01 PM, NA esisted Resident #94 with and urinary incontinence care stated she also asked toileting after breakfast and if having to go to the so stated the nurse aides residents every 2 hours but and forgot to check on after breakfast.  20 PM, NA #1 and NA #2 PA with incontinence care coted to have on a brief that yellow urine. Resident #94 we slightly pinkish colored in buttocks but had no	F 28	DON as necessary when trepatterns are identified.	ends and/or	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTII A. BUILDIN	PLE CONSTRUCTION  G	(X3) DATE SUR COMPLETI		
		345193	B. WING		05/04/2	2017	
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSI	NG CE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713				
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE CO	(X5) DMPLETION DATE	
F 282	Continued From page plans.	e 11	F 28	32			
	CVA (stroke), and he Review of the care plon incontinence of blood toilet per schedule. The for direct care staff to every 2 hours while at A review of the quarte (MDS) dated 04/11/1 moderately impaired making and required MDS also indicated Fextensive assistance frequently incontinent indicated Resident #2 behaviors that had on the Care Area Assest 04/11/17 for urinary in Resident #2 to have episodes, remained of staff were to cue him assist as needed.	ses which included aphasia, miplegia or hemiparesis.  an dated 01/11/17 focused adder and required cueing to he intervention in place was a cue Resident #2 to void awake.  erly Minimum Data Set 7 indicated Resident #2 had cognition with poor decision supervision and cues. The Resident #2 needed with toileting and was at of bladder. The MDS 2 had rejection of care occurred 1-3 days.  sement of the MDS dated incontinence described bladder incontinent on a toileting program and to to toilet every 2 hours and					
	05/04/17 at 9:48 AM revealed Resident #2	ation of Resident #2 made on thru 05/04/17 at 12:26 PM 2 was alert and awake and or toileting needs. There were s noted during the					

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
345193		B. WING		05/04/2017	
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSIN	IG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	
F 282 F 312 SS=D	the Nurse Aide (NA): had not been cued for of more than 2 hours.  During an interview or Nurse #2 it was reveal ensure Resident #2 vi  During an interview or the Administrator it with was for direct care standard and follow Res 483.24(a)(2) ADL CA DEPENDENT RESID  (a)(2) A resident who activities of daily living services to maintain or personal and oral hyo This REQUIREMENT by: Based on observatio interviews the facility	on.  n 05/04/17 at 12:48 PM with 44 she revealed Resident #2 r toileting needs for a period  n 05/04/17 at 1:04 PM with aled she had not checked to as cued for toileting needs.  n 05/04/17 at 2:56 PM with as revealed his expectation aff to provide care every 2 dent #2's plan of care. RE PROVIDED FOR ENTS  is unable to carry out g receives the necessary good nutrition, grooming, and giene. is not met as evidenced  ns, record review, and staff failed to check for 4 sampled residents who is staff for toileting and	F 28	2	
	1. Resident #2 was a 01/22/08 with the diag (stroke), and hemiple  Review of the care pl 01/11/17 focused on and cue to toilet per signal.	idmitted to the facility gnoses of aphasia, CVA		On May 4, 2017, resident #94 was provided incontinence care at 12:06 provided incontinence care at 12:06 provided incontinence care every 2 hours by a CNA.  On May 4, 2017, CNA #1 and CNA #2 were counseled by the DON on provided incontinence care to dependent resided.	ing

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	IDENTIFICATION NI IMBED:		E CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345193	B. WING_			0	5/04/2017	
NAME OF P	ROVIDER OR SUPPLIER		'	S	TREET ADDRESS, CITY, STATE, ZIP CODE	<u> </u>		
				4	10 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURS	SING CE		В	BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	3E	(X5) COMPLETION DATE	
F 312	Continued From pa	ge 13	F 3	312				
	#2 to void every 2 h	ours while awake and assist						
	with toileting as nee				The ADON and RN Supervisor conduc	cted		
					rounds on May 5, 2017 of all other			
	A review of the qua	rterly Minimum Data Set			dependent residents to identify resider	nts		
		/17 indicated Resident #2 had			in need of incontinence care or toiletin			
	moderately impaired	d cognition with poor decision			cues as outlined in their care plans.			
	making and require	d supervision and cues. The						
	MDS also indicated	Resident #2 needed			On May 30, 2017, the DON will inservi	ice		
		e with toileting and was			all CNAs on incontinence care for			
		ent of bladder. The MDS			dependent residents. Make-up inservio	ces		
	showed Resident #2 had rejection of care				will be provided by June 1, 2017. Any			
	behaviors that had	occurred 1-3 days.			CNA on leave will be required to make	-up		
	The Core Area Ace	accurate of the MDC dated			the inservice prior to return to duty.			
		essment of the MDS dated incontinence described			All newly hired CNAs will be oriented of	an.		
		inue to have bladder			incontinence care for residents by the			
		s and remained on a toileting			Supervisor. Incontinence care has been			
		vere cue him to toilet every 2			added to the skills check list for new h			
	hours and assist as							
					Licensed nurses will be responsible fo	r		
	Observation of Res	ident #2 made on 05/04/17 at			monitor that residents under their direct			
	9:48 AM revealed h	im lying in bed alert and			supervision are receiving incontinence	;		
	watching television.	The final observation made			care and toilet cueing as outlined in the	е		
	on 05/04/17 at 12:2	6 PM revealed Resident #2			residents□ care plans. Any discrepand	cies		
		in bed with a strong odor of			identified during audit will receive			
		ring surrounding a large wet			corrective action by nursing staff as			
		eets. There were no negative			directed by the auditor.			
		ring the observations.						
		oserved wearing pants with an			A random audit of residents will be			
		rounding the perineal and			conducted by the DON, ADON, or Nur	sing		
	buttocks area.				Supervisor for incontinence care and cueing to toilet weekly for 4 weeks or			
	During an interview	on 05/04/17 at 12:48 PM with			longer until substantial compliance is			
	_	IA) #4 she confirmed the bed			achieved and maintained as determine	ed.		
		d stained with a yellow ring.			by the QA Committee. Any discrepance			
		Resident #2's pants were wet			identified during audit will receive			
		ocks area. She was unable to			corrective action.			
	I -	d not cued or checked for						
		ore than 2 hours. She			The DON will monitor for compliance a	and		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		LE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345193	B. WING	<del> </del>	0	5/04/2017	
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSI	NG CE		STREET ADDRESS, CITY, STATE, ZIP COI 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 312	and was to be check hour shift.  During an interview of Nurse #2 she confirm Resident #2 was being or incontinence care.  During an interview of Director of Nursing it expectation was for of Resident #2 every 2 incontinence care as During an interview of the Administrator it was for direct care still	#2 was on a toileting program ed 3 to 4 times each eight on 05/04/17 at 1:04 PM with ned she had not checked if ng provided cues for toileting on 05/04/17 at 2:39 PM with was revealed her direct care staff to check hours and provide	F 31	report results to the QA Com QA Committee will review au and monitor for any trends of The QA Committee will direct corrective action with superv DON as necessary when trent patterns are identified.	idit findings r patterns. it and institute rision from the		
	11/21/16 with diagno non-Alzheimer's dem Minimum Data Set (I indicated Resident # memory problems ar assistance with trans and toileting. The M #94 was occasionally MDS further indicate plan including approa	nentia. The quarterly MDS) dated 02/17/17 94 had short and long term					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		I		(X3) DATE SURVEY COMPLETED
	345193	B. WING		05/04/2017
ROVIDER OR SUPPLIER	ING CE		410 BUCKNER BRANCH ROAD	
(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPI DEFICIENCY)	OULD BE COMPLETION
During a continuous on 05/04/17 from 9:4 #94 was not checked. On 05/04/17 at 9:41 observed in the dinir if he wanted to go do #94 responded "no" NA #1 left the room.  On 05/04/17 at 9:46 walking up to Reside helped him to his roo be seated in a chair checked for urinary in checked for urinary in checked for urinary in the needed someth unable to tell NA #2 moved the rolling was side and pulled up the the beverage that was to Resident #94. Refor urinary incontined.	observation of Resident #94 41 AM to 12:06 PM, Resident d for incontinence.  AM, Nurse Aide (NA) #1 was ng room asking Resident #94 own to his room. Resident and NA #1 said "all right" and  AM, NA #2 was observed ent #94 in the hallway and om where he was assisted to Resident #94 was not incontinence.  7 AM, Resident #94 was call light and calling out "hello"  9 AM, NA #2 was observed m of Resident #94 and asked hing. Resident #94 was what he needed. NA #2 alker of Resident #94 to the ne bedside table and offered as sitting on the bedside table esident #94 was not checked ince.  on 05/04/17 at 11:53 AM, NA #94 was usually checked	F 312		
	CORRECTION  ROVIDER OR SUPPLIER  N VIEW MANOR NURSI  SUMMARY S (EACH DEFICIEN REGULATORY OF PARTICIPATION OF	ROVIDER OR SUPPLIER  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15 least every 2 hours for urinary incontinence care."  During a continuous observation of Resident #94 on 05/04/17 from 9:41 AM to 12:06 PM, Resident #94 was not checked for incontinence.  On 05/04/17 at 9:41 AM, Nurse Aide (NA) #1 was observed in the dining room asking Resident #94 if he wanted to go down to his room. Resident #94 responded "no" and NA #1 said "all right" and NA #1 left the room.  On 05/04/17 at 9:46 AM, NA #2 was observed walking up to Resident #94 in the hallway and helped him to his room where he was assisted to be seated in a chair. Resident #94 was not checked for urinary incontinence.  On 05/04/17 at 10:07 AM, Resident #94 was observed using his call light and calling out "hello"	CORRECTION    IDENTIFICATION NUMBER:   A. BUILDING	A BUILDING  345193  B. WING  STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713  SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)  Continued From page 15  Least every 2 hours for urinary incontinence care."  During a continuous observation of Resident #94 on 05/04/17 from 9:41 AM to 12:06 PM, Resident #94 was not checked for incontinence.  On 05/04/17 at 9:41 AM, Nurse Aide (NA) #1 was observed in the dining room asking Resident #94 if he wanted to go down to his room. Resident #94 responded "no" and NA #1 said "all right" and NA #1 left the room.  On 05/04/17 at 9:46 AM, NA #2 was observed walking up to Resident #94 was not checked for urinary incontinence.  On 05/04/17 at 10:07 AM, Resident #94 was observed using his call light and calling out "hello" repeatedly.  On 05/04/17 at 10:09 AM, NA #2 was observed walking into the room of Resident #94 was observed using his call light and calling out "hello" repeatedly.  On 05/04/17 at 10:09 AM, NA #2 was observed walking up to Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 was unable to tell NA #2 what he needed walking the needed wal

PRINTED: 05/30/2017 FORM APPROVED OMB NO. 0938-0391 (X3) DATE SURVEY

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
		345193	B. WING			05/04/2017	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING CE		•	4	TREET ADDRESS, CITY, STATE, ZIP CODE  10 BUCKNER BRANCH ROAD  BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 312	#1 stated she had asstransfers, dressing an at 7:15 AM. NA #1 st Resident #94 about to Resident #94 denied bathroom. NA #1 als tried to check all the rishe had gotten busy Resident #94 since a On 05/04/17 at 12:06 assisted Resident #94 was no was visibly wet with y	n 05/04/17 at 12:01 PM, NA sisted Resident #94 with and urinary incontinence care tated she also asked bileting after breakfast and having to go to the o stated the nurse aides residents every 2 hours but and forgot to check on fter breakfast.  PM, NA #1 and NA #2 4 with incontinence care. The ted to have on a brief that rellow urine. Resident #94 we slightly pinkish colored buttocks but had no	F	312			
F 323 SS=D	Director of Nursing (E trained to check on the for incontinence care expectations were for residents every 2 houplans.  483.25(d)(1)(2)(n)(1)-HAZARDS/SUPERVIOLATION (d) Accidents.  The facility must ensure from accident hazard.	rs and follow their care  -(3) FREE OF ACCIDENT SION/DEVICES  ure that -  ronment remains as free	F	323			6/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` ′	LE CONSTRUCTION	' '	(X3) DATE SURVEY COMPLETED	
		345193	B. WING	· · · · · · · · · · · · · · · · · · ·		05/04/2017
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSIN	IG CE		STREET ADDRESS, CITY, STATE, ZIP COD 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 323	(n) - Bed Rails. The fappropriate alternative bed rail. If a bed or somust ensure correct in maintenance of bed into the following element (1) Assess the reside from bed rails prior to (2) Review the risks at the resident or reside informed consent prior (3) Ensure that the beappropriate for the result of the	es to prevent accidents.  facility must attempt to use es prior to installing a side or ide rail is used, the facility installation, use, and ails, including but not limited ents.  Int for risk of entrapment installation.  Ind benefits of bed rails with int representative and obtain or to installation.	F 32	On May 1, 2017, the bottle of remover was removed from re #97 s room by the DON.  On May 1, 2017, all rooms an on the secure unit were check CNA s for any chemicals. No chemicals were found on the secure unit were check complete to the co	esident  ad bathrooms ked by cother secure unit.  e will be on the Make-up June 1, be required or to return to inted when	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345193	B. WING _	B. WING		05/	04/2017
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOLINITAL	N VIEW MANOR NURSII	NG CE		4	10 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NORSII	VG CE		В	RYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 323	Continued From page	e 18	F 3	323			
		ssment (CAA) summary of			A reminder to check rooms for		
		esident #97 had previous			inappropriately stored chemicals was p		
	_	and was moved to the			in the front of all CNA flow sheet books	•	
	secure unit for safety	•			the DON and ADON on May 26, 2017.		
	An observation of the	secure unit made on			On May 26, 2017, the Social Worker s	ent	
		revealed a bottle of fingernail			a letter to responsible parties notifying		
		sitting on the back of the			them of the need to check personal ite	ms	
	toilet in the shared ba	athroom of Resident #97.			including chemicals in with the nurse o	'n	
					duty for the safety of all residents.		
	An observation of the				On May 20, 2017, the Admissions		
		OON) on 05/01/17 at 5:15 gernail polish remover was			On May 26, 2017, the Admissions Coordinator added the notification of		
		the toilet in Resident #97's			acceptable and non-acceptable persor	nal	
	bathroom.				items to the admission packet.		
	During an interview v	vith the DON on 05/01/17 at			The DON or the ADON will do random	1	
	_	d the bottle of fingernail			audits for improperly stored chemicals		
	•	houldn't be available to			weekly for 4 weeks or longer until		
	residents and she rei	moved the nail polish.			substantial compliance is maintained a		
	During on absorbatio	- of the consumer white on			determined by the QA Committee. Any		
		n of the secure unit on it was revealed a wandering			discrepancies identified during audit wi receive corrective action. Any deficient		
		it was revealed a wandering itering Resident #97's room.			practices will be documented and		
	rediaent was seen er	itering resident wer e reem.			corrected immediately.		
	During an interview of	on 05/04/17 at 2:46 PM the			,		
	DON revealed it was	her expectation for			The Administrator will monitor for		
		to never be within reach of			compliance. Any deficient practice will	be	
	residents on the secu	ure unit.			documented and reported to the QA  Committee and corrective action will be	e	
	During an interview of	on 05/04/17 at 2:54 PM the			taken.		
	Administrator revealed	ed it was his expectation for					
		chemicals to be stored in a					
		of the reach Residents.					
F 332	, , , ,	F MEDICATION ERROR	F 3	332			6/1/17
SS=E	RATES OF 5% OR M	IUKE					
	(f) Medication Errors.	The facility must ensure					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  345193		(X2) MULTIPLE A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED		
		345193	B. WING		05/04/2017	
	NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING CE			STREET ADDRESS, CITY, STATE, ZIP CODE 10 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1 00.04,201.	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		
F 332	that its-  (1) Medication error in greater; This REQUIREMENT by: Based on observation physician interviews, administration error in	e 19 rates are not 5 percent or Γ is not met as evidenced ons, record review, staff and the facility medication ate was greater than 5% as cation errors out of 26	F 332	The doctor was notified by a licensed nurse on May 3, 2017 that resident #15 had not received his medications at the designated administration times, reside	e	
	of 19.23% for 2 of 7 medication pass (ReThe findings included 1. Resident #15 was 12/31/16 with diagno	readmitted to the facility on ses which included anxiety, and hypophosphatemia (low		had missed his Spiriva dose, and Phos-Nak powder was not given with a meal as ordered. The doctor gave ordered to a licensed nurse to administer the missed Spiriva dose and to continue the same administration times for the remainder of May 3, 2017 and orders were implemented by a licensed nurse Resident #15 was notified of these ord	ers ne	
	A review of the medic revealed a physician medications:  a. Lorazepam - three times daily for a 03/06/17 - designary	cal record for Resident #15 's order for the following  give 0.5 milligram tablet anxiety with a start date of ated administration times were		The doctor was notified by a licensed nurse on May 3, 2017 the resident #47 had not received his medications at the designated administration time. The doctor gave orders to a licensed nurse continue the same administration times for the remainder of May 3, 2017 and orders were implemented by a licensed nurse. President #47 and the responsibility.	to s	
	every day for chronic date of 03/03/17 - time was 8:00 AM  c. Phos-Nak con packets by mouth with hypophosphatemia w	le contents of 1 capsule lung disease with a start designated administration ncentrated powder - give 2 th meals for		nurse. Resident #47 and the responsib family member were notified of these orders.  The ADON and RN Supervisor did an audit on May 4, 2017 on all residents for medications ordered to be given with meals. A list of residents with medication ordered to be given with meals was puthe front of all Medication Administration Records (MAR) and all licensed nurses	or ons t in	

PRINTED: 05/30/2017 FORM APPROVED OMB NO. 0938-0391

NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING CE  ### SUPPLIED  ### SUPPLI			(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION  G		(X3) DATE SURVEY COMPLETED	
MOUNTAIN VIEW MANOR NURSING CE  ### BUCKNER BRANCH ROAD BRYSON CITY, NC 28713  ### PROVIDERS PLAND C CORRECTION CACH DEPTICIARY UNDST AE PRECEDED BY FULL REGULATORY OR ISO IDENTIFYING INFORMATION)  ### PRECEDIATION OF DEFIDIENCES TAG  ### CACH DEPTICIARY OR ISO IDENTIFYING INFORMATION)  An interview was conducted with Nurse #1 on 05/03/17 starting at 9:33 AM. Nurse #1 was observed administering Lorazepam to Resident ##15 at 9:54 AM. Nurse #1 stated she could give medications an hour before or an hour after the designated administration time. Nurse #1 also stated she did not call the physician if a medication was administered late, but would call the physician if a resident refused to take a medication.  A second interview was conducted with Nurse #1 on 05/03/17 at 10:00 AM. Nurse #1 was observed administrating phos-Nak to Resident ##15 at 9:58 AM. Nurse #1 stated the medication Phos-Nak was supposed to be given with a meal, but the resident had eaten at 8:00 AM and it was still okay to give it. Nurse #1 and but the resident had eaten at 8:00 AM and it was still okay to give it. Nurse #1 acknowledged she had forgotten to administer Spiriva to Resident #15. Nurse #1 acknowledged she had forgotten to administer Spiriva to Resident #15 and it had been due at 8:00 AM.  An interview was conducted with the Director of Nursing (DON) on 05/03/17 at 10:33 AM. The DON stated her expectations were for medications to be given per the physician's order and for the physician to be notified if medications were given late. The DON further stated she would speak with Nurse #1 and notification given within designated times, with meals so ordered, and notification of the doctor,  On May 29, 2017 the DIN will inservice all licensed nurse so medications being given within designated times, with meals so ordered, and notification of the doctor,  On May 29, 2017 the DON will inservice all licensed nurse so medications being given within designated times, with meals so ordered, and notification of the doctor,			345193	B. WING			05/04/2017	
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Facility ID: 923363

PRINTED: 05/30/2017 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			05/	04/2017	
NAME OF P	ROVIDER OR SUPPLIER		1	STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	0-7/2017	
				410	BUCKNER BRANCH ROAD			
MOUNTAI	IN VIEW MANOR NURSI	NG CE		BR	YSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 332	that had been given.  An interview was cor (MD) on 05/04/17 at had been notified abovariances at the facility he always expected the was any type of variate especially if the medisubstance. The MD as shorter time between scheduled doses of Linary had a potential for ca MD stated he didn't hisolated missed dose unless the resident with The MD stated he did giving Resident #15 Is stomach had the pote effect but it did have esophageal irritation.  2. Resident #47 was 03/28/17 with diagnowith neuropathy (nemburning and pain in the chronic lung disease failure and continuou venous ulcers (wound by poor circulation).  A review of the medic revealed a physician medications:  a. Oxycodone 1 one tablet by mouth of the medical continuous and the tablet by mouth of the medical cations:	aducted with the physician 1:39 PM. The MD stated he but several medication ity yesterday. The MD stated to be called anytime there unce with medications and cation was a controlled stated he didn't think having en administration of the Lorazepam for Resident #15 rusing an adverse effect. The have a concern about an e of Spiriva for Resident #15 ras in respiratory distress. In think a single episode of Phos-Nak on an empty ential for causing an adverse the potential for causing	F		as ordered. Make-up inservices will be provided by June 1, 2017. Any nurse of leave will be required to make-up the inservice prior to return to duty. All new licensed nurses will be oriented on commedication administration procedures the RN Supervisor.  DON/ADON will randomly monitor licensed nurses for timely administration of medication and medication administered per physician's order with meals weekly for 4 weeks or longer unsubstantial compliance is achieved and maintained as determined by the QA Committee. Any deficient practice observed will be addressed immediate the nurse will be educated by the DON or ADON, and the deficient practic will be brought to the attention of the administrator. The QA Committee will discuss any deficient practices found a whether corrective action is necessary including the use of disciplinary procedures.  A prompt of acceptable medication administration time variations was place in the front of all MAR charts by the AD on May 25, 2017.  The Administrator will monitor for compliance and report results to the QC Committee. The QA Committee will revaudit findings and monitor for any trend or patterns. The QA Committee will direated in the form the Administrator as will supervision from the Administrator as	n w rect by on till d ly, ce nd ed oON		

Facility ID: 923363

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPL A. BUILDING	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED			
		345193	B. WING		05/04/2017		
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSII	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE  410 BUCKNER BRANCH ROAD  BRYSON CITY, NC 28713			
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F 332	by mouth 4 times and designated administ 12:00 PM, 4:00 PM and An interview was cornously 13:00 PM, 4:00 PM and An interview was cornously 13:00 PM, 4:00 PM and An interview was cornously 13:00 PM, 4:00 PM and An interview was cornously 13:00 PM, and the physician administered late, but resident refused to the An interview was cornously 13:00 PM, and the physician administered late, but resident refused to the An interview was cornously 13:00 PM, and 14:00 PM, and 15:00 PM,	a.5 mg tablet - give one tablet ay - start date of 04/12/17 - stration times of 8:00 AM, and 8:00 PM.  Inducted with Nurse #1 on 0:33 AM. Nurse #1 was ng Lorazepam and ent #47 at 9:40 AM. Nurse give medications an hour er the designated Nurse #1 also stated she did if a medication was it would call the physician if a ake a medication.	F 332	are identified.			
	and for the physician were given late. The would speak with Nu the physician (MD) a that had been given.  An interview was cor (MD) on 05/04/17 at had been notified abovariances at the facil he always expected was any type of varia especially if the medi substance. The MD a shorter time betwee scheduled doses of L	to be notified if medications DON further stated she rse #1 and have her contact bout the late medications  aducted with the physician 1:39 PM. The MD stated he out several medication ity yesterday. The MD stated to be called anytime there ance with medications and ication was a controlled stated he didn't think having en administration of the corazepam or Oxycodone for cotential for causing an					

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		345193	B. WING _	<del></del>	05/04/2017
	ROVIDER OR SUPPLIER  N VIEW MANOR NURSII	NG CE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	
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F 332	Continued From pag	e 23	F 3	32	
F 520 SS=D	adverse effect. 483.75(g)(1)(i)-(iii)(2) COMMITTEE-MEMB QUARTERLY/PLANS	ERS/MEET	F 5	20	5/31/17
	(g) Quality assessme	ent and assurance.			
	(1) A facility must ma and assurance comn minimum of:	intain a quality assessment nittee consisting at a			
	(i) The director of nur	rsing services;			
	(ii) The Medical Direc	ctor or his/her designee;			
	staff, at least one of	a board member or other			
	(g)(2) The quality ass committee must :	sessment and assurance			
	coordinate and evalu	terly and as needed to ate activities such as h respect to which quality urance activities are			
		ement appropriate plans of tified quality deficiencies;			
	Secretary may not re records of such communication such disclosure is rel	rmation. A State or the quire disclosure of the mittee except in so far as ated to the compliance of the requirements of this			

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
345193			B. WING _			05/04/2017	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING CE				STREET ADDRESS, CITY, STATE, ZIP COE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	)E		
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 520	Continued From page 24		F 5	520			
	(i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.  This REQUIREMENT is not met as evidenced by:  Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions put in place by the committee from the annual recertification survey on 4/14/16 regarding Provide Assistance with Activities of Daily Living (ADL). The deficiency for ADLs was cited again during the recertification survey of 5/4/17. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program.  Findings Included:			Mountain View Manor Nursir currently holds and will contir regularly scheduled QA Commeetings a minimum of quark. The QA committee has estable Care Practices subcommittee weekly facility rounds. The sum will consist of 4 members of the Committee, at least one memourse; members will be rotated. The rounds will include randown ADLs. Any deficient practice brought to the attention of the nurse and corrected immediations.	nue to hold mittee terly.  blished a e to do ubcommittee the QA nber will be a ed quarterly. om audits of will be e charge		
	observations, recor the facility failed to 4 sampled residents staff for toileting and (Residents #2 and a	stance with ADLs: Based on d review, and staff interviews check for incontinence for 2 of s who were dependent upon d incontinence care #94).		The Care Practices subcommore report the results of the round Committee a minimum of quark QA Committee will discuss an practices found these results corrective action is necessary the use of disciplinary procedure.  The Administrator will review	ds to the QA arterly. The ny deficient and whether y including dures.		
	facility was cited for fingernail care and present recertification	ation survey of April 2016 the failure to provide grooming, shaving to residents. On the on survey the facility failed to de incontinence care.		and findings of the subcomm quarterly. The Administrator was responsible for identifying iss addressed by utilizing this neensure corrective actions are	will be sues w system to taken to		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345193	B. WING			05/04/2017	
NAME OF PROVIDER OR SUPPLIER  MOUNTAIN VIEW MANOR NURSING CE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	(EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		
F 520	During an interview on Director of Nursing respect to the been done for dependent ADL care. She also restopped the audits an an improvement in the residents. She recommend to the province of	n 05/04/17 at 3:17 PM the evealed weekly audits had dent residents who received evealed the facility had ad indicated there had been e ADL care for dependent mended the facility should eekly audits to ensure ADL	F5	20			