STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING ____________________________
B. WING ____________________________

(C) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:
345193

(X3) DATE SURVEY COMPLETED
C 10/27/2015

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

F 000  INITIAL COMMENTS

No deficiencies were cited as a result of the complaint investigation Event ID # EX1311.

F 000

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

Electronically Signed

11/02/2015

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.