PRINTED: 07/26/2019 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			C 06/27/2019	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSIN	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	,	00,21,2010	
PREFIX (EACH DEFICIENC	SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECTION (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		HOULD BE	(X5) COMPLETION DATE		
E 000 Initial Comments An unannounced rec	certification survey was	E 00	00			
conducted on 1/06/18 facility was found in conducted requirement CFR 483 Preparedness. Even F 000 INITIAL COMMENTS	3.73, Emergency at ID QJEF11	F 00	00			
A recertification survinvestigation survey of 06/24/19 through 06/four allegations investigations investigations of the complete of the comple	ey and complaint was conducted from 27/19. There was a total of stigated and they were all essment After Signifcant Chg	F 63			7/25/19	
determines, or should there has been a sign resident's physical or purpose of this section means a major declir resident's status that itself without further in implementing standa interventions, that had one area of the residence plan, or both.) This REQUIREMENT by: Based on record revision facility failed to comp (MDS) related to a signal single residence of the residence plan, or both.)	hin 14 days after the facility d have determined, that nificant change in the mental condition. (For on, a "significant change" ne or improvement in the will not normally resolve ntervention by staff or by rd disease-related clinical as an impact on more than ent's health status, and nary review or revision of the		Disclaimer: We respectfully req plan of correction be considered allegation of substantial complia	d our ance.		
within 14 days for 1 c Hospice (Resident #7 The findings included ABORATORY DIRECTOR'S OR PROVIDER/	d:		Preparation and/or completion of correction in general, or any of action set forth, herein, in particular not constitute an admission of a	corrective ular, does	(X6) DATE	

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

07/22/2019 **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.

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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345193	B. WING _				C 27/2019
NAME OF PI	ROVIDER OR SUPPLIER	ı		STF	REET ADDRESS, CITY, STATE, ZIP CODE	1 00/	
				410	BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURSIN	IG CE		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 CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 637	Continued From page	e 1	F 6	37	by Mountain View Manor of the		
	Resident #7 was adn	nitted to the facility on			conclusions set forth in the Statement	of	
	02/08/19 with diagno	_			Deficiencies (Form 2567). The Plan of		
	dysphagia, atrial fibri				Correction and specific correction action	n	
	squamous cell carcin				are prepared and/or executed solely as		
	obstructive pulmonar	y disease.			provision of Federal and/or State law. Hospice/Sig Change TAG		
	Review of Resident #	7's physician orders					
	revealed Resident #7	was admitted to Hospice on			1. A significant change Minimum Data	Set	
	03/14/19.				(MDS) assessment for resident # 7 wa opened by the /MDS Coordinator on	S	
	Review of Resident #	7's MDS records revealed			6/25/19 and completed by the		
	the most recent MDS	was submitted on 03/11/19.			Interdisciplinary Team (IDT) on 7/2/19.		
		s were submitted after			The assessment was transmitted by th		
	03/11/19. The Signific	cant Change in Status			MDS Coordinator on 07/09/2019.		
		was not completed and			Resident # 7 will continue to have MDS	3	
	submitted within 14 d	ays after Resident #7 was			assessments completed by the IDT and	d	
	admitted to Hospice	on 03/14/19.			submitted by the MDS Coordinator in a timely manner per the Resident	l	
	During an interview o	onducted on 06/25/19 at			Assessment Instrument (RAI) guideline	es.	
	1:31 PM, the MDS Co	pordinator stated she was			2. Residents who are receiving Hospic	е	
	responsible for the co	ompletion and submission of			services are at risk to be affected by th	е	
	Resident #7's MDS a	nd confirmed that the last			same practice. An MDS audit of reside	nts	
	MDS submitted for R	esident #7 was on 03/11/19.			receiving Hospice services was		
	She acknowledged th	nat since Resident #7			completed by a registered nurse on		
	admitted to Hospice	on 03/14/19, it was an error			7/2/2019. The audit verified that a		
		was not in place by 03/28/19.			significant change MDS was completed	t	
		r added that she was the			when the resident elected to receive		
	· ·	r who had handled all the			Hospice services. No other corrective		
		stance from a staff member			action required. The four other residen		
	, ,	d the workload had been			who currently receive Hospice services		
		y. In the past, she had been			had a significant change completed in	a	
	notified by nursing st				timely manner when they elected to		
		nanges. However, she had			receive Hospice benefits.		
	not been notified of F	· · · · · · · · · · · · · · · · · · ·			3. The Director of Nursing (DON) provi		
	admission on 03/14/1	9.			education to the MDS Coordinator and	tne	
		1 1 1 00/05/10 1			IDT on 7/2/19 on the requirement to		
	_	onducted on 06/25/19 at			complete a significant change MDS wh		
	⊥2:08 PM. the Director	of Nursing (DON) stated			a resident elects or discontinues Hospi	ce	

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		345193	B. WING				27/2019
	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 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 637	weeks after Resident Hospice. The MDS C provided with assista staff in the past few n this incident was main effective communicat Coordinator being full changes with residen the MDS Coordinator	#7 had admitted to oordinator had been nce from several different nonths. The root cause of nly due to lack of an ion to ensure MDS ly informed of all the ts. It was her expectation for s to follow the Centers of Services (CMS) rules and te MDS as required	F	537	services. A pre and posttest was given the DON to the IDT team on 07/11/201 to assess learning. Employee orientation for any new members of the IDT will include training on completing a significant change assessment when a resident elects or discontinues Hospice services. An MDS audit was completed by a registered nurse on 07/02/2019. The registered nurse verified during the audithat a significant change MDS was completed when the resident elected to receive Hospice Services. No further corrective action was required. A significant change communication for was revised on 06/26/2019 to include a option for any resident that elects to receive Hospice services. The form is completed by the licensed nursing staff a means of communication between th licensed nursing staff and the IDT/MDS Coordinator. The licensed nurses will complete this form whenever a change condition is noted or if the resident elector discontinues Hospices Services. The form will be kept at the nurses' station fuse on any shift. The form will be completed by the licensed nurse and given to the MDS Coordinator. If the M Coordinator is not available, the form me given to the Assistant Director of Nursing (ADON) or placed in the MDS Coordinator receives the form, the clinicator can be reviewed and the ARD for the significant change MDS can be set per RAI guidelines by the MDS Coordinator.	g dit o man f as e S in cts e for DS nay cal or	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED		
		345193	B. WING			l	C
		343133	B: Wiito			06/	27/2019
NAME OF P	ROVIDER OR SUPPLIER			SI	FREET ADDRESS, CITY, STATE, ZIP CODE		
ΜΟΙΙΝΤΔΙ	N VIEW MANOR NURSIN	NG CE		41	0 BUCKNER BRANCH ROAD		
MOONIA	IN VIEW IIIANON NONOII	10 02		ВІ	RYSON CITY, NC 28713		
(X4) ID PREFIX TAG	X (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI TAG	EFIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 637	Continued From page	e 3	F	637	In addition to the form, the clinical team will review telephone orders in the clini meeting. The review will include any ne orders that may have been written to e or discontinue Hospice Services. Any relephone order related to election or discontinuance of Hospice Services will be communicated to the MDS Coordinator. If the MDS Coordinator is available, the form may be given to the Assistant Director of Nursing (ADON) oplaced in the MDS Coordinator's mailb The licensed nurses' education provide by the DON started on 06/26/2019 whether form was initiated. The inservice education by the DON/ADON will continutil licensed nurses have received the education. The education will be completed by 07/25/2019. A weekly audit was initiated on 7/09/20 by the Assistant Director of Nursing to verify that any resident who elects Hospice benefits has a significant charm MDS completed. The audits will continued weekly for a minimum of four weeks or until substantial compliance has been achieved. Corrective action will be take for any identified deficient practice. 4. The DON and/or ADON will review the results of the weekly audits for any trenor patterns and report to the Quality Assurance Performance Improvement Committee. The Quality Assurance Committee consists of the Administrate Director of Nursing, Medical Director, at least 3 other staff members. The Quality Assurance Committee will reviet the results of the audits and direct corrective action as necessary. The	cal ew lect new ll not or ox. ed en nue en ne	

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	PLE CONSTRUCTION G	' '	DATE SURVEY COMPLETED
		345193	B. WING			C 06/27/2019
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		00/21/2013
(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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APF DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
F 637	Continued From pag	e 4	F 6:	Quality Assurance Committee mapprove changes in the frequence audits and/or discontinue the audithe new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019	cy of the dits once ed	
F 640 SS=E	CFR(s): 483.20(f)(1): §483.20(f) Automate requirement-§483.20(f)(1) Encodi a facility completes a facility must encode each resident in the (i) Admission assess (ii) Annual assessme (iii) Significant chang (iv) Quarterly review (v) A subset of items reentry, discharge, a (vi) Background (faci is no admission asses §483.20(f)(2) Transnafter a facility comple a facility must be cap CMS System information contained in the MDS standard record layo and that passes stan CMS and the State.	ng data. Within 7 days after a resident's assessment, a the following information for facility: ment. ent updates. e in status assessments. assessments. upon a resident's transfer, and death. e-sheet) information, if there essment. hitting data. Within 7 days etes a resident's assessment, bable of transmitting to the ation for each resident S in a format that conforms to uts and data dictionaries, dardized edits defined by	F 6	+0		7/25/19
	14 days after a facilit	nittal requirements. Within y completes a resident's y must electronically transmit and complete MDS data to				

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345193	B. WING			C 6/ 27/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COL		012112013	
				410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSIN	NG CE		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 CO (EACH CORRECTIVE ACTIOI CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 640	(iv) Significant correct (v) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, ar (viii) Background (factinitial transmission of does not have an adressessment data in the for a State which has by CMS, in the formal approved by CMS. This REQUIREMENT by: Based on record revision factors and the formal approved by CMS. This REQUIREMENT by: Based on record revision factors are facility failed to compute discharge minimum of 2 significant change II	luding the following: nent. nt. e in status assessment. tion of prior full assessment. tion of prior quarterly s upon a resident's transfer, nd death. ee-sheet) information, for an MDS data on resident that mission assessment. rmat. The facility must ormat specified by CMS or, an alternate RAI approved t specified by the State and is not met as evidenced iews and staff interviews, the	F 64	,	sident # 2, ed on DS for resident #		
	Medicare and Medica required timeframe for	aid Services (CMS) within the or 5 of 5 residents reviewed nents (Residents #51, #2,		transmitted on 07/11/2019 by Coordinator. Resident #2, #3 # 51 will continue to have ME assessments completed and in a timely manner per RAI gr	the MDS 3, #4, #5, and DS transmitted		
	diagnoses including A dementia. Review of Resident #	admitted on 1/14/19 with Alzheimer's Disease and 51 Minimum Data Set evealed the resident's last		2. All residents have the pote affected by the same practice audit of current residents was by 7/2/2019 by a registered retimeliness of completion and of the MDS per RAI guideline action will be taken for any Massessment that was not con	ential to be e. An MDS s completed nurse for submission es. Corrective		

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	2) MULTIPLE CONSTRUCTION (2 BUILDING		(X3) DATE SURVEY COMPLETED	
		345193	B. WING		06	C 6/27/2019	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	, ,	72172010	
				410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSI	NG CE		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 CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
F 640	Continued From page	e 6	F 64	0			
F 640	transmitted MDS was an admission assess discharge assessmel been completed or tr. An interview with the 6/26/19 at 12:00 PM responsible for makin assessments were lowed MDS Coordinator stated the MDS assessments with the MDS Coordinator stated at the MDS assessments with the MDS Coordinator stated at the MDS assessments with the MDS Coordinator stated at the MDS at transmitted timely. An interview with the 06/27/19 at 1:23 PM Coordinator was responsible for manner to be in complete frames. The Direct MDS Coordinator has worked one 8 hour direct frames are complete the MDS as a diagnoses including at Review of Resident #2 was a diagnoses including at Review of Resident #4 Minimum Data Set (No. 1975).	s dated 1/20/19 and coded ment. Resident #51 had a nt dated 2/9/19 that had not ansmitted as of 6/26/19. MDS Coordinator on revealed she was ng sure the MDS locked and transmitted. The sted she needed more help to ments completed and e required time frames. The sted she was responsible for arge MDS assessment is not completed or Director of Nursing on revealed the full time MDS consible for completing and assessments in a timely pliance with the required ector of Nursing stated the dhelp from Nurse #1, who asy per week to complete 5 to ents and Nurse #2 worked 4 afternoons per week to help is sessments.	F 64	timely manner. 3. The Director of Nursing provideducation to the MDS Coordinate IDT on 07/02/2019 on timely con and submission of the MDS per guidelines. A pre and posttest was by the DON to the MDS Coordin 07/11/2019 to assess learning. Employee orientation will include education by a registered nurse accurate coding of Section M of for new MDS Coordinators. An MDS audit was completed by registered nurse on 07/02/2019. consisted on reviewing current refor timely completion of the MDS per RAI guidelines. Corrective action be taken for any resident identification have an MDS assessment not contimely. The MDS Coordinator will give the and/or ADON an MDS schedule beginning of the week and updated DON and/or ADON at the end of as to what assessments have be completed and transmitted. The and/or ADON may use the schedule for completion and submission on MDS. This process was initiated 07/09/2019. A weekly MDS audit will be compared registered nurse to verify that the schedule has been completed time RAI guidelines and that the MDS	or and the inpletion RAI as given ator on the MDS as a The audit esidents as schedule etion will ed to impleted in a DON at the week een DON dule as a e software of the on olleted by he MDS mely per		
	Resident #2 had a sig	gnificant change assessment ad not been completed or		assessments were transmitted. weekly audits were initiated on 0 and will continue weekly for a mi four weeks or until substantial co	The 7/09/2019 nimum of		

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	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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MOUNTAI	N VIEW MANOD NUDOU	NC CE		410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSI	NG CE		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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 640	Continued From pag	e 7	F 64	.0			
1 040	An interview with the 6/26/19 at 12:00 PM making sure the asset transmitted. The MD needed more help to completed and transitime frames. The MD was responsible for Fichange MDS assess not completed or transitime frames with the 06/27/19 at 1:23 PM Coordinator was responsible for manner to be in completed or transmitting the MDS manner to be in completed one 8 hour do 6 quarterly assessment to 5 hours a couple at complete the MDS at 3. Resident #5 was addiagnoses including anxiety and depression Review of Resident #5 had an at 5/15/19 that had not transmitted as of 6/20 An interview with the 6/26/19 at 12:00 PM responsible for making were locked and transing the docked and transmitted as of 6/20 An interview with the 6/26/19 at 12:00 PM responsible for making were locked and transing the docked and transing the	MDS Coordinator on revealed was responsible for essments were locked and S Coordinator stated she get the MDS assessments mitted within the required as Coordinator stated she Resident #2's significant ment dated 4/18/19 that was asmitted time. Director of Nursing on revealed the full time MDS consible for completing and assessments in a timely pliance with the required ector of Nursing stated the d help from Nurse #1, who asy per week to complete 5 to cents and Nurse #2 worked 4 afternoons per week to help assessments. Idmitted on 6/27/14 with catrial fibrillation, heart failure, on. #5's last transmitted MDS) assessment was dated as a quarterly assessment. Idmitted on 6/27/14 with catrial fibrillation, heart failure, on. #5's last transmitted MDS) assessment was dated been completed or 6/19. MDS Coordinator on revealed she was any sure the assessments	F 64	has been achieved. Corrective be taken for any identified deficipractice. 4. The DON and/or ADON will results of the weekly audits for or patterns and report to the Quastrance Performance Impro Committee. The Quality Assurance Committee consists of the Adm Director of Nursing, Medical Di at least 3 other staff members. Quality Assurance Committee the results of the audits and dir corrective action as necessary. Quality Assurance Committee approve changes in the freque audits and/or discontinue the athe new system has been deer effective to maintain substantial compliance. 5. Completion date is 07/25/20	review the any trends uality evement ance eninistrator, arector, and The evill review rect. The may ency of the audits once ened al		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING			DATE SURVEY COMPLETED			
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	ROVIDER OR SUPPLIER N VIEW MANOR NURSI	NG CE		STREET ADDRESS, CITY, STATE, ZIP 6 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	CODE	00/2//2019
(X4) ID PREFIX TAG			ID PREFII TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 640	MDS Coordinator sta Resident #5's annual 5/15/19 that was not timely. An interview with the 06/27/19 at 1:23 PM Coordinator was restransmitting the MDS manner to be in comtime frames. The Dir MDS Coordinator haworked one 8 hour of 6 quarterly assessmit to 5 hours a couple a complete the MDS at 4. Resident #3 was a diagnoses including diabetes, and malnual Review of Resident #3 mad a sidated 5/1/19 and coded at Resident #3 had a sidated 5/1/19 that had transmitted as of 6/2 An interview with the 6/26/19 at 12:00 PM responsible for making were locked and transcordinator stated side MDS assessment	atts completed and be required time frames. The sted she was responsible for all MDS assessment dated completed or transmitted. Director of Nursing on revealed the full time MDS ponsible for completing and assessments in a timely appliance with the required sector of Nursing stated the ad help from Nurse #1, who lay per week to complete 5 to ents and Nurse #2 worked 4 afternoons per week to help assessments. Admitted 11/17/18 with heart failure, hypertension, trition. #3's last transmitted MDS) assessment was dated a discharge assessment and not been completed or 6/19. AMDS Coordinator on revealed she was ang sure the assessments assmitted. The MDS he needed more help to get atts completed and	F	540		
	diabetes, and malnu Review of Resident and Minimum Data Set (II 2/14/19 and coded and Resident #3 had a side dated 5/1/19 that had transmitted as of 6/2 An interview with the 6/26/19 at 12:00 PM responsible for making were locked and transportation coordinator stated significant that the MDS assessment transmitted within the	#3's last transmitted MDS) assessment was dated a discharge assessment. ignificant change assessment d not been completed or 6/19. e MDS Coordinator on revealed she was ng sure the assessments nsmitted. The MDS he needed more help to get nts completed and e required time frames. The ated she was responsible for				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION A. BUILDING A. BUILDING		(X:	(X3) DATE SURVEY COMPLETED			
		345193	B. WING			C 06/27/2019
	ROVIDER OR SUPPLIER N VIEW MANOR NURSIN			STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	<u>l</u>	06/27/2019
(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 COR (EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 640	assessment dated 5/ or transmitted timely. An interview with the 06/27/19 at 1:23 PM Coordinator was resp transmitting the MDS manner to be in comptime frames. The Dire MDS Coordinator had worked one 8 hour da 6 quarterly assessment to 5 hours a couple a complete the MDS as 5. Resident #4 was a diagnoses including Adementia, anxiety and Review of Resident #4 Minimum Data Set (N 2/11/19 and coded as Resident #4 had an a 5/14/19 that had not be transmitted as of 6/26/19 at 12:00 PM responsible for making were locked and transmitted within the MDS coordinator stated shift the MDS assessment transmitted within the MDS Coordinator stated shift the MDS coordinator shift th	Director of Nursing on revealed the full time MDS consible for completing and assessments in a timely pliance with the required ector of Nursing stated the dihelp from Nurse #1, who ay per week to complete 5 to ents and Nurse #2 worked 4 fternoons per week to help seessments. Idmitted 5/26/17 with Alzheimer's disease, didepression. E4's last transmitted MDS) assessment was dated a quarterly assessment. Innual assessment dated been completed or 6/19. IMDS Coordinator on revealed she was ag sure the assessments smitted. The MDS ne needs more help to get	F6	40		

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	ROVIDER OR SUPPLIER	IG CE		41	REET ADDRESS, CITY, STATE, ZIP CODE 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 PREFIX TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 641 SS=D	Coordinator was respectansmitting the MDS manner to be in complime frames. The Dire MDS Coordinator had worked one 8 hour da 6 quarterly assessment to 5 hours a couple at complete the MDS as Accuracy of Assessment FR(s): 483.20(g) §483.20(g) Accuracy The assessment must resident's status. This REQUIREMENT by: Based on record revifacility failed to accurate the MDS in Secon 3 consecutive MD resident reviewed for #91). Resident #91 was ad 01/12/2015 with an ad Alzheimer's Dementian Review of a doctor's crevealed an order to a second manner of the s	revealed the full time MDS consible for completing and assessments in a timely cliance with the required ector of Nursing stated the d help from Nurse #1, who ay per week to complete 5 to ents and Nurse #2 worked 4 ffernoons per week to help essessments. The is not met as evidenced fiew and staff interview the ately code the Minimum ection J for pressure ulcers S assessments for 1 of 1 pressure ulcers (Resident mitted to the facility dmitting diagnosis of a. corder dated 10/30/2018 apply skin protectant buttocks every shift for		641	1. A modification Minimum Data Set (MDS) assessment for resident # 91 was completed on 7/16/19 to include wound by the MDS Coordinator. The modified assessment was transmitted by the MDS Coordinator on 07/16/2019. Resident # was discharged from the facility on 01/23/2019 and no further corrective action may be taken. 2. Residents who have wounds are at r to be affected by the same practice. Ar MDS audit of residents with wounds was completed on 7/2/19 by a registered nurse. Corrective action will be taken by registered nurse for any MDS assessment to the coded correctly related to the	ds DS 91 risk n as by a nent	7/25/19
	revealed an order to a strips to excoriated an	order dated 12/05/2018 apply a paste on gauze nd open areas on the very shift, and to change			presence of wounds. 3. The Director of Nursing provided education to the MDS Coordinator and IDT on 7/2/19 on coding of Section M		

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	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	LE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345193	B. WING		C 06/27/2019
	ROVIDER OR SUPPLIER	ING CE	STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		00/2//2013
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F 641	Continued From page	ge 11	F 64	1	
	Resident #91 was be related skin breakdo treatment was started Stage 2 pressure uld 0.5cm (centimeters cm deep Review of the discharce revealed Resident # facility and was codunhealed pressure revealed in Section no unhealed pressure Review of the discharce Review of t	ment Record revealed being treated for pressure own. His most recent ed on 12/05/2018 for one cer on the sacrum measuring of wide x 2.5 cm length x 0.1 arge MDS dated 12/06/2018 #91 anticipated a return to the ed in Section J that he had no ulcers. assion MDS dated 12/13/2018 J that Resident #91's skin had are ulcers. arge MDS dated 01/23/2019 J that Resident #91's skin had		related to the presence of wounds. And posttest was given by the DON to MDS Coordinator on 07/11/2019 to assess learning. Employee orientation will include education by a registered nurse on accurate coding of Section M of the Normal for new MDS Coordinators. An MDS audit related to wounds was completed by the registered nurse comparing the wound report and the clinical record for the past 60 days to assessments completed during that the period. Corrective action was taken from any assessments that did not include correct coding in Section M related to presence of wounds. The MDS Coordinator will be given a wound report each week by a register nurse who completes the wound report a reference to compare to the clinical record when coding section M on the MDS. The wound report and for other section was taken from the MDS. The wound report and for other section of the MDS. The wound report and for other section of the MDS. The wound report and for other section was and for other section was a section of the clinical record when coding section M on the MDS. The wound report and for other section was a section was a section of the section was a section was a section of the section was a se	MDS MDS ime or ethe othe red ort as
	Resident #91 was to program effective 0 quarter due to risk f breakdown. The gorelated skin breakdown approaches/interverpressure relieving cobed as needed. 2. Initial log sheet to wrepositioning was procheck for incontine if wet/soiled. 5. Staffafter each incontine cream as needed. 6	lan dated 12/07/2018 revealed to be on a turn and reposition 5/01/2015 and updated each or pressure related skin al was to have no pressure own for 90 days. The intions included: 1. Provide ushion for the wheelchair and furn at least every 2 hours. 3. erify that turning and erformed for their shift. 4. Ince every 2 hours and change if will cleanse and dry well ent episode and apply barrier is. The licensed nurses will enthly on the pressure sore		MDS. The wound nurse and/or other registered nurse completing the wou report received education by the DOI 07/11/2019. The process where the I Coordinator receives a weekly wound report started on 07/18/2019. A weekly MDS audit will be complete a registered nurse to compare the woreport, the clinical record, and MDS assessments completed in that time period. The weekly audits were initiat on 07/18/2019. The audits will continue weekly for a minimum of four weeks until substantial compliance has been achieved per the QA committee. Corrective action will be taken for an identified deficient practice.	nd N on MDS d d by bund ted ue or

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED C 06/27/2019	
		345193				
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSING CE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1 00/2	772013
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATI DEFICIENCY)		(X5) COMPLETION DATE
F 641	coded pressure ulcer 3 MDS assessments been transmitted as of did weekly chart audi information for input the did not know how she pressure ulcers for Reshe would start the core-submit the assession An interview with the 06/26/019 at 2:30 PM aware the MDS Coording the MDS coording the MDS coording the MDS assessments for Resident #91 corresponding to the expectation that the MDS assessments for her expectation that the MDS assessments for her expectation that the MDS assessments for the expectation that the model of the expectation that the expectation that the model of the expectation that the expectation that all the MDS assessments for the expectation that the	MDS Coordinator on M revealed she had not so in the J section on the last for Resident #91 that had complete. She revealed she is and obtained her to the MDS assessment and the had missed coding the esident #91. She stated that correction process and ments. Director of Nursing on revealed she was not dinator was not coding cition J of the assessments ectly. She further revealed lator had been doing the rethe last 3 years, and it was the MDS should have been should be coded at the Quality Assessment entions that were put in fication and complaint were being monitored to seessments and did not set the QAPI meetings when a monitored, most likely a	F 64	4. The DON and/or ADON will revieresults of the weekly audits for any or patterns and report to the Quality Assurance Performance Improvem Committee. The Quality Assurance Committee consists of the Administ Director of Nursing, Medical Director at least 3 other staff members. The Quality Assurance Committee will results of the audits and direct corrective action as necessary. The Quality Assurance Committee may approve changes in the frequency audits and/or discontinue the audits the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	trends y hent trator, or, and e review e of the s once	
F 867 SS=D	QAPI/QAA Improvem CFR(s): 483.75(g)(2)		F 86	57		7/25/19

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER		x2) MULTIPLE CONSTRUCTION BUILDING		(X3) DATE SURVEY COMPLETED	
	345193		B. WING _			C 06/27/2019	
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSING CE				STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		<u></u>	
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F 867			F 8	67			
	S483.75(g) Quality assessment and assurance. S483.75(g)(2) The quality assessment and assurance committee must: (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; This REQUIREMENT is not met as evidenced by: Based on record review and staff interview, the facility's Quality Assessment and Assurance (QAA) Committee failed to maintain implemented procedures and monitor interventions that the committee had previously put into place following the recertification survey of 06/29/18. This was for one deficiency that was originally cited in May 2018 and was subsequently recited on the current recertification of 06/27/2019. The repeated deficiency was in the area of Accuracy of Assessments. The continued failure of the facility during two federal surveys of record show a pattern of the facility's inability to sustain an effective Quality Assurance Program. The findings included: This tag is cross referenced to: 1. F-641: Accuracy of Assessments. Based on record review and staff interview the facility failed to accurately code the Minimum Data Set (MDS) in Section J for pressure ulcers on 3 consecutive MDS assessments for 1 of 1 resident reviewed for pressure ulcers. During the recertification and complaint survey of 06/29/18 the facility failed to accurately code Minimum Data Sets for 2 of 5 residents reviewed for unnecessary medications and 1 of 1 resident			1. A significant change Minimum Set (MDS) assessment for resider was opened by the MDS Coordina 6/25/19 and completed by the Interdisciplinary Team (IDT) on7/2 Resident # 7 will continue to have assessments completed by the ID submitted by a registered nurse in manner per the Resident Assessn Instrument (RAI) guidelines. A modification Minimum Data Set assessment for resident # 91 was completed on 07/16/2019 to include wounds by the MDS Coordinator. Resident # 91 was discharged from facility on 01/23/2019 and no furth corrective action may be taken. MDS assessments for resident # 2 #4, and #5 were completed on 07/11/2019 by a remurse. Resident #2, #3, #4, #5, and will continue to have MDS assess completed and transmitted per RAI guidelines. 2. All residents have the potential affected by the same practice. An audit of current residents was completed some complete same practice.	nt # 7 ator on 2/19. MDS T and a timely nent (MDS) de m the ner 2, #3, //03/2019 was re gistered nd # 51 ments Al to be MDS		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345193		IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 867	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		F	867	by 07/02/2019 by a registered nurse for timely encoding and transmission of the MDS. An MDS audit was completed by registered nurse on 07/02/2019 on the current residents receiving Hospice and a significant change was completed aft the resident elected Hospice benefits. AMDS audit for the past 60 days of residents with wounds was completed 07/02/2019 by a registered nurse reviewing MDS coding related to wound Corrective action will be taken for any MDS assessment that was not complet or submitted in a timely manner. 3. The Administrator provided education to the QA team on 07/18/2019. A pre a posttest was given to assess learning. New members that are added to the QA team will have education provided by the Administrator or DON during their orientation period. MDS Assessments will be audited for timely completion/submission and accuracy of Section M by a registered nurse beginning on 07/02/2019 and continuing through 07/25/2019. Audits transition to be completed on a monthly basis at that time for a minimum of 3 months or until the QA committee deen that substantial compliance for accuracy and timely completion/submission. Corrective action will be taken for any MDS assessment that was not completed/submitted in a timely manner or for coding inaccuracies. 4. The DON and/or ADON will review the results of the weekly audits for any trendred or patterns and report to the Quality Assurance Performance Improvement	e y a differ An on ds. ded an had he will / hed by	

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 345193		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	ı	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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F 867	Continued From page	e 15	F	867	Committee. The Quality Assurance Committee consists of the Administrate Director of Nursing, Medical Director, a at least 3 other staff members. The Quality Assurance Committee will revie the results of the audits and direct corrective action as necessary. The Quality Assurance Committee may approve changes in the frequency of the audits and/or discontinue the audits on the new system has been deemed effective to maintain substantial compliance. 5. Completion date is 07/25/2019.	and ew ne		