PRINTED: 05/10/2016 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 COMF	SURVEY
		245402	a www				С
345193			B. WING _			04/	14/2016
NAME OF PR	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N VIEW MANOD NUDGIA	IC CE		41	10 BUCKNER BRANCH ROAD		
WOONTAI	MOUNTAIN VIEW MANOR NURSING CE			В	RYSON CITY, NC 28713		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG			PREFIX TAG	REFIX (EACH CORRECTIVE ACTION SHOULD			COMPLETION DATE
F 000	INITIAL COMMENTS	;	F	000			
F 226			E	226			5/11/16
SS=D	ABUSE/NEGLECT, E		F 22				3/11/10
	policies and procedur	t, and abuse of residents					
	by: Based on record revinterview, the facility of abuse policy that the notified immediately of suspected incidences follow their abuse policy reporting and thoroug allegation from a resicontact with a staff m (Resident #117). The findings included A policy titled "Abuse dated 04/10/2001 and the Administrator in 2 "Employees having k abuse, neglect or exp	dent of inappropriate sexual ember for 1 of 1 residents. I: , Neglect and Exploit Policy" d signed as last reviewed by			This Plan of Correction is being submitted pursuant to the applicable Federal and State regulation. Nothing contained herein shall be construed as admission that the facility violated any Federal or State regulation or failed to follow any applicable standard of care. Resident #117 was discharged on April 14, 2016. No further corrective action of be taken. Reports of any allegation or suspicion of abuse, neglect and/or exploitation received during the last 30 days will be audited for proper reporting and thorou investigation. Any discrepancies identified will receive corrective action immediates	can of gh ied	
		ner absence to their nurse. When an incident or abuse is reported, the			or as soon as practicable. On April 14, 2016, nurse #3 was		
ABORATORY	DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATURE			TITLE		(X6) DATE

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

Electronically Signed 05/05/2016 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 AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345193	B. WING	B. WING		C 04/44/2046	
NAME OF DE	ROVIDER OR SUPPLIER	3-3133		STREET ADDRESS, CITY, STATE, ZIP CO		4/14/2016	
NAIVIE OF FI	NOVIDER OR SUFFLIER				DE		
MOUNTAI	N VIEW MANOR NURSIN	NG CE		410 BUCKNER BRANCH ROAD			
			BRYSON CITY, NC 28713				
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO TH DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	Continued From page	e 1	F 22	26			
	Administrator will appoint a representative to investigate the incident. The representative's investigation shall consist of: interviews with the resident's roommate, family members and visitors."			counseled by the Director of (DON) to report any suspect abuse, neglect, or exploitation resident to the Administrator	ed incident of on of a immediately.		
	02/26/16 with diagno injury, spina bifida, m generalized anxiety opersonality disorder. Set (MDS) assessmeresident was cognitive.	dmitted to the facility on ses including spinal cord lajor depressive disorder, disorder, panic disorder and An Admission Minimum Data lent dated 03/03/16 indicated lely intact for daily decision dicated she had rejection of of observation period.		On May 9, 2016, the DON at Services Director (SSD) will on the facility s abuse, neglexploitation policy and proceincluding immediate reporting Administrator and thorough in The inservice will be videotate viewing by staff unable to att 9, 2016, and staff not attenditions.	inservice staff ect and dures g to the nvestigation. ped for later end on May ing on May 9,		
	On 04/11/16 at 11:40 AM Resident #117 requested to speak to a member of the survey team. Resident #117 had multiple complaints about her care at the facility and stated Nurse #2 fondled her breasts while doing her admission nursing assessment on February 29, 2016, the day she was admitted (Resident was admitted 02/26/16). Resident #117 stated she told him she wasn't comfortable with what he was doing and asked him why he was doing that. Resident #117's speech was pressured and rapid during the conversation and she moved quickly from one area of concern to another. Her affect remained the same throughout the conversation and she didn't exhibit any emotional distress when talking about her breasts being fondled. When asked if any other staff member was present with the nurse, the resident stated she couldn't remember.			On May 11, 2016, the State will inservice staff on the poliprocedures for reporting and any suspected or alleged ab or exploitation of a resident. a posttest to verify understar subject matter. The Administ Personnel Manager will concure to determine that all staff have ducation on the facility and exploitation education at May 9, 2016, inservice, the Minservice or both. Staff identicated at least one of the not be allowed to work until the completed a makeup inservice facility abuse, neglect and policy and procedures.	icy and I investigating use, neglect, Staff will take nding of the strator and/or duct an audit we received buse, neglect t either the May 11, 2016, ified as not inservices will they have ce on the		
	stated she told two N #6) on the evening sl	eported the incident, she lurse Aides (NA # 5 and NA hift of 04/03/16.		The facility□s Abuse, Negled Exploitation Policy and Proceupdated and approved by the Administrator on May 3, 201	edures was e		

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		345193	B. WING _			04/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
		awa a=		410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NUR	SING CE		BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFIX TAG	PROVIDER'S PLAN OF CC (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THI DEFICIENCY)	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	Continued From page	age 2	F 2	226			
	investigation of Re 04/04/16. There was Administrator or Di	d the facility initiated an sident #117's allegations on as no indication that the SSD, irector of Nursing (DON) were allegation until 04/04/16.		revised policy and procedure neglect and exploitation will the manual maintained at each restation.	oe in a		
	made aware of the allegation until 04/04/16. Review of the facility's documentation did not indicate that Resident #117's roommate, any other residents, family members or visitors were interviewed, as the policy indicated would be done. An interview with NA # 5 on 04/12/16 at 2:48 PM revealed she ordinarily worked the 7:00 AM - 3:00 PM shift but was working 04/03/16 on the 3:00 PM - 11:00 PM shift. NA # 5 stated she was assisting NA # 6 with providing care to Resident # 117 on 04/03/16 when Resident # 117 reported that Nurse #2 fondled her breasts when he was doing her admission assessment. NA # 5 stated Resident # 117 often talked about other residents and staff in a sexual manner. NA # 5 stated Resident # 117 had made sexual overtures to male and female staff so all care was provided by 2 staff members. NA # 5 stated she asked Resident # 117 if she was scared and the resident laughed and said she thought Nurse # 2 was 'hot'. When asked if she reported the allegations made by Resident # 117, NA # 5 stated she didn't report the allegations but her co-worker NA # 6 reported it to Nurse # 3.			Newly hired employees will r training on the facility s abuse and exploitation policy and p including reporting time fram for a thorough investigation or orientation at the time of hire	se, neglect rocedures es and need during		
				Allegations and/or suspicions neglect and/or exploitation w immediately reported to the A The Administrator will be resussign a staff member or me investigate any allegations or of abuse, neglect and/or expthorough investigation, includinterviews of appropriate per completed within 5 working of Administrator will monitor the and review the outcome of the investigation including directive reporting and corrective action. The Director of Social Service any report of abuse, neglect, exploitation of a resident to measurement.	s of abuse, ill be Administrator. ponsible to mbers to r suspicions loitation. A ding sons, will be days. The e progress ne ing any on necessary.		
	revealed she regul 11:00 PM shift and provide care for Re Resident # 117 oft desires and fantas care. NA # 6 state	NA # 6 on 04/13/16 at 3:40 PM arly worked the 3:00 PM - was frequently assigned to esident # 117. NA # 6 stated en talked about sexual activity, ies when staff were providing d the first time Resident # 117 er about Nurse # 2 was on		the facilities policy and proce abuse, neglect, and exploitat followed; the SSD will review for a minimum of 4 weeks or substantial compliance has be achieved and maintained as by the Quality Assurance (Quality Assurance)	edures for tion are being the reports until been determined A)		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING				(X3) DATE SURVEY COMPLETED	
					C 04/14/2016		
	NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSING CE			STREET ADDRESS, CITY, STATE, ZIP CO 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG			ID PREFIX TAG	PROVIDER'S PLAN OF C (EACH CORRECTIVE ACTIC CROSS-REFERENCED TO TH DEFICIENCY	ON SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE	
F 226	were getting the resident reher breasts when he assessment. NA # 6 had not previously m staff and had not made staff since that night, the allegation to Nursurse on 04/03/16. Note that niterview with NA revealed her to leav NA # 6 stated she did anyone else. An interview with NA revealed she was regarded she was regarded she was regarded for Resident # 1 present with Nurse # admission nursing as 117. NA # 7 reported moving the resident accould see her skin and any skin breakdown addidn't recall Nurse # 2 any time during the among the past facility policy was for abuse, she stated shoon right away. Whe allegation made by R # 2, Nurse # 3 stated the allegation on 04/0 PM shift. When asket that time, Nurse # 3 stated that time t	PM when she and NA # 5 dent ready for bed. NA # 6 sported that Nurse #2 fondled was doing her admission stated that Resident # 117 ade any allegations against NA # 6 stated she reported se # 3, who was the charge IA # 6 stated Nurse # 3 e a note on the DON's door. In't report the allegation to # 7 on 04/13/16 at 4:04 PM gularly assigned to provide 17. NA # 7 stated she was 2 when he did the seessment for Resident # that she and NA # 8 were and her clothing so Nurse # 2 and document her tattoos and or bruises. NA # 7 stated she 2 touching Resident # 117 at assessment. 3/16 at 5:36 PM with Nurse # eceived training on abuse fientation and during a year. When asked what the reporting allegations of e was supposed to notify the	F 22	brought to the attention of the Administrator for corrective a as practicable. The Administrator will monitor compliance. The audits by the Services Director will be revious QA Committee and any trend patterns identified will receivaction.	or for ne Social lewed by the ds and/or		

` '		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	TIPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345193	B. WING _			C 04/14/2016
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP OF 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	CODE	0-4/1-4/2010
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		ID PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE
F 226	Continued From pag	e 4	F 2	226		
		ON, Nurse # 3 stated she ce in Resident # 117's				
	SSD revealed she was Resident # 117's alle 04/04/16 about 10:00 investigation, the SS Resident # 117 and sprovide care for her. 117 didn't have a roo alleged incident. The interview any other rethink any other reside knowledge about the stated she wasn't aw	4/16 at 1:52 PM with the as first made aware of gation against Nurse # 2 on 0 AM. When asked about the D stated she interviewed staff who were assigned to The SSD stated Resident # Immate at the time of the SSD stated she didn't esidents because she didn't ents would have any alleged incident. The SSD trare that the facility's Abuse in residents should be				
	DON revealed she w Resident # 117's alle 04/04/16 when Nurse stated she would hav her as soon as the al An interview on 04/14 Administrator about I were to report allega	4/16 at 2:28 PM with the nis expectation for when staff tions or suspicions of abuse				
	He stated he expected supervisor to notify e SSD right away. When expected Nurse # 3 to 04/03/16, he stated he	edge of abuse immediately. ed the charge nurse or either himself, the DON or the en asked if would have to call on Sunday evening, he would have expected regardless of the time or day				

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NAME OF P	ROVIDER OR SUPPLIER	0.0.00	;	STREET ADDRESS, CITY, STATE, ZIP CODE	04/14/2016		
MOUNTAI	N VIEW MANOR NURSI	NG CE		BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		(EACH DEFICIENCY MUST BE PRECEDED BY FULL PRE		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOUL CROSS-REFERENCED TO THE APPROF	D BE COMPLETION
F 312 SS=E	483.25(a)(3) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal and oral hygiene.		F 312		5/9/16		
	by: Based on record revinterviews the facility grooming, fingernail asampled residents reliving care to depend 30, 12, 2, 81, and 10 The findings included 1. Resident #30 was 11/21/08 with diagno intellectual difficulties impairment, and demmost recent quarterly dated 01/14/16 revea cognitively impaired askills and required exactivities of daily livin dressing, personal hy with bathing. No behwere coded during the period. The current care plar revealed Resident #3 extensive assistance dementia, and visual	admitted to the facility on sees which included s, neuralgia, visual sentia without behaviors. The wide Minimum Data Set (MDS) aled the resident was for daily decision making stensive assistance with all g (ADL) including eating, which will be aviors of rejection of care see quarterly MDS look back in last reviewed 04/11/16		On April 14, 2016, resident #30's na were trimmed and cleaned and the chipped nail polish was removed by Certified Nursing Assistant (CNA). Chairs were removed and clothes were turned the correct way on Resident a CNA. Resident #30's face and har were cleansed by a CNA during care April 14, 2016. Resident #30's will continue to receive assistance with care, shaving, facial cleansing and dressing from nursing staff on a dail more frequent basis as needed. On April 14, 2016, resident #12's na were trimmed and cleaned by a CNA resident's face and hands were clea by a CNA and the CNA assisted Ref # 12 to put on clean clothing on April 2016. Resident # 12 will continue to receive assistance with nail care and facial cleansing by nursing staff on a or more frequent basis as needed. On April 13, 2016, resident #2's sho was given by a CNA. Resident # 2 v shaved and nails were trimmed and cleaned by a CNA on April 13, 2016	a Chin re #30 by nds e on nail y or iils A. The insed sident iil 14, d a daily ower vas		

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		345193	B. WING		C 04/14/2016		
NAME OF PE	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 0-7	714/2010	
	10 7.52.1 0.1 00. 1 2.2.1			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 .SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDER OF THE APPROPRIES OF THE	ILD BE	(X5) COMPLETION DATE	
F 312	Continued From page	e 6	F 31	2			
	interventions docume	nted limited to extensive		Resident # 2 will continue to receive	re		
		imited to total assist with		assistance with nail care, shaving	and		
	•	personal hygiene. Further		facial cleansing by nursing staff on			
		provide Resident #30 with		or more frequent basis as needed.			
		be neat, clean and free of					
		propriately for the season.		On April 13, 2016, resident #81 wa	S		
		, .p		shaved by a CNA. Resident #81's			
	A review of the facility	's weekly shower schedule		were trimmed and cleaned by a CN			
indicated Resident #30 was scheduled for		•		Resident #81 will continue to recei			
	showers on Monday a	and Thursday during the day		assistance with shaving, nail care	and		
	shift.	, ,		facial cleansing by nursing staff on			
				or more frequent basis as needed.	·		
	Review of the Physician Progress notes dated						
	03/08/16 revealed Re	sident #30 had dementia,		On April 13, 2016, resident #100 w	as		
	visual impairment and	d mental retardation and was		shaved and nails were trimmed an	d		
	able to ambulate in fa	cility but had noted		cleaned by a CNA. Resident #100	will		
		functional abilities. The		continue to receive assistance with			
	Physician assessmen			shaving and nail care by nursing st			
		ntia required significant		daily or more frequent basis as nee	eded.		
		t and frequent monitoring.					
	The note further reve			On April 14, 2016, the Director of N			
		ogressive cognitive and		counseled nursing assistant #1 and			
	functional decline.			proper grooming, fingernail care, a	nd		
	On 04/44/40 at 40:07	DM Decident #20 wee		shaving of dependent residents.			
		PM Resident #30 was		Numerical staff conducted valued of	-11 -6		
		on her own into the activity		Nursing staff conducted rounds of other facility residents on April 14,			
		dementia unit wearing a red					
		ide out and backwards with or showing, purple pants,		to identify residents in need of sharnail care, facial cleansing and/or of			
		ound the mouth had what		hygiene measures; any discrepand			
		or something white in color at		identified during the rounds receive			
		nger nails on both hands		corrective action by a CNA.	,u		
		ed edges, tan substance		Someonive donori by a Olyn.			
		f old pink colored nail polish		On May 9, 2016, the Director of Nu	ırsina		
		chin was observed with		will inservice all nursing assistants			
	•	hin hairs, about 1/2 to 1 inch		proper grooming, fingernail care, a			
	long.	Hand, about 1/2 to 1 mon		shaving of will take a posttest to ve			
	.~9.			understanding of the subject. The			
	On 04/11/16 at 2:32 F	PM Resident #30 was		inservice will be videotaped and a	makeup		

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		345193	B. WING			С	
		345193	B. WING			04/14/2016	
NAME OF PI	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COI	DE		
MOUNTAI	N VIEW MANOR NURSI	NG CF		410 BUCKNER BRANCH ROAD			
				BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		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	Continued From pag	e 7	F 31	12			
	observed with her sh	irt turned the right way but		inservice provided to nursing	staff not		
		outh remained with the white		attending on May 9, 2016.	•		
	substance, her nails	remained unchanged and					
	the chin hairs remain	ned as observed earlier.		Newly hired nursing staff will	receive		
				training on proper grooming	including nail		
		AM Resident #30 was		care and shaving during the	orientation		
		the halls, wearing a clean		period.			
	·	ng with staff and other					
		#30 was observed to remain		The facility's policy and proce			
	· ·	ean finger nails with old		assistance with activities of o			
		the 1/2 to 1 inch long hairs on		(ADLs) will be updated to pro			
	her chin.			specific guidance and direction	_		
	Op 04/12/16 at 4:25	PM Resident #30 was		staff. Copies will be maintain policies and procedures mar			
		e long grey chin hairs and		nurses' stations.	idais at the		
		nce staining all around her		naises stations.			
		, her finger nails remained		Licensed nurses will be resp	onsible during		
	1	s observations with brown		their shift of duty to monitor t			
		nails, untrimmed and rough		under their direct supervision			
		Director was observed to		receiving timely and appropr			
	come into the room a	and offered snacks and		assistance with ADLs. Any d	iscrepancies		
	drinks of little cakes	and lemonade. Resident #30		identified will receive immedi	ate corrective		
	took the offered snac started to eat it.	ck cake with her hands and		action as soon as practicable	Э.		
				A random audit of a minimun	n of 15		
	On 04/13/16 at 8:43	AM Resident #30 was		residents will be conducted b	y the DON,		
	observed in the small	Il dining room on secured unit		ADON, or Nsg. Supervisor of			
		sident #30's fingernails		appearance and hygiene inc	luding nail		
		, unclean and with old nail		care, shaving, clothing appro	•		
	·	was observed with her		and overall cleanliness week	-		
		ner on a tray eating with a		minimum of 4 weeks or longe			
		nd and her left hand and		substantial compliance is acl			
		atmeal. No staff were		maintained as approved by t			
		ig room supervising the		Committee. Any discrepancie			
	residents' breakfast ı	meai.		during the audit will receive of			
	During an abassistic	on on 04/12/16 at 0:45 AM		action as soon as practicable	ð.		
		on on 04/13/16 at 9:15 AM up to the surveyor and placed		The Director of Nursing will r	monitor for		
		vevor's hand and wrist. Both		compliance. The QA Commit			

		I DENTIFICATION NUMBER:		LE CONSTRUCTION	I ' '	(X3) DATE SURVEY COMPLETED	
		345193	B. WING			C / 14/2016	
NAME OF PI	ROVIDER OR SUPPLIER	0.0.00		STREET ADDRESS, CITY, STATE, ZIP CODE	04	/14/2016	
				410 BUCKNER BRANCH ROAD			
MOUNTAIN VIEW MANOR NURSING CE			BRYSON CITY, NC 28713				
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F 312	Continued From page	e 8	F 31	2			
	substance. On 04/13/16 at 11:04 #1, who provided care interviewed. NA #1 st limited to extensive a including showers, gr and personal hygiene Resident #30 receive Monday and Thursda hair washing, shaving needs were found in nurses' station. NA # and shaving were als needed. NA #1 furthe was normally very co required multiple atte NA #1 revealed she h	y and that showers included and nail care and resident's the care plan book at the explained that nail care o provided daily and as explained Resident #30 operative but sometimes mpts to complete nail care. The provided the prior Monday not provide nail care or		review the audit findings and mon any trends or patterns. The QA Committee will direct and institute corrective action with oversight fro Director of Nursing as necessary trends and/or patterns are identified.	e om the when		
	On 04/13/16 at 09:15 care for Resident #30 rassistance with all AL grooming, eating, dre NA #2 further stated I showers on Mondays showers and groomin shaving and nail care found in the care plar NA #2 explained that also provided daily ar explained Resident # cooperative but some attempts to complete she had worked the p	AM NA #2, who provided b, was interviewed. NA #2 required limited to extensive bL including showers, ssing and personal hygiene. Resident #30 received her and Thursdays and that ag included hair washing, and resident's needs were a book at the nurses' station. nail care and shaving were and as needed. NA #2 further					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			C 4/14/2016
	ROVIDER OR SUPPLIER N VIEW MANOR NURS	ING CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1	4142010
(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 COR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 312	further revealed Relunch and she, NA a #30's face or hands make it a normal ro or hands after meal On 04/13/16 at 1:40 (DON) was interview residents' care need book at the nurses' stated the residents care unit received the shower days which care and required docare, shaving and pstated it was her exishaving were compfrequently between The DON stated that for nail care and keneat, shaved daily, and cleaned, faces appropriately. On 04/14/16 at 3:08 interviewed. The Adshould be clean and Administrator verificates in the should be shaved and cleaned appropriately. 2. Resident #12 wa 12/21/14 with diagnal lack of coordination most recent annual dated 01/25/16 reveals.	for Resident #30. NA #2 sident #30 had spaghetti for #2 did not wash Resident after lunch and does not utine to wash residents' face	F3	12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			C 04/14/2016	
	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 BY 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 312	Continued From pag	e 10	F3	12			
	with all activities of d	uired extensive assistance aily living (ADL) including d total assistance with					
	revealed Resident #' assistance with ADL dementia. The goal r #12 to be clean, nea dressed appropriatel up in her Geri chair of	n last reviewed on 02/04/16 12 required extensive to total due to diagnosis of ecorded was for Resident and free of odors and y. The interventions included laily and required extensive th all ADL except will feed					
	indicated Resident #	y's weekly shower schedule 12 was scheduled for and Thursday on the 3-11					
	Resident #12 was up combed and all her f including the thumb v + long with jagged and	n on 04/11/16 at 2:34 PM in the Geri chair, hair was ingernails on both hands were approximately 1/2 inch and pointed edges and a noe under all the nails.					
	observed in dining all in a light blue sweat hands including the tapproximately 1/2 inc	AM Resident #12 was rea in the Geri chair dressed shirt. Her fingernails on both humb were observed ch+ long with jagged and brownish tan substance					
	observed in her roon light blue sweat shirt	PM Resident #12 was n in the Geri chair, wearing a that had reddish brown front of it and reddish brown					

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 04/14/2016	
	ROVIDER OR SUPPLIER	IG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	<u>'</u>	04142010	
(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 COR ((EACH CORRECTIVE ACTION : CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 312	bottom lips and stained first, second and third Resident #12's finger untrimmed with brown and with the additional around the cuticles. On 04/13/16 at 8:51 / observed in her room breakfast tray in front fingernails were observed in her room breakf	erved around her top and ed around the cuticles of her I fingers of her right hand. nails remained unchanged, in substance under the nails al reddish brown stains AM Resident #12 was in the Geri chair with her of her having breakfast. Her rived unchanged on both numb and were the Hong with jagged and brownish tan substance esident #12 was observed ght hand dipping into her three fingers and thumb of atmeal. She then placed imeal on them into her AM Nursing Assistant (NA) er for Resident #12, was	F3				
	extensive assistance showers, grooming, or hygiene. NA #1 further received her showers during evening shift a hair washing, shaving needs were found in nurses' station. NA #1 was provided daily ar explained Resident #1 multiple attempts to of #1 revealed she had	ated Resident #12 required with all ADL including Iressing and personal er stated Resident #12 on Mondays and Thursdays and that showers included g and nail care and resident's the care plan book at the 1 explained that nail care and as needed. NA #1 further 12 sometimes required omplete finger nail care. NA worked the prior Monday not provide finger nail care					

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE SURVEY COMPLETED	
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NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	ODE		
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WIOUNTAI	N VIEW WANCK NUP	KSING CE		BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICI	Y STATEMENT OF DEFICIENCIES ENCY MUST BE PRECEDED BY FULL OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
F 312	Continued From p	page 12	F3	312			
	care for Resident # assistance with al grooming and per stated Resident # Mondays and Thut that showers inclunail care and resident explained that naineeded. NA #2 fur sometimes require complete nail care worked Monday, Thursday. NA #2 care for Resident Resident #12 had not wash her face after lunch and do to wash residents #2 verified that Resonly recently start. On 04/13/16 at 1: (DON) was interviresidents' care ne book at the nurses stated the resident care unit received shower days which care and required care, shaving and stated it was her eshaving were comfrequently between	2:15 AM NA #2, who provided #12, was interviewed. NA #2 12 required extensive I ADL including showers, sonal hygiene. NA #2 further 12 received her showers on instalays during evenings and ided hair washing, shaving and ided ided ided in the explained Resident #12 I care was provided daily and as of a multiple attempts to idea. NA #2 revealed she had included she did not provide nail if a normal routine idea in the care plants in the idea in the care plants in the included shaving and in the included shaving and in included shaving and in included shaving and in included shaving and in included with showers and more in showers if they were dirty, that the NA's were responsible					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED	
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	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1 0	4/14/2016
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOUNDERSON OF THE APPROPRIES OF T	ILD BE	(X5) COMPLETION DATE
F 312	neat, shaved daily, keep and cleaned, faces were appropriately. On 04/14/16 at 3:08 interviewed. The Adishould be clean and Administrator verifier residents to be shave trimmed and cleaned appropriately. 3. Resident # 2 was 01/22/08 with diagnod dementia, history of paralysis, and gait in quarterly Minimum D02/18/16 revealed the impaired for daily derequired extensive adaily living (ADL) incompared for daily derequired extensive are plan followed assistance with ADL and paralysis related care plan goal was for cleanliness, be neat ADL care plan include extensive assistance toileting, personal hyprovide showers as	PM the Administrator was ministrator stated all residents well groomed. The dit was his expectation for all ed daily and have their nails d, faces washed and dressed admitted to the facility on oses which included stroke with right sided astability. The most recent oata Set (MDS) dated are resident was cognitively cision making skills and ssistance with all activities of cluding personal hygiene and bathing. No behaviors of the coded during the quarterly od.	F 3	12		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
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(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	Continued From pag		F3	12		
	Resident #2 was in the was observed with 1 fingernails of all finger observed very long a inches long with jagg were observed with a under the nails. On 04/12/16 at 9:34 observed in bed with Resident #2's finger same as the previous The fingernails of all were observed very inches long with jagg were observed with a	en on 04/11/16 at 2:38 PM eled watching TV. Resident #2 /2 inch long chin hairs. The ers on both hands were approximately 1/2 to 3/4 led edges. All the fingernails a brown and tan substance AM Resident #2 was 1/2 inch long chin hairs. Inails were observed the as observation on 04/11/16. Ithe fingers on both hands long approximately 1/2 to 3/4 led edges. All the fingernails a brown and tan substance				
	Resident #2 was in h long chin hairs. Residents and 04/11/16 and 04/2 the fingers on both h long approximately 1 jagged edges. All the with a brown and tand During an observation Resident #2 was in h long chin hairs. Residents and the same at The fingernails of all resident's hands wer approximately 1/2 to	on on 04/12/16 at 4:23 PM his wheel chair with 1/2 inch dent #2's fingernails were as the previous observations 12/16. The fingernails of all ands were observed very 1/2 to 3/4 inches long with a fingernails were observed substance under the nails. On on 04/13/16 at 8:43 AM his wheel chair with 1/2 inches dent #2's fingernails were as the previous observation. The fingers on both of the e observed very long 3/4 inches long with jagged halls were observed with a series were				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: (X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED					
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F 312	Continued From page		F	312			
	#1, who provided carrinterviewed. NA #1 st to be in his room, fed extensive assistance showers, grooming, shygiene. NA #1 furthereceived his showers showers and grooming shaving and nail care found in the care plan NA #1 explained that also provided daily arexplained Resident # multiple attempts to care. NA #1 revealed Monday and Tuesday care or shaving for Resident #2, stated Resident #2, stated Resident #2 pred himself, and requivith all ADL including shaving and personal stated Resident #2 rewednesdays and that included hair washing resident's needs were at the nurses' station. care and shaving werneeded. NA #2 furthere sometimes required recomplete shaving and she had worked the provided she did not prevealed she did not prevent the sometimes required recomplete shaving and she had worked the prevealed she did not prevea	with all ADL including having daily, and personal er stated Resident #2 on Wednesdays and that g included hair washing, and resident's needs were book at the nurses' station. nail care and shaving were d as needed. NA #1 further c sometimes required omplete shaving and nail she had worked the prior and did not provide nail esident #2. AM NA #2, who provided was interviewed. NA #2 eferred to be in his room, red extensive assistance showers, grooming, daily hygiene. NA #2 further ceived his showers on t showers and grooming g, shaving and nail care and e found in the care plan book NA #2 explained that nail e also provided daily and as r explained Resident #2 nultiple attempts to d nail care. NA #2 revealed rior Monday, Tuesday,					

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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F 312	(DON) was interview residents' care need book at the nurses' stated the residents care unit received the shower days which is care and required days are and was here are shaving were complified to the DON stated that for nail care and keen neat. On 04/14/16 at 3:08 interviewed. The Ad should be clean and Administrator further come to get him or the assist in encouraging showers, shaving are Administrator reveal month since they can all residents to be nails trimmed and clear and	PM the Director of Nursing yed. The DON stated the is were listed in the care plan station. The DON further on the secured demential teir showers on scheduled included shaving and nail teir showers to provide nail tersonal hygiene. The DON poectation that nail care and teted with showers and more showers if they were dirty. It the NA's were responsible to the NA	F 312				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			(X2) MULTIP A. BUILDING	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
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F 312	living (ADL) including assistance with bathi of care were coded d back period. The current care plan revealed Resident #8 assistance with ADL dementia, depression goals recorded includican, neat, free of or appropriately. The infine Resident #81 require personal hygiene includicated Resident #8 showers on Monday shift. During an observation Resident #81 was obgrowth of beard stuble During an observation Resident #81 was agheavy growth of beard than on 04/11/16. During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obhave a heavy growth During an observation Resident #81 was obtax and provided that the provided resident #81 was obtax and provided the provided resident #81 was obtax and provided reside	with all activities of daily personal hygiene and total ng. No behaviors or rejection during the quarterly MDS look in last reviewed 02/25/16 at required extensive due to diagnosis of an and mental disorder. The ded Resident #81 will be dors and dressed terventions included dextensive assistance with luding shaving and bathing. By's weekly shower schedule at was scheduled for and Thursday on the day on on 04/11/16 at 2:50 PM asserved to have a heavy ble. In on 04/12/16 at 9:25 AM and observed to have a red stubble that was longer on on 04/12/16 at 4:31 PM asserved in the activity room to of beard stubble. In on 04/13/16 at 8:43 AM asserved in the dining room of beard stubble that was	F 31	2		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED C	
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F 312	#1, who provided interviewed. NA # extensive assistar showers, groomin further stated Reson Mondays and and that showers and nail care and the care plan bool explained that nai provided daily and explained Resider with his grooming she had worked the Tuesday and did resident # assistance with al grooming and per stated Resident # Mondays and Thut that showers and washing, shaving needs were found nurses' station. Not also provided daily explained Resider with his grooming she had worked the Wednesday of this she did not provided Wednesday afterron 0n 04/13/16 at 1:40 mondays and Thut that showers and washing, shaving needs were found nurses' station. Not also provided daily explained Resider with his grooming she had worked the Wednesday of this she did not provided Wednesday afterron 0n 04/13/16 at 1:40 mondays and the care to Resider with his grooming she had worked the worked	:04 AM Nursing Assistant (NA) care to Resident #81, was 1 stated Resident #81 required nee with all ADL including g and personal hygiene. NA #1 ident #81 received his showers Thursdays during the day shift included hair washing, shaving resident's needs were found in k at the nurses' station. NA #1 I care and shaving were also d as needed. NA #1 further nt #81 was normally cooperative and showers. NA #1 revealed ne previous Monday and not provide shaving for Resident extensive I ADL including showers, sonal hygiene. NA #2 further 81 received his showers on ursdays during the day shift and grooming included hair and nail care and resident's 1 in the care plan book at the A #2 explained that shaving was y and as needed. NA #2 further nt #81 was normally cooperative and showers. NA #2 revealed ne prior Monday, Tuesday, and is week. NA #2 further revealed e shaving for Resident #81 until	F3	312			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:				' '	(X3) DATE SURVEY COMPLETED		
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	NG CE		STREET ADDRESS, CITY, STATE, ZIP COD 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	E	04/14/2010		
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residents care needs book at the nurses's stated the residents of care unit received the shower days which in care and required da care, shaving and pestated it was her exp shaving were complefrequently between some The DON stated that for shaving and keep On 04/14/16 at 3:08 interviewed. The Administrator verified residents to be shave trimmed and cleaned appropriately. 5. Resident #100 was 01/13/16 and readmind diagnoses which include pression and anxied Admission Minimum 01/20/16 revealed the cognitively impaired to skills and required exactivities of daily living hygiene and total assistence and total assi	were listed in the care plan tation. The DON further on the secured dementia eir showers on scheduled included shaving and nail illy attempts to provide nail resonal hygiene. The DON ectation that nail care and eted with showers and more howers if they were dirty. The NA's were responsible ing residents clean and neat. PM the Administrator was ministrator stated all residents well groomed. The let was his expectation for all ed daily, have their nails let, faces washed and dressed admitted to the facility on ted on 02/24/16 with uded Alzheimer's dementia, ety. The most recent Data Set (MDS) dated a resident was severely for daily decision making tensive assistance with all g (ADL) including personal sistance with bathing. No not care were coded on the back period.	F3	312				
dementia and cogniti	ve impairment. The goal						
	ROVIDER OR SUPPLIER N VIEW MANOR NURSIT SUMMARY ST (EACH DEFICIENCE REGULATORY OR Continued From page residents care needs book at the nurses' s stated the residents of care unit received the shower days which in care and required da care, shaving and pe stated it was her exp shaving were comple frequently between s The DON stated that for shaving and keep On 04/14/16 at 3:08 interviewed. The Adm should be clean and Administrator verified residents to be shave trimmed and cleaned appropriately. 5. Resident #100 was 01/13/16 and readmi diagnoses which incl depression and anxie Admission Minimum 01/20/16 revealed the cognitively impaired is skills and required ex activities of daily livin hygiene and total ass behaviors of rejection MDS during the look The current care plar revealed Resident #1 total assistance with dementia and cogniti	A 345193 ROVIDER OR SUPPLIER N VIEW MANOR NURSING CE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 residents care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for shaving and keeping residents clean and neat. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed	ROVIDER OR SUPPLIER N VIEW MANOR NURSING CE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 residents care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care, shaving and personal hygiene. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NA's were responsible for shaving and keeping residents clean and neat. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed appropriately. 5. Resident #100 was admitted to the facility on 01/13/16 and readmitted on 02/24/16 with diagnoses which included Alzheimer's dementia, depression and anxiety. The most recent Admission Minimum Data Set (MDS) dated 01/20/16 revealed the resident was severely cognitively impaired for daily decision making skills and required extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing. No behaviors of rejection of care were coded on the MDS during the look back period. The current care plan last reviewed 01/28/16 revealed Resident #100 required extensive to total assistance with ADL due to diagnosis of dementia and cognitive impairment. The goal	ROUNDER OR SUPPLIER N VIEW MANOR NURSING CE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) COntinued From page 19 residents care needs were listed in the care plan book at the nurses' station. 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The most recent Admission Minimum Data Set (MDS) dated 01/20/16 revealed the resident was severely cognitively impaired for daily decision making skills and required extensive assistance with bathing. No behaviors of rejection of care were coded on the MDS during the look back period. The current care plan last reviewed 01/28/16 revealed Resident #100 required extensive to total assistance with ADL due to diagnosis of dementia and cognitive impairment. The goal	A BUILDING 345193 ROWDER OR SUPPLIER N VIEW MANOR NURSING CE SUMMANY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MIST SE PRECEDED BY FULL RESULATORY OR LSC IDENTIFYING INFORMATION) Continued From page 19 residents care needs were listed in the care plan book at the nurses' station. The DON further stated the residents on the secured dementia care unit received their showers on scheduled shower days which included shaving and nail care and required daily attempts to provide nail care and required daily attempts to provide nail care and required that has howers and more frequently between showers if they were dirty. The DON stated it was her expectation that nail care and shaving were completed with showers and more frequently between showers if they were dirty. The DON stated that the NAS were responsible for shaving and keeping residents clean and neat. On 04/14/16 at 3:08 PM the Administrator was interviewed. The Administrator stated all residents should be clean and well groomed. The Administrator verified it was his expectation for all residents to be shaved daily, have their nails trimmed and cleaned, faces washed and dressed appropriately. 5. Resident #100 was admitted to the facility on 01/13/16 and readmitted on 02/24/16 with diagnoses which included Alzheimer's dementia, depression and anxiety. The most recent Admission Minimum Data Set (MDS) dated 01/20/16 revealed the resident was severely cognitively impaired for daily decision making skills and required extensive assistance with all activities of daily living (ADL) including personal hygiene and total assistance with bathing. No behaviors of rejection of care were coded on the MDS during the look back period. The current care plan last reviewed 01/28/16 revealed Resident #100 required extensive to total assistance with ADL due to diagnosis of dementia and cognitive impairment. The goal		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G	, ,	(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			C 04/14/2016
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	·	04/14/2010
(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 CORR (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
F 312	interventions include total to extensive ass	d dressed appropriately. The d Resident #100 required	F 3	12		
	indicated Resident #	y's weekly shower schedule 100 was scheduled for s during the day shift.				
		PM Resident #100 was yy growth of beard stubble.				
	observed in the TV ro	AM Resident #100 was com with a heavy growth of as a little longer than the f 04/11/16.				
	observed in the activ	PM Resident #100 was ity room and remained vy growth of beard stubble.				
	observed sitting in th unshaved with the he	AM Resident #100 was e TV room and remained eavy growth of beard stubble thicker than the previous day				
	#1, who provided car interviewed. NA #1 s extensive assistance showers, grooming a further stated Reside showers on Tuesday showers and grooming shaving and nail care found in the care plan NA #1 explained that	AM Nursing Assistant (NA) re for Resident #100, was tated Resident #100 required with all ADL including and personal hygiene. NA #1 ant #100 received his during the day shift and that any included hair washing, and resident's needs were an book at the nurses' station.				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		L IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			C 04/1/	4/2016	
NAME OF PI	ROVIDER OR SUPPLIER		 	STREET ADDRESS, CITY, STATE, ZIP (CODE	<u> U-7/1-</u>	7/2010	
				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 PREFI) TAG	PROVIDER'S PLAN OF (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIA		(X5) COMPLETION DATE	
F 312	Continued From page	e 21	F3	312				
	explained Resident # cooperative with his g #1 revealed she had	100 was normally grooming and showers. NA						
	care for Resident #100 stated Resident #100 assistance with all AD grooming and person stated Resident #100 Tuesday during the d and grooming include nail care and resident care plan book at the explained that nail ca provided daily and as explained Resident # cooperative with his g #2 revealed she had Wednesday and Thur revealed she did not	oL including showers, al hygiene. NA #2 further received his showers on ay shift and that showers ad hair washing, shaving and at's needs were found in the nurses' station. NA #2 re and shaving were also needed. NA #2 further 100 was normally grooming and showers. NA worked Monday, Tuesday,						
	(DON) was interviewed residents' care needs book at the nurses' st stated the residents of care unit received the shower days which in care and required dail care, shaving and per stated it was her expensiving were comple frequently between stated.	PM the Director of Nursing ed. The DON stated the were listed in the care plan ration. The DON further on the secured dementia eir showers on scheduled recluded shaving and nail ly attempts to provide nail resonal hygiene. The DON rectation that nail care and ted with showers and more nowers if they were dirty.						

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345193	B. WING_			04/	14/2016	
	ROVIDER OR SUPPLIER N VIEW MANOR NURSIN	IG 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 SC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BI CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 312 F 371 SS=E	On 04/14/16 at 3:08 Finterviewed. The Admishould be clean and vadministrator verified residents to be shave trimmed and cleaned appropriately. 483.35(i) FOOD PROSTORE/PREPARE/S. The facility must - (1) Procure food from considered satisfacto authorities; and	PM the Administrator was ninistrator stated all residents well groomed. The it was his expectation for all d daily, have their nails, faces washed and dressed ocure, ERVE - SANITARY		3312			5/9/16	
	by: Based on observation facility failed to label a walk in refrigerator, do removed from the free and date frozen food burn, date foods individuals-in refrigerator ar	· :			On April 11, 2016, the 2 open and out date boxes of juice were discarded by a dietary staff member. On April 11, 2016, the 3 open boxes of juice not labeled and out of date were discarded by a dietary staff member. On April 11, 2016, the unsealed bag of frosted biscuits not labeled or dated was discarded by a dietary staff member. On April 11, 2016, the unsealed bag of frosted biscuits not labeled or dated was discarded by a dietary staff member.	a as		

		IDENTIFICATION NI IMPED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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345193		345193	B. WING		04	4/14/2016	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP (CODE		
				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 (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 371	Continued From pag	e 23	F 3	71			
	juice, partially thawed	ach of apple and cranberry d, not labeled and dated		frozen vegetables was disc dietary staff member.	·		
		the freezer with the of a use by date of 04/08/16 ach of apple, cranberry and		On April 11, 2016, the 2 ur frozen cookie dough in ope labeled or dated were disc dietary staff member.	en boxes not		
	prune juice, partially	thawed, not labeled and I from the freezer with the		On April 11, 2016, the unse			
		of a use by date of 04/05/16.		frozen yellow squash in an labeled or dated was disca	•		
	was observed to con	tain:		dietary staff member.			
	biscuits in an open be dated when it was op B. One unsealed bag	g of frosted frozen country ox which was not labeled or bened. g of frozen mixed vegetables n was not labeled or dated		On April 11, 2016, the 13 in unlabeled and undated plate cereal bowls were labeled the dietary aide that prepathat morning before servin	estic wrapped and dated by red them earlier		
	freezer truck was obs A. 2 unsealed bags of	31 AM the walk-in outside served to contain: of frosted frozen cookie tes which were not labeled or		On April 11, 2016, the brow with ice cream which was opened was discarded by member.	not dated when		
	dated when they wer B. 1 unsealed bag of			On April 11, 2016, the fast wrapped burrito not labeled discarded by a dietary staf	d or dated was f member.		
	4. On 04/11/16 at 10 shelf was observed to 13 individually plastic	231 AM the dry storage area to contain one tray containing to wrapped cereal bowls which lated as to when they were		On April 11, 2016, the plas with a Tupperware contain was not labeled or dated w by a dietary staff member. The Dietary Manager and/inspect food and beverage daily. Any discrepancies w and/or dating will receive of	er lunch that vas discarded or designee will e storage areas vith labeling		
		31 AM one of two nurse's com refrigerators were		immediately or as soon as	practicable.		

OL: \IL: \	O T OIT MEDIO TITLE OF	WEDIO/ ND OEI (VIOLO				CIVID ITE	7. 0000 000 1
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	' '	(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
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		345193	B. WING			04/	14/2016
NAME OF P	ROVIDER OR SUPPLIER			S.	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAI	N VIEW MANOR NURSIN	NG CE			10 BUCKNER BRANCH ROAD		
				В	RYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES YMUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI TAG		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 371	Continued From page 24 observed to contain: A. One brown paper bag with a pint container of ice cream with a residents name on it which was not dated. B. One fast food paper wrapped burrito which was not labeled or dated. C. One plastic grocery bag with a Tupperware container lunch which was not labeled or dated. On 04/11/16 at 11:48 AM Kitchen Aide (KA) #1 was interviewed. KA #1 verified all the above observations at the time they were observed. KA #1 stated all opened bags and boxes in the		F 371		On May 9, 2016, the registered dietician will inservice all dietary and nursing staff on the importance of checking products expiration dates, proper labeling, dating, and readiness of service. The nursing and dietary staff will take a post-test to verify understanding of the subject. A make-up inservice will be provided for staff not attending the May 9, 2016, inservice. Reminder signs about proper labeling and dating of food and beverage items will be posted in the dietary department and nourishment rooms.		
	when they were oper refrigerator thawing s when they were remains any individually preparation of the second of th	AM the Director of Nursing ed. The DON stated it was			The dietary manager will conduct rand audits of the walk-in refrigerator, walk-freezer, dry storage area, and nourishment rooms for unsealed, unlabeled, or undated products weekly weeks at a minimum or longer until substantial compliance is achieved an maintained as determined by the QA Committee. Any deficient practice will corrected immediately and/or as soon practicable.	in / x 4 d be	
	(RD) was interviewed expectation that all of freezer should have the when they were oper refrigerator thawing swhen they were remainly individually preparations should have data.	AM the Registered Dietician d. The RD stated it was her pened bags and boxes in the been labeled and dated hed, all boxes of juices in the should have been dated byed from the freezer, and ared and wrapped bowls of ated labels on them.			The freezer truck is no longer in use of the property. The Administrator will monitor for compliance. The QA Committee will review the audits conducted by the Die Manager to monitor for any trends and patterns and institute corrective action necessary.	etary /or	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
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		345193	B. WING _			04/	14/2016
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSING CE				41	TREET ADDRESS, CITY, STATE, ZIP CODE 10 BUCKNER BRANCH ROAD RYSON 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	FIX (EACH CORRECTIVE ACTION SHOULD BE			(X5) COMPLETION DATE
F 372 SS=D	expectation that all operation of the facility. The findings included On 04/11/16 at 11:05 three was observed piled above.	I. The DM stated it was his bened bags and boxes in the been labeled and dated ed, all boxes of juices in the hould have been dated wed from the freezer, and ared and wrapped bowls of ted labels on them. PM the Administrator was binistrator stated it was his bened bags and boxes in the been labeled and dated ed, all boxes of juices in the hould have been dated wed from the freezer, and ared and wrapped bowls of ted labels on them. E GARBAGE & REFUSE Disse of garbage and refuse This is not met as evidenced and staff interviews the the garbage dumpster and dumpsters located outside		371	No specific residents were identified no could be identified. On April 11, 2016, the trash dumpster liwas closed by a staff member and all trash was contained inside the dumpster liwas closed by a staff member and all trash was contained inside the dumpster liwas closed by a staff on the importance of keeping the dumpster lid closed and containing the trash inside the staff on the importance of keeping the dumpster lid closed and containing the trash inside the staff of the staff	id ers. s	4/29/16

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345193		` '	I ` ′	IPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
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		B. WING _		04	/14/2016		
NAME OF P	ROVIDER OR SUPPLIER		·	STREET ADDRESS, CITY, STATE, ZIP (
				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 OF ((EACH CORRECTIVE AC' CROSS-REFERENCED TO DEFICIEN	TION SHOULD BE THE APPROPRIATE	(X5) COMPLETION DATE	
F 372		age 26 :05 AM Kitchen Aide (KA) #1 KA #1 verified the trash	F3	closed dumpster. Staff will to verify understanding of matter. The inservice was a make-up inservice will be	the subject videotaped and		
	dumpster was ope above the opening the lid was hangin	en, trash was piled to the top g, hanging from the sides, and g from the back side. KA #1		staff not attending the Apri inservice.	i 29, 2016		
	in the dumpster ar	t all trash should be contained nd the lid closed to prevent ground and animals getting into		Signs reminding staff to ke dumpster lids closed will b dumpster area.			
	Services Director (ESD verified the tr was piled to the to hanging from the s	205 AM the Environmental (ESD) was interviewed. The rash dumpster was open, trash p above the opening, and sides, and the lid was hanging		Newly hired employees wi on proper disposal of refus the dumpster lid closed by Services or designee at th during orientation.	se and keeping Environmental e time of hire		
	trash bags in and verified that all tras dumpster and the	e. The ESD then pushed the closed it. The ESD further sh should be contained in the lid closed to prevent overflow animals getting into it.		Random weekly audits will by the dietary manager of monitor for trash being cor the dumpsters and the lids minimum of 4 weeks or lor substantial compliance is a	the dumpster to ntained inside closed for a nger until		
	(DM) was interview expectation that all	99 PM the Dietary Manager wed. The DM stated it was his Il departments disposing of		maintained as determined Committee.	by the QA		
	the trash was secu closed. The DM fu contained in the de	e dumpster should ensure that ure and the dumpster was urther stated all trash should be umpster and the lid closed to onto the ground and animals		The Environmental Service monitor for completion of t report any deficient practic administrator.	he audits and		
	on 04/14/16 at 3:0 interviewed. The appectation that al trash in the outside the trash was section.	D8 PM the Administrator was Administrator stated it was his Il departments disposing of e dumpster should ensure that ure and the dumpster was histrator further stated all trash		The Administrator will mon The QA Committee will rev of the dumpster to monitor or patterns and will institut action as necessary.	view the audits for any trends		

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '	IPLE CONSTRUCTION NG	(X3) DATE SUR COMPLETE		
		345193	B. WING _		C 04/14/2	016	
	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	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COF ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE CO	(X5) MPLETION DATE	
F 372	Continued From pag	e 27	F3	772			
	1	in the dumpster and the lid erflow onto the ground and t.					
F 441 SS=D	483.65 INFECTION SPREAD, LINENS	CONTROL, PREVENT	F4	41	5/9	/16	
	The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection.						
	Program under which (1) Investigates, con-	ablish an Infection Control					
	should be applied to	ocedures, such as isolation, an individual resident; and of of incidents and corrective ections.					
	communicable disea from direct contact w direct contact will tra (3) The facility must hands after each dire hand washing is indi	require staff to wash their ect resident contact for which cated by accepted					
	(c) Linens Personnel must hand	dle, store, process and					

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 345193			` ′	X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED	
		B. WING		C 04/14/2016			
NAME OF PROVIDER OR SUPPLIER				STREET ADDRESS, CITY, STATE, ZIP CODE		4/14/2016	
				410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSI	NG CE	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	EFIX (EACH CORRECTIVE ACTION SHOULD		(X5) COMPLETION DATE	
F 441	Continued From page	e 28	F 4	41			
	transport linens so as to prevent the spread of infection.						
	This REQUIREMENT by:	「 is not met as evidenced					
	Based on observations and staff interview the facility failed to perform hand hygiene after each resident contact while delivering meal trays on 1 of 4 halls (B hall).			Staff will appropriately sanitized wash their hands with soap and before and after direct resident and when delivering meal trays. Resident #35.	d water t contact		
	The findings include:				of Nursing		
	During observations on 04/11/16 at 12:20 PM of lunch delivery on the B Hall, NA #4 was observed removing the tray for Resident # 35 from the cart. NA #4 entered the resident's room and called her name. She then rubbed Resident #35 across her upper chest and told her to wake up. NA #4 removed the cover from the tray then took the bread out of the wrapper with her bare hands and			On April 11, 2016, the Director counseled the CNA #4 on prop hygiene and sanitary practices during meal tray delivery. Also #4 was counseled by the DON must be sanitized or washed wand water after any direct cont resident.	oer hand s after , the CNA I that hands vith soap		
	room of Resident #38 sanitizing her hands, and removed the tray took the tray in Residuhe bread from the bases.	bread. NA #4 then left the without washing or returned to the meal cart for Resident #27. NA #4 lent #27's room, removed ag with her bare hands and hand while spreading butter		On April 15, 2016, DON and N Supervisor observed that nurs appropriately sanitized and/or their hands with soap and wate and after direct resident contact delivering meal trays to other r	ing staff washed er before ct and when		
	on it. Without washing or sanitizing her hands, NA #4 returned to the meal cart and removed the tray for Resident #54 and delivered the tray to his room. NA #4 removed the bread from the bag with her bare hands and held the bread in her hand while spreading butter on it. Without washing or sanitizing her hands, NA #4 started back toward the tray cart to deliver more trays.			On May 9, 2016, the Director of will give an inservice on the rethat staff must wash hands after direct resident contact includin meal delivery. A make-up inserviced to nursing staff not at May 9, 2016 inservice.	quirement er each g during rvice will be tending the		
	On 04/11/16 at 12:30	PM an interview with NA #4		Newly hired nursing employee receive training on hand hygie			

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			С		
NAME OF PROVIDER OR SUPPLIER			B. WING _	STREET ADDRESS, CITY, STATE, ZIP CODE		04/14/2016	
				410 BUCKNER BRANCH ROAD			
WIOUNIAI	N VIEW MANOR NURSIN	IG CE		BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE	
F 441	F 441 Continued From page 29		F 4	41			
F 441	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		F 4	after direct resident contact induring meal tray deliver at the during the orientation period. Nursing staff will be provided vindividual bottles of hand sanit promote appropriate hand hygotheir shift of duty and inclusive service. The DON, ADON, or Nsg. Supconduct weekly audits on a minute of the service of the servi	with tizer to giene during of meal pervisor will inimum of hitor for pekly audits m of 4 hial haintained hmittee. g the audit hcluding as directed onitor for pee will for any		