STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING _____ B. WING _____	C 05/28/2021

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	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	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
E 000	Initial Comments An unannounced recertification survey was conducted on 5/25/21 through 5/28/21. The facility was found in compliance with the requirement CFR 483.73, Emergency Preparedness. Event ID OP8Y11	E 000		
F 000	INITIAL COMMENTS A recertification survey and complaint investigation survey was conducted from 5/25/21 through 5/28/21. There were a total of seventeen allegations investigated and they were all unsubstantiated. Event ID# OP8Y11.	F 000		
F 558 SS=D	Reasonable Accommodations Needs/Preferences CFR(s): 483.10(e)(3) §483.10(e)(3) The right to reside and receive services in the facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents. This REQUIREMENT is not met as evidenced by: Based on record review, observation, resident interview and staff interviews, the facility failed to provide access to control the light fixture behind the bed for 1 of 1 resident reviewed for accommodate of needs (Resident #44). The findings included: Resident #44 was admitted to the facility on 04/21/21 with diagnoses included diabetes mellitus with polyneuropathy, arthritis, osteoporosis, history of falling, muscle weakness, and cognitive communication deficit.	F 558	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law.	6/21/21

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 06/17/2021

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F 558	Continued From page 1 Review of the admission Minimum Data Set (MDS) dated 04/28/21 assessed Resident #44 with severe impairment in cognition and impaired vision. Resident #44 needed extensive assistance with 1-person physical assist for transfers and required limited assist with 1 person for walking in the room during the 7-day look back period. Review of the Care Area Assessment dated 04/28/21 revealed Resident #44 had a history of falling at home prior to admission. Review of care plans revealed Resident #44 was at risk of Activities of Daily Livings (ADL) self-care performance deficit and falls related to activity intolerance, confusion, dementia, fatigue, limited mobility, and pain. The goals were to improve current level of function in all ADL and be able to perform mobility tasks with limited assist through the review date. Resident #44 had high risk for falls related to gait balance problems. She required extensive assistance by one staff to move between surfaces. Review of Resident # 44's medical records revealed she had stayed in the current room since admitted on 04/21/21. During an observation conducted on 05/25/21 at 2:14 PM, the cord attached to the light fixture behind Resident #44's bed to control the light was broken. It extended approximately 3.5 inches from the light fixture and approximately 60 inches above the floor. The room did not have adequate lighting as the light was switched off during observation. During an interview with Resident #44, she stated she could not switch on or off the light behind her bed without assistance.	F 558	The light cord for Resident # 44 was repaired (made longer) by the maintenance supervisor on May 27, 2021. The light cord for Resident #44 remains in good repair and long enough for the resident to use to accommodate the needs of the resident for lighting. Current residents in the facility have the potential to be affected by the same deficient practice. The Maintenance Supervisor completed a house audit on May 27, 2021 to verify that light cords in the resident□s rooms were functional and could be reached by the resident. Corrective action was completed by the Maintenance Supervisor for any light cords that needed to be longer to accommodate the lighting needs of the resident during the audit on May 27, 2021. 1. A registered nurse will provide education to each department on the importance of the light cord being long enough for the resident to reach to accommodate the resident□s needs. The education will include how to report if the light cord needs to be made longer to accommodate the resident□s needs. A posttest will be given to assess learning and promote competency. A score on the post test of 80 or above will be considered passing. The education will be completed by June 21, 2021. 2. New employee orientation will include education on the importance of the light cord being long enough for the resident to reach and how to report if the light cord	

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F 558	Continued From page 2 A subsequent observation was made on 05/26/21 at 9:32 AM, the switching cord attached to the light fixture behind Resident #44's bed remained unfixed. During an interview with Resident #44 on 05/27/21 at 9:01 AM, she stated the cord attached to the light fixture had been broken since the first day she moved into the room. She had impaired vision and could see only bigger objects. Resident #44 explained it was very inconvenient to her as she did not like to sleep with the light on and she had to depend on the staff to control the light fixture for the past 1.5 months. During a joint observation with Nurse #1 on 05/27/21 at 2:42 PM, the cord attached to the light fixture behind Resident #44 was still in disrepair. Nurse #1 stated the light behind Resident #44's bed was always on. She never noticed that the cord was broken. She indicated that it should be fixed as soon as possible to ensure accessibility to control the light fixture at all times. During an interview with Nurse Aide (NA) #1 on 05/27/21 at 3:06 PM, she recalled seeing the broken switching cord but she did not know why she never thought of reporting it to maintenance department staff or charting it in the work order logbook in the nurse's station. During an interview with the Maintenance Manager on 05/27/21 at 3:21 PM he stated that he had conducted routine walk through at least once weekly on every Wednesday or Thursday to check for maintenance needs in the facility. He	F 558	needs to be made longer to accommodate the resident□s needs. 3. The preventative maintenance checklist for residents' rooms used by the Maintenance Supervisor was updated to include verifying that the light cord to the overbed light is long enough for the resident to use to adjust the lighting in the room. The checklist was updated by the Maintenance supervisor on June 16,2021. 4. The housekeeping checklist used to clean rooms was updated to include verifying that the light cord to the overbed light is long enough for the resident to use to adjust the lighting in the room. The checklist was updated on June 16, 2021 by the housekeeping supervisor. 5. Work order notebooks are available at each nurse□s station for staff members to complete if a resident□s light cord needs to be repaired. 6. Random weekly light cord audits and audits of the checklists will be completed by an administrative staff member and/or Maintenance Supervisor. The audits will continue weekly for a minimum of four weeks or longer until substantial compliance has been achieved and maintained as determined by the Quality Assurance/ Performance Improvement Committee (QAPI) committee. The Director of Nursing (DON) and/or Assistant Director of Nursing will review the results of the weekly audits for any trends or patterns and report to the Administrator and QAPI committee. The QAPI committee consists of the Administrator, Director of Nursing,	

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F 558	Continued From page 3 had completed a walked through last Thursday and he did not know why he missed the broken cord for the light fixture in Resident #44's room. He indicated that there was a work order logbook in each nurse's station for nursing staff to request or report maintenance needs and he checked the logbook at least once daily. During an interview with the Director of Nursing on 05/27/21 at 3:26 PM she stated it was her expectation for all the light fixtures to be in good repair to accommodate residents' needs and preferences. During an interview with the Administrator on 05/27/21 at 3:35 PM she stated it was her expectation for all the residents to have full access and control to their light fixtures to accommodate their needs and preferences.	F 558	Medical Director, and at least 3 other staff members. The QAPI committee will review the results of the audits and direct correct action, as necessary. The QAPI committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.	
F 806 SS=D	Resident Allergies, Preferences, Substitutes CFR(s): 483.60(d)(4)(5) §483.60(d) Food and drink Each resident receives and the facility provides- §483.60(d)(4) Food that accommodates resident allergies, intolerances, and preferences; §483.60(d)(5) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice; This REQUIREMENT is not met as evidenced by: Based on observation, resident and staff interviews and record review, the facility failed to honor food preferences for 1 of 1 resident reviewed for food preferences (Resident #55).	F 806	Disclaimer: We respectfully request this plan of correction be considered our allegation of substantial compliance. Preparation and/or completion of this plan	6/21/21

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F 806	Continued From page 4 Findings included: Resident #55 was admitted to the facility on 2/20/2013. The annual minimum data set (MDS) assessment, dated 5/7/21, indicated Resident #55 was cognitively intact and required setup help only with meals. An observation on 5/25/21 at 12:10 PM revealed Resident #55 was served pinto beans, greens, chopped potatoes with the peeling and cornbread. The tray card on the meal tray stated, "No Greens" and revealed a dislike for potatoes with the peeling. An interview with Resident #55 on 05/25/21 at 12:10 PM revealed she had told the kitchen many times not to send greens and they have continued to send the greens. She also revealed she could not eat potatoes with the peelings and had requested to have potatoes without peelings. An interview with the Dietary Manager on 05/25/21 at 2:29 PM revealed when Resident #55 reported her dislike for greens and potatoes with the peeling, she visited with her and discussed her request for no greens and her dislike of potatoes with the peelings. The food items were recorded and were displayed on the tray cards, which were printed out and placed on every meal tray. The Dietary Manager stated Resident #55's tray card revealed she did not want greens or potatoes with the peeling. On the serving line, the tray cards were placed between the cook and the aide, so both could see them. The cook plated the food and the aide added condiments, drinks, desserts and supplements to the meal tray. Both the cook and the aide should have caught that	F 806	of correction in general, or any corrective action set forth, herein, in particular, does not constitute an admission of agreement by Mountain View Manor of the conclusions set forth in the Statement of Deficiencies (Form 2567). The Plan of Correction and specific correction action are prepared and/or executed solely as a provision of Federal and/or State law. Food preferences will be honored for Resident # 55. All residents with specific food preferences have the potential to be affected by the same deficient practice. The Dietary Manager and/or designee will interview current residents to determine if they have experienced food preferences not being honored, update the resident preferences as necessary on the tray card, and honor the resident□s food preferences going forward. The legal healthcare representative/responsible party will be interviewed if the resident is unable to be interviewed. The interviews will be completed by June 21, 2021. 1. The Director of Nursing (DON) or other Registered Nurse will provide education to the nursing staff on honoring preferences, the need to read tray cards when delivering meal trays and the need to offer an alternative if a resident receives a food that they prefer not to eat. A posttest will be given to assess learning and promote competency. A score on the post test of 80 or above will be considered passing. The education will be completed by June	

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F 806	Continued From page 5 greens and potatoes with skins were plated for Resident #55 and provided a substitute for the greens and the potatoes with the peelings. An interview with the Administrator on 05/28/21 at 11:38 AM revealed the resident's dislikes should have been honored. The tray line server was responsible for reading the tray card when plating the food. The aide on the serving line was the backup and should have caught the error and a substitution for the greens and the potatoes should have been offered.	F 806	21, 2021. 2. The Dietary Manager or Assistant Dietary Manager will provide education to the dietary staff on the importance of honoring dietary preferences and reading the tray cards when preparing the meals. A posttest will be given to assess learning and promote competency. A score of 80 or above on the post test will be considered passing. The education will be completed by June 21, 2021. 3. New employees in the nursing and dietary departments will be educated during the initial orientation period to the facility on the importance of honoring resident□s preferences related to meal services and the importance of reading the tray cards. 4. The tray card system has been updated to allow dietary staff to print resident dislikes according to each specific meal. 5. The tray card, including the resident□s preferences, will be read and the meal prepared by the cook. The meal tray will then be passed to the dietary aide where the tray card will be read, drinks added, and preferences verified. The meal tray will then be delivered by the nursing staff where the final check of preferences will be verified prior to set up of the tray. 6. Random weekly audits on honoring resident meal preferences will be completed by a Registered Nurse by checking the tray cart to see that preferences were honored. The audits by the Registered Nurse will continue weekly for a minimum of four weeks or longer until substantial compliance has	

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F 806	Continued From page 6	F 806	been achieved and maintained as determined by the QAPI Committee. The Director of Nursing (DON) and/or Assistant Director of Nursing will review the results of the weekly audits for any trends or patterns and report to the Administrator and QAPI committee. The QAPI committee consists of the Administrator, Director of Nursing, Medical Director, and at least 3 other staff members. The QAPI committee will review the results of the audits and direct correct action, as necessary. The QAPI committee may approve changes in the frequency of the audits and/or discontinue the audits once the new system has been deemed effective to maintain substantial compliance.	