PRINTED: 09/30/2019 FORM APPROVED OMB NO. 0938-0391

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ` ′	PLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED
		345193	B. WING _		R 08/29/2019
	ROVIDER OR SUPPLIER	NG CE	•	STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1 33/20/23 13
(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 CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE AF DEFICIENCY)	HOULD BE COMPLETION
{F 000}	INITIAL COMMENTS	;	{F 00	00}	
{F 640} SS=E	Tags F637 and F641 08/29/19. Repeat tag were also cited as a investigation survey t same time as the rev compliance. Encoding/Transmittin	conducted on 08/29/19. were corrected as of gs were cited. New tags result of the complaint hat was conducted at the isit. The facility is still out of g Resident Assessments (4)	{F 64	10}	9/18/19
	§483.20(f) Automated requirement- §483.20(f)(1) Encoding a facility completes a facility must encode the each resident in the foundation (ii) Admission assessing (iii) Annual assessme (iiii) Significant chang (iv) Quarterly review (v) A subset of items reentry, discharge, and	d data processing ng data. Within 7 days after resident's assessment, a he following information for acility: ment. nt updates. e in status assessments. assessments. upon a resident's transfer, and death. e-sheet) information, if there			
	after a facility comple a facility must be cap CMS System informa contained in the MDS standard record layor	itting data. Within 7 days tes a resident's assessment, able of transmitting to the tion for each resident in a format that conforms to uts and data dictionaries, dardized edits defined by			
	14 days after a facilit	uittal requirements. Within y completes a resident's must electronically transmit			
ABODATORY	NIDECTORIS OR RROVINER/	SUPPLIER REPRESENTATIVE'S SIGNATU	DE	TITI F	(X6) DATE

Electronically Signed 09/20/2019

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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBED:		PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345193	B. WING _			R 08/29/2019	
	ROVIDER OR SUPPLIER	SING CE		STREET ADDRESS, CITY, STATE, ZIP CO 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		3072372013	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL DR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF ((EACH CORRECTIVE ACTI CROSS-REFERENCED TO TI DEFICIENC'	ON SHOULD BE HE APPROPRIATE	(X5) COMPLETION DATE	
{F 640}	the CMS System, (i)Admission asses (ii) Annual assessr (iii) Significant char (iv) Significant corrussessment. (v) Significant corrussessment. (vi) Quarterly revier (vii) A subset of ite reentry, discharge, (viii) Background (initial transmission does not have an a §483.20(f)(4) Data transmit data in the for a State which he by CMS, in the for approved by CMS. This REQUIREME by: Based on record of facility failed to corrusal and one que (MDS) assessment Refer transmit one entry tracking records we completion date for Resident Assessment #9, and #10). Findings included: 1. Resident #5 was 08/01/19.	a, and complete MDS data to including the following: ssment. Inge in status assessment. Inge in status assessment and death. Inge in status assessment. Inge in status assessment and death. Inge in status assessment. Inge in status assessment and death. Inge in status assessment. Inge in sta	{F 64	Disclaimer: We respectfully plan of correction be conside allegation of substantial conformation and/or complet of correction in general, or a action set forth, herein, in proceedings of constitute an admission by Mountain View Manor of conclusions set forth in the Deficiencies (Form 2567). To Correction and specific corrare prepared and/or execute provision of Federal and/or The Minimum Data Set (ME Resident # 5 with the Assession of the constitution of the second control of the	dered our mpliance. ion of this plan any corrective articular, does of agreement the Statement of The Plan of rection action red solely as a State law. DS) of essment		
	Paviow of Pasidar	at #5's electronic medical		Reference Date (ARD) date			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		ATE SURVEY OMPLETED
		345193	B. WING			R 08/29/2019
NAME OF PI	ROVIDER OR SUPPLIER		<u> </u>	STREET ADDRESS, CITY, STATE, ZIP CODE		00/20/2010
				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 COF (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
{F 640}	Continued From page	e 2	{F 64	0}		
		ast transmitted MDS was acking record with an ARD of		completed in the electronic he on 9/10/19 by the RN/MDS Co The MDS assessment was su submitted and accepted in the	oordinator. ccessfully	
	assessment with an	sident #5's electronic aled an admission MDS ARD of 08/07/19. The status as "in progress" which		Improvement and Evaluation (QIES) on 9/10/19 by the RN/I Coordinator.	System	
indicated it had 08/29/19.	indicated it had not b 08/29/19.	een completed as of		The MDS of Resident # 6 with date of 8/5/19 was completed electronic health record on 9/5	in the 5/19 by the	
	Coordinator on 08/29 Coordinator confirme completing and trans	nducted with the MDS 0/19 at 12:20 PM. The MDS and she was responsible for omitting MDS assessments. For explained her focus had		RN/MDS Coordinator. The ME assessment was successfully and accepted in the QIES on the RN/MDS Coordinator.	submitted	
	been on completing a assessments that we annual recertification still behind on comple assessments that we recertification date. Sassessment dated 08	and transmitting MDS ere late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS ere due after the She acknowledged the MDS 8/05/19 for Resident #5 was		The MDS of Resident # 7 with date of 8/6/19 was completed electronic health record on 8/2 RN/MDS Coordinator. The ME assessment was successfully and accepted in the QIES on the RN/MDS Coordinator.	in the 20/19 by the OS submitted	
	timeframe. An interview was con Administrator on 08/2 Administrator stated	An interview was conducted with the Administrator on 08/29/19 at 3:51 PM. The Administrator stated after the facility's annual		The MDS of Resident# 8 with date of 8/7/19 was transmitted QIES system on 8/29/19 by th Coordinator. The MDS assess successfully submitted and act to QIES as 8/00/10 by the DIES.	I into the le RN/MDS sment was scepted in	
	the impression MDS completed and transitimeframe based on compliance audits. Twas unaware there wexpected MDS assess	certification survey on 06/27/19, he was under the impression MDS assessments were being simpleted and transmitted within the required the neframe based on the results of the facility's simpliance audits. The Administrator stated he as unaware there was still an issue and expected MDS assessments to be completed and consmitted within the regulatory timeframe.		the QIES on 8/29/19 by the RI Coordinator. The MDS of Resident # 9 with date of 7/28/19 was transmitte QIES system on 8/29/19 by th Coordinator. The MDS assess successfully submitted and act the QIES on 8/29/19 by the RI	the ARD ed into the se RN/MDS sment was ecepted in	
	2. Resident #6 was a	idmitted to the facility on		Coordinator.	-	

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		R 08/29/2019
NAME OF PI	ROVIDER OR SUPPLIER	1		STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/20/2010
				410 BUCKNER BRANCH ROAD	
MOUNTAI	N VIEW MANOR NURSI	NG CE		BRYSON CITY, NC 28713	
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES BY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD) CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
{F 640}	Continued From page 08/10/18.	e 3	{F 640	The MDS of Resident # 10 with the Al	RD
	record revealed the la	f6's electronic medical ast transmitted MDS was assessment with an ARD of		date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/M Coordinator. The MDS assessment was successfully submitted and accepted the QIES on 8/29/19 by the RN/MDS	DS as
	of this assessment windicated it had not b 08/29/19. An interview was con Coordinator on 08/29 Coordinator confirme completing and trans	lled an annual MDS ARD of 08/05/19. The status as "in progress" which		Coordinator. Residents # 5, #6, #7, #8, #9, and # 1 will continue to have timely assessme completed in the electronic health receive the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator in the QIES system per Resident Assessment Instrument (RAI) guideline All residents have the potential to be affected by the same practice. An MD audit will be completed by an RN to residents.	nts ord d nto es.
	been on completing a assessments that we annual recertification still behind on comple assessments that we recertification date. S assessment dated 08	and transmitting MDS are late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS		current residents and the timeliness of MDS assessments. Any resident who not had an MDS completed or transm in a timely manner will have corrective action taken by the MDS Coordinator. The audits were completed on 09/16/2 and corrective action was taken by the MDS Coordinator for any discrepancies identified. The Director of Nursing provided inservances	f has itted e
	Administrator stated recertification survey the impression MDS completed and transitimeframe based on compliance audits. Twas unaware there w	29/19 at 3:51 PM. The after the facility's annual on 06/27/19, he was under assessments were being mitted within the required the results of the facility's The Administrator stated he		education to all MDS Coordinators on 09/05/2019 on timely completion and transmission of the MDS Assessment: posttest was given to access learning promote competency. The MDS Coordinators all successfully passed to posttest with a score of 100. A copy of the RAI guidelines related to timelines of completion and transmiss of MDS assessments was posted in the	s. A and he o the ion

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NI IMBED:		(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
							R	
		345193	B. WING _			08	/29/2019	
NAME OF P	ROVIDER OR SUPPLIER	•		5	STREET ADDRESS, CITY, STATE, ZIP CODE			
				4	410 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURS	ING CE		ı	BRYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)		(X5) COMPLETION DATE	
(F.0.40)								
{F 640}	Continued From page		{F 6	40}				
	transmitted within th	e regulatory timeframe.			MDS office by the Director of Nursing			
	3. Resident #7 was 12/01/17.				9/16/19 as a reference guide for the M Coordinator.An RN will complete weekly audits of MDS assessments reviewing completi	he		
	Review of Resident	#7's electronic medical			and transmission dates. The audits be			
	record revealed the	last transmitted MDS was			on 09/05/19 and will continue at a	J		
	coded as a quarterly	y assessment with an ARD of			minimum of four weeks or until the QA	.PI		
	05/13/19.				committee has deemed substantial			
					compliance has been reached and the	!		
		esident #7's electronic			system has been deemed effective.			
		aled a quarterly MDS			The MDS Coordinator will meet with the	ie		
		ARD of 08/06/19. The status			Administrator and/or Assistant			
		was "in progress" which been completed as of			Administrator at a minimum of two tim week to review completion and	38 a		
	08/29/19.	been completed as of			transmission of the MDS assessments	: in		
	00/29/19.				the electronic health record. These) 11 1		
	An interview was co	inducted with the MDS			meetings were initiated on 08/30/19. T	he.		
		9/19 at 12:20 PM. The MDS			Administrator may choose to decrease			
		ed she was responsible for			frequency of the meetings to weekly a			
		smitting MDS assessments.			one month, based on the			
		or explained her focus had			recommendations of the QAPI commit	tee,		
	been on completing	and transmitting MDS			if timely completion and transmission	of		
	assessments that w	ere late prior to the facility's			the MDS assessments are occurring p	er		
		n survey on 06/27/19 but was			RAI guidelines.			
	-	leting and transmitting MDS			The Administrator will review the resul	ts of		
		ere due after the facility's			the audits and the weekly compliance			
		n date. She acknowledged			meetings with MDS Coordinator for			
		nt dated 08/06/19 for			timeliness of completion and submissi			
		e and not completed within			for any trends or patterns and report to)		
	the regulatory timeform	rame.			the Quality Assurance Performance			
	An interview was co	inducted with the			Improvement Committee. The QAPI Committee consists of the Administrat	or		
		/29/19 at 3:51 PM. The			Director of Nursing, Medical Director,			
		I after the facility's annual			at least 3 other staff members and me			
		y on 06/27/19, he was under			at a minimum of quarterly. The QAPI	0.0		
		S assessments were being			Committee will review the results of th	e		
		smitted within the required			weekly reviews of MDS timeliness of	-		
		the results of the facility's			completion and submissions and direct	:t		

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345193	B. WING			R
NAME OF D	ROVIDER OR SUPPLIER	343133	B: Willo_	STREET ADDRESS, CITY, STATE, ZIP CO	<u> </u>	08/29/2019
NAIVIE OF P	ROVIDER OR SUPPLIER				DE	
MOUNTAI	N VIEW MANOR NURSIN	IG CE		410 BUCKNER BRANCH ROAD		
				BRYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG			(X5) COMPLETION DATE
{F 640}	Continued From page	e 5	{F 64	40}		
	was unaware there w expected MDS asses transmitted within the 4. Resident #8 was r	he Administrator stated he as still an issue and sments to be completed and regulatory timeframe.		corrective action as necessal Committee may approve characteristic frequency of the audits and/of the audits once the new syst deemed effective to maintain compliance.	anges in the or discontinue tem has been	
	record revealed an er	8's electronic medical htry tracking record with an e status of this assessment transmission date of		Completion date 09/18/19		
	Coordinator confirme completing and transit The MDS Coordinato been on completing a assessments that we annual recertification still behind on completassessments that we recertification date. Sassessment dated 08	d she was responsible for mitting MDS assessments. rexplained her focus had and transmitting MDS re late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS				
	Administrator stated a recertification survey the impression MDS a completed and transr timeframe based on t compliance audits. T was unaware there w	9/19 at 3:51 PM. The after the facility's annual on 06/27/19, he was under assessments were being nitted within the required he results of the facility's he Administrator stated he				

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII				SURVEY PLETED
		345193	B. WING			1	R
	ROVIDER OR SUPPLIER			410 BU	CKNER BRANCH ROAD ON CITY, NC 28713	1 00/	29/2019
(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 CORRECTION (EACH CORRECTIVE ACTION SHOULD E CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
{F 640}	5. Resident #9 was 06/15/18. Review of Resident # record revealed a de with an ARD of 07/28 assessment was "extended of 08/28/19. An interview was con Coordinator on 08/29 Coordinator confirme completing and trans. The MDS Coordinator been on completing assessments that we annual recertification still behind on comple assessments that we recertification date. Stracking record dated was late and not transtimeframe. An interview was con Administrator on 08/2 Administrator stated recertification survey the impression MDS completed and transitimeframe based on a compliance audits. The was unaware there we expected MDS assess transmitted within the	e regulatory timeframe. admitted to the facility on gets electronic medical ath in facility tracking record for 19. The status of this corted" with a transmission adducted with the MDS for 19 at 12:20 PM. The MDS d she was responsible for mitting MDS assessments. For explained her focus had and transmitting MDS for elate prior to the facility's survey on 06/27/19 but was beting and transmitting MDS for edue after the She acknowledged the MDS for 107/28/19 for Resident #9 smitted within the regulatory adducted with the for 19/19 at 3:51 PM. The for 29/19 at 3:51 PM. The for 19/19 at 3:51 PM. The for 19/19 at 3:51 PM. The for 29/19 at 3:51 PM. The for 29/19 at 3:51 PM. The for 29/19 at 3:51 PM. The for 30/27/19, he was under for 30/27/19, he	{F 6	40}			

	TATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION (X3) DATE SUP- ND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING (X2) MULTIPLE CONSTRUCTION (X3) DATE SUF- ND PLAN OF CORRECTION (X3) DATE						
						1	R
		345193	B. WING			08/	29/2019
	ROVIDER OR SUPPLIER N VIEW MANOR NURSIN	IG CE		410 B	ET ADDRESS, CITY, STATE, ZIP CODE UCKNER BRANCH ROAD SON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PROVIDER'S PLAN OF CORRECT PREFIX (EACH CORRECTIVE ACTION SHO TAG CROSS-REFERENCED TO THE APPF DEFICIENCY)			(X5) COMPLETION DATE
{F 640}	record revealed a dea with an ARD of 08/11 assessment was "exp date of 08/28/19. An interview was con Coordinator on 08/29 Coordinator confirme completing and trans. The MDS Coordinato been on completing a assessments that we annual recertification still behind on completing assessments that we recertification date. Stracking record dated was late and not transtimeframe. An interview was con Administrator on 08/2 Administrator stated a recertification survey the impression MDS completed and transr timeframe based on to compliance audits. Twas unaware there we expected MDS assess	et10's electronic medical ath in facility tracking record /19. The status of this ported" with a transmission ducted with the MDS /19 at 12:20 PM. The MDS d she was responsible for mitting MDS assessments. It is rexplained her focus had and transmitting MDS re late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS re due after the She acknowledged the MDS 08/11/19 for Resident #10 smitted within the regulatory ducted with the enderence with the enderence where the sessessments were being mitted within the required the results of the facility's the Administrator stated he	{F 6	40}			

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	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP	LE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		C 08/29/2019
	ROVIDER OR SUPPLIER	IG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	1 00/23/2013
(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 CORREC (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE COMPLETION
F 000	INITIAL COMMENTS		F 00	0	
		complaint investigation d on 08/28/19 through four allegations were			
F 604 SS=D	<u>-</u>	-	F 60	4	9/18/19
	§483.10(e) Respect a The resident has a rig and dignity, including	to be treated with respect			
	physical or chemical in purposes of discipline	ht to be free from any restraints imposed for or convenience, and not esident's medical symptoms, 12(a)(2).			
	neglect, misappropria and exploitation as de includes but is not lim corporal punishment,	involuntary seclusion and ical restraint not required to			
	§483.12(a) The facilit	y must-			
	from physical or chen purposes of discipline are not required to tre symptoms. When the indicated, the facility alternative for the lease	that the resident is free nical restraints imposed for or convenience and that eat the resident's medical use of restraints is must use the least restrictive st amount of time and evaluation of the need for			
ABORATORY	 DIRECTOR'S OR PROVIDER/S	SUPPLIER REPRESENTATIVE'S SIGNATUR	<u> </u> E	TITLE	(X6) DATE

Electronically Signed 09/20/2019

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 (X AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
			A. BOILDI			Ι,	С	
		345193	B. WING				29/2019	
NAME OF PI	ROVIDER OR SUPPLIER	1	1	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/20 10	
				41	10 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSIN	NG CE		В	RYSON CITY, NC 28713			
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)	
PRÉFIX TAG	,	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG		(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE	
F 604	Continued From page	e 1	F	604				
		Γ is not met as evidenced	•	٠.				
	by:	is not met as evidenced						
	_ ·	iew and staff interviews, the			Disclaimer: We respectfully request th	is		
		ain an environment free of			plan of correction be considered our			
	, -	r 1 of 2 residents (Resident			allegation of substantial compliance.			
	' '	raint usage by placing a			Preparation and/or completion of this p	lan		
	,	nt #1's waist and tying it to			of correction in general, or any correcti			
		Ichair to prevent rising.			action set forth, herein, in particular, do			
					not constitute an admission of agreeme	∍nt		
	Findings included:				by Mountain View Manor of the			
					conclusions set forth in the Statement	of		
		nitted to the facility on			Deficiencies (Form 2567). The Plan of			
		e diagnoses that included			Correction and specific correction action			
	Alzheimer's disease,	anxiety and history of falls.			are prepared and/or executed solely as provision of Federal and/or State law.	a		
	Review of the quarter	rly Minimum Data Set (MDS)			•			
	dated 07/01/19 indica	ated Resident #1 had						
	moderate impairment	t in cognition, required			Resident #1 removed the sheet that ha	d		
	extensive to total ass	istance with all activities of			been tied around her wheelchair by tak	ing		
		ayed no behaviors during the			the sheet over her head according to s	taff		
		eriod. The MDS noted			interviews conducted by the Social			
		alls and no use of physical			Service Director (SSD) on 06/30/2019.			
	restraints during the	assessment period.			The sheet was not reapplied to the			
					resident by the nursing staff. Resident	#1		
		t1's fall care plan, with a			displayed no signs or symptoms of			
		19, revealed she had the			distress or discomfort per staff interview	V		
		ted to an unsteady gait,			conducted by the SSD on 06/30/2019.			
	wheelchair use, and	d for staff to observe and			Resident # 1 will continue to use a wheelchair when out of bed and will no			
	monitor Resident #1's				have a restraint applied without a medi			
		de reminders as needed.			symptom as assessed by a Registered			
	andosisted and provi	ao ioninadio ao Needea.			Nurse (RN) and with a physician s ord			
	Review of the facility	s abuse investigations			for use.			
		n was reported on 06/29/19			All residents are at risk to be affected b	y		
		dent #1 had been restrained			the same practice. Nursing staff	-		
	to her wheelchair witl	h a sheet by Nurse #1.			interviews will be conducted by the SS	D,		
					Assistant Administrator (AA) and/or			
	Review of Resident #	f1's medical record revealed			designated Registered Nurse (RN) acr			
	no nursing progress i	note or incident report			all shifts as a means of helping to ident	ifv		

Facility ID: 923363

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMF	SURVEY PLETED
		345193	B. WING _			1	C / 29/2019
NAME OF P	ROVIDER OR SUPPLIER	_		S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	123/2013
					10 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NUR	SING CE					
					RYSON 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	X	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 604	Continued From p	age 2	F	604			
	· ·	lent that occurred on 06/29/19.	. ` `		if any other residents were affected by	tho	
	Telated to the incid	lent that occurred on 00/29/19.			same practice of using a sheet as a	uie	
	Paview of Pacider	nt #1's skin assessment			restraint. Any deficient practice identification	ad	
		30/19 revealed no new bruising			during the interviews related to restrain		
		to the incident on 06/29/19.			and/or improper use of restraints will b		
	or injuries related	to the moldent on our to.			reported to the Administrator and Direct		
	Resident #1 was u	inable to be interviewed due to			of Nursing (DON) for corrective action.		
	cognition.				The interviews will be completed by		
	559				09/18/19.		
	During a telephone	e interview on 08/28/19 at 11:07			The facility□s guidelines on restraints		
		e Assistant (PCA) #1 confirmed			were updated by a RN on 9/3/19 to		
		to Resident #1's hall on			include more specific examples of wha	ıt	
	_	ot provide direct care. PCA#1			can be considered a restraint, as well a		
		alked by Resident #1's room,			guidelines for use of a restraint if need		
		ting in the wheelchair with a			to treat a medical symptom. Copies of		
	sheet around her	waist and tied to the back of the			revised and approved guidelines will b	е	
	wheelchair. She s	tated Resident #1 did not			maintained in the nursing office and the	е	
	appear distressed	but was trying to get up out of			DON will place copies on each nurses		
	the wheelchair. P	CA #1 was unable to recall the			station in a manual for reference by the	9	
		d occurred but stated it was			nursing staff.		
		00 AM and did not feel that she			The Director of Nursing (DON) provide		
		way for very long because			inservice education to the licensed and		
	Resident #1 "wigg	led her way right out of it."			non-licensed nursing staff on 09/10/19		
					The training reviewed the updated		
		nterviews on 08/28/19 at 12:39			restraint guidelines. A posttest to acce		
		NA #5 verified she was one of			learning and promote competency was		
	_	to Resident #1's hall on			given. Mandatory make-up inservices		
		e had observed Resident #1			be provided by 09/18/19. Any licensed		
		with a sheet wrapped around			staff and non-licensed staff on leave w		
		to the back of her wheelchair.			be required to make-up the inservice p	HOL	
		ecall the exact time of her attention at the exact time of her			to return to duty. New nursing employee orientation will	he	
		1 was already in the room when old her Nurse #1 had placed the			updated to include training on restraint and the updated restraint policy.	5	
		dent #1. NA #5 stated prior to			Weekly staff interviews related to use of	nf a	
		t #1 with assistance both she			sheet as a restraints will be completed		
	· -	e room to discuss their			the SSD, AA, and/or designated RN fo	•	
		ne other NAs on the hall. She			total of four weeks at a minimum or lor		
		ned returned to the room			until substantial compliance is achieve	•	

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION	(X3) DATE COMP	SURVEY LETED
			A. BUILDI	NG _		,	C
		345193	B. WING			l	29/2019
NAME OF P	ROVIDER OR SUPPLIER			S	TREET ADDRESS, CITY, STATE, ZIP CODE		
MOUNTAL	N 1/15/4/ MANOR NURO	NO 05		4	10 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURSI	NG CE		В	RYSON CITY, NC 28713		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PRÉFIX TAG		CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 604	Continued From pag	ne 3	F	604			
	· ·	eady "halfway wiggled out of			and maintained as determined by the		
		ded up removing it the rest of			Quality Assurance Performance		
		e sheet up over her head.			Improvement (QAPI) Committee. The		
	and way by paining an	o choose up over her head.			weekly staff interviews were initiated or	1	
	During telephone int	erviews on 08/28/19 at 1:45			09/04/19. Weekly rounds will be		
		A #6 confirmed she was one			conducted randomly by the DON and/o	r	
		to Resident #1's hall on			RN Supervisor on all shifts to identify if		
	06/29/19. NA #6 exp	plained Resident #1 had very			resident is inappropriately restrained fo		
	poor safety awareness and frequently attempted				four weeks or longer until substantial		
		from her wheelchair. She			compliance is achieved and maintained		
		orked together to keep her in			as determined by the QAPI Committee		
	,	ded redirection whenever she			The weekly rounds by the DON and/or		
	-	p from her wheelchair so she			supervisor were initiated on 09/06/19.	Any	
	_	et hurt. NA #6 stated it was			discrepancies will receive immediate		
		nen she was informed by NA			corrective action by a licensed nurse.		
	#7 that Resident #1	#1 and when she walked			The DON will review the results of the weekly interviews and rounds for any		
	_	oticed a sheet was wrapped			trends or patterns and report to the QA	ΡI	
	i i	d tied to the back of the			Committee. The QAPI Committee		
		ded as she walked into the			consists of the Administrator, DON,		
	room, Resident #1 p	ulled the sheet up over her			Medical Director, and at least 3 other s	taff	
	· ·	before she was able to			members and meets at a minimum of		
	assist her. She reca	illed Resident #1 displayed			quarterly. The QAPI Committee will rev	riew	
	no signs of distress v	while attempting to remove			the results of the interviews and reside	nt	
	the sheet or the remain	ainder of the afternoon.			observation audits and direct corrective	;	
					action as necessary. The QAPI		
		on 08/29/19 at 10:03 AM, NA			Committee may approve changes in th		
		as one of the NAs assigned to			frequency of the audits and/or disconting		
		n 06/29/19. NA #7 stated			the audits once the new system has be		
		"good and bad days" where			deemed effective to maintain substanti	aı	
		d be calm and the other days idgety." She added they			compliance.		
	-	sual site due to her poor			Completion date 09/18/19		
		nd to prevent her from falling.			Completion date 09/10/19		
		dent #1 was restless on					
		g frequent attempts to stand					
		ner wheelchair. NA #7 further					
		id not see Resident #1 sitting					
		vent into her room to check on					

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTI A. BUILDIN	PLE CONSTRUCTION G		OATE SURVEY COMPLETED
		345193	B. WING _			C 08/29/2019
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		33/23/23 10
(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 CORREC (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY)	ULD BE	(X5) COMPLETION DATE
F 604	her waist and tied to NA #7 stated Reside distress and before pleft the room to get a indicated as she, NA into the room, Reside the restraint" by pulliphead and removing it added Nurse #1 cam were all standing in thad taken the sheet stated they told Nurse removed it herself. During a telephone in PM, Nurse #1 confirmed used a sheet to waist to keep her seastressed that it was rekeep her safe while shood glucose monitor. Nurse #1 explained from the Receptionist supervising Resident	th a sheet wrapped around the back of the wheelchair. In #1 displayed no signs of providing any assistance, she mother NA as a witness. She #5 and NA #6 walked back ent #1 was "halfway out of ang the sheet up over her at from around her waist. She is into the room while they he doorway and asked who off the wheelchair. NA #7 is e #1 that Resident #1 had interview on 08/28/19 at 2:25 and that on 06/29/19 she wrap around Resident #1's atted in the wheelchair but not done to harm her, just she finished the 12:00 PM oring for other residents. Resident #1 was a fall risk	F 6	,		
	lunch and Resident # hall, she was unable supervise Resident # Resident #1 had bee morning, constantly where wheelchair, woul "pushed her to her wit was a rather "hection" 10 minutes or so to glucose monitoring capproximately 11:30	to find any of the NAs to to find not sit still, and it had its end." Nurse #1 indicated to day" and she only needed get the 12:00 PM blood ompleted, so at AM she took Resident #1 to heet around her waist and				

STATEMENT OF DEFICIENCIE AND PLAN OF CORRECTION	:S	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		ONSTRUCTION	· /	E SURVEY IPLETED
		345193	B. WING _			0.5	C 3/29/2019
NAME OF PROVIDER OR SU		IG CE		410	EET ADDRESS, CITY, STATE, ZIP CODE BUCKNER BRANCH ROAD /SON CITY, NC 28713	1 00	12312013
PREFIX (EACI	H DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL .SC IDENTIFYING INFORMATION)	ID PREFI TAG	×	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPI DEFICIENCY)	BE	(X5) COMPLETION DATE
approximate pulling it up stand up an Nurse #1 s Resident # and get hur waist to kee was facility resident an not bind, ha moving. Nr. not intention was only trop back, shour Resident # of placing at Early and to 6:30 06/29/19. #1 often sat worked and back down The Receptionis unusual ab on 06/29/19 restrained in Administratincident invitations.	She stated and attempt tressed shall, she was at and only epher safe policy never the arm or residures #1 remaily caus ying to ensure #1 remaily captionist and \$1 mad you was presented and \$1:30 A 1 was presented effect for st was una out Reside 9 she never to her when the property was una out Reside 9 she never the property was una out Reside	ed it only took Resident #1 iutes to remove the sheet by head, throw it behind her, to push her wheelchair. e was not trying to restrain is just fearful she would fall put the sheet around her e. Nurse #1 confirmed it ver to physically restrain a the loosely tied sheet did train Resident #1 from stated she did not and would e Resident #1 any harm, she sure her safety and looking und someone to sit with of making the bad judgement bund her waist. Interview on 08/29/19 at 9:06 indicated she worked every of during the hours of 8:00 erified she worked on obtionist confirmed Resident elobby whenever she constant redirection to sit elechair to keep from falling. ed she typically took her M but was unable to recall if sent in the reception area lunch on 06/29/19. The lible to recall anything ent #1's behavior and stated er observed Resident #1 elchair with a sheet. In 08/29/19 at 3:51 PM, the ed he was notified of the sident #1 on 06/30/19. The led prior to utilizing a	F	604			

	PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	, ,	IPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED	
	345193	B. WING _		08/2	29/2019
NAME OF PROVIDER OR SUPPLIER MOUNTAIN VIEW MANOR NURSING CE	E		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		
PREFIX (EACH DEFICIENCY MUS	ENT OF DEFICIENCIES ST BE PRECEDED BY FULL DENTIFYING INFORMATION)	ID PREFI TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 604 Continued From page 6 restraint on a resident, a n complete an assessment of the restraint and evaluate would respond and benefit restraint. The Administrate #1 made a bad judgement restraint might be necessed circumstances for a reside sheet to wrap around a resit to the back of the wheeled appropriate or acceptable Encoding/Transmitting Re CFR(s): 483.20(f)(1)-(4) §483.20(f) Automated data requirement- §483.20(f)(1) Encoding data facility completes a residenciality must encode the foreach resident in the facility (i) Admission assessment up (iii) Significant change in second (iv) Quarterly review assess (v) A subset of items upon reentry, discharge, and decomplete (vi) Background (face-sheet is no admission assessments) shall be capable CMS System information for contained in the MDS in a standard record layouts are and that passes standardic CMS and the State.	that verified the need late how the resident it from the use of the tor stated he felt Nurse at call and added while a lary in some ent's safety, using a lesident's waist and tying lachair would never be an erestraint to use. Pesident Assessments example at a Within 7 days after dent's assessment, a collowing information for your states as session to the session of the resident's transfer, eath. Pet) information, if there ent. If a data. Within 7 days are sident's assessment, of transmitting to the for each resident a format that conforms to and data dictionaries,		604		9/18/19

PRINTED: 09/30/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	IPLE CONSTRUCTION IG		DATE SURVEY COMPLETED
		345193	B. WING _			C 08/29/2019
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	_ E	00/23/2013
(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 COI (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 640	14 days after a facility assessment, a facility encoded, accurate, athe CMS System, incompletion assessment (ii) Annual assessment (iii) Significant chang (iv) Significant correct assessment. (vi) Significant correct assessment. (vi) Quarterly review. (vii) A subset of items reentry, discharge, all (viii) Background (fact initial transmission of does not have an additional state which has by CMS, in the formal approved by CMS. This REQUIREMENT by: Based on record revifacility failed to complemental and one quarr (MDS) assessments Assessment Referent transmit one entry and tracking records with completion date for 6 Resident Assessment #9, and #10).	aittal requirements. Within y completes a resident's or must electronically transmit and complete MDS data to aluding the following: nent. Int. Int.	F6	The Minimum Data Set (MDS Resident # 5 with the Assessr Reference Date (ARD) date of completed in the electronic heron 9/10/19 by the RN/MDS County The MDS assessment was submitted and accepted in the Improvement and Evaluation (QIES) on 9/10/19 by the RN/Coordinator.	nent f 8/7/19 was ealth record pordinator. accessfully e Quality System MDS	
	Findings included: 1. Resident #5 was a	dmitted to the facility on		The MDS of Resident # 6 with date of 8/5/19 was completed electronic health record on 9/5	in the	

Facility ID: 923363

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		IDENTIFICATION NUMBER:		X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
		345193	B. WING _				C 29/2019	
NAME OF PI	ROVIDER OR SUPPLIER			ST	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00//	23/2013	
				41	10 BUCKNER BRANCH ROAD			
MOUNTAI	N VIEW MANOR NURSIN	IG CE			RYSON CITY, NC 28713			
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFI) TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE	
F 640	record revealed the lacoded as an entry tra 08/01/19. Further review of Resmedical record reveal assessment with an Allo of this assessment with indicated it had not be 08/29/19. An interview was con Coordinator on 08/29 Coordinator confirmer completing and transful The MDS Coordinator been on completing assessments that we annual recertification still behind on completassessments that we recertification date. Sassessment dated 08 late and not complete timeframe. An interview was con Administrator on 08/2 Administrator stated a recertification survey the impression MDS a completed and transful timeframe based on the compliance audits. The medical recordinate is the same of the compliance audits.	5's electronic medical ast transmitted MDS was cking record with an ARD of sident #5's electronic led an admission MDS ARD of 08/07/19. The status as "in progress" which een completed as of ducted with the MDS /19 at 12:20 PM. The MDS d she was responsible for mitting MDS assessments. In explained her focus had and transmitting MDS re late prior to the facility's survey on 06/27/19 but was sting and transmitting MDS re due after the She acknowledged the MDS /05/19 for Resident #5 was red within the regulatory ducted with the 9/19 at 3:51 PM. The after the facility's annual on 06/27/19, he was under assessments were being nitted within the required the results of the facility's he Administrator stated he	F	540	RN/MDS Coordinator. The MDS assessment was successfully submittee and accepted in the QIES on 9/06/19 to the RN/MDS Coordinator. The MDS of Resident # 7 with the ARD date of 8/6/19 was completed in the electronic health record on 8/20/19 by RN/MDS Coordinator. The MDS assessment was successfully submittee and accepted in the QIES on 9/06/19 to the RN/MDS Coordinator. The MDS of Resident# 8 with the ARD date of 8/7/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 9 with the ARD date of 7/28/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted and accepted in the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted and accepted in the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the ARD date of 8/11/19 was transmitted and accepted in the QIES system on 8/29/19 by the RN/MDS Coordinator.	the doy		
	was unaware there w expected MDS asses	as still an issue and sments to be completed and			Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessmen			

	DF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION G	· ,	TE SURVEY MPLETED
		345193	B. WING			C 8/29/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE		0/20/2010
				410 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURSIN	NG CE		BRYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES AY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION I CROSS-REFERENCED TO THE A DEFICIENCY)	SHOULD BE	(X5) COMPLETION DATE
F 640	Continued From page	e 9	F 6	40		
	transmitted within the	regulatory timeframe.		completed in the electronic hea	alth record	
		dmitted to the facility on		by the Interdisciplinary Team (Interdisciplinary Team	IDT) and linator into t	
	Review of Resident #	6's electronic medical		All residents have the potentia	I to be	
	record revealed the la	ast transmitted MDS was		affected by the same practice.	An MDS	
		assessment with an ARD of		audit will be completed by an F		
	05/09/19.			current residents and the timel		
				MDS assessments. Any reside		
	Further review of Res			not had an MDS completed or		
	medical record revealed an annual MDS in a timely manner will have correct					
		ARD of 08/05/19. The status		action taken by the MDS Coord		
	indicated it had not be	as "in progress" which		The audits were completed on and corrective action was take		
	08/29/19.	een completed as of		MDS Coordinator for any discr identified.	-	
	An interview was con	ducted with the MDS		The Director of Nursing provide	ed inservice	
		1/19 at 12:20 PM. The MDS		education to all MDS Coordina		
		d she was responsible for		09/05/2019 on timely complete		
		mitting MDS assessments.		transmission of the MDS Asses		
		or explained her focus had		posttest was given to access le		
		and transmitting MDS		promote competency. The MD		
		re late prior to the facility's		Coordinators all successfully p		
	annual recertification	survey on 06/27/19 but was		posttest with a score of 100.		
	still behind on comple	eting and transmitting MDS		A copy of the RAI guidelines re	elated to the	
	assessments that we	re due after the		timelines of completion and tra	Insmission	
	recertification date. S	She acknowledged the MDS		of MDS assessments was pos		
		3/05/19 for Resident #6 was		MDS office by the Director of N	•	
	-	ed within the regulatory		9/16/19 as a reference guide for	or the MDS	
	timeframe.			Coordinator.		
	.			An RN will complete weekly au		
	An interview was con			MDS assessments reviewing of	•	
		29/19 at 3:51 PM. The		and transmission dates. The a	•	
		after the facility's annual		on 09/05/19 and will continue a		
		on 06/27/19, he was under		minimum of four weeks or until		
	-	assessments were being		committee has deemed substa		
		mitted within the required the results of the facility's		compliance has been reached system has been deemed effe		
	・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・・	ing regula of the facility 5	1	- avaiciii ilda peeli üeellieli ellel	CALLY CA.	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:			CONSTRUCTION		E SURVEY PLETED
		345193	B. WING _			1	C / 29/2019
NAME OF PI	ROVIDER OR SUPPLIER			ST	FREET ADDRESS, CITY, STATE, ZIP CODE	1 00	12312013
				41	0 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURSIN	IG CE		ВІ	RYSON CITY, NC 28713		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	<	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)		(X5) COMPLETION DATE
F 640	Continued From page	e 10	F 6	640			
	was unaware there w expected MDS asses	The Administrator stated he as still an issue and asments to be completed and a regulatory timeframe.			The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two times week to review completion and transmission of the MDS assessments	es a	
	12/01/17.	admitted to the facility on			the electronic health record. These meetings were initiated on 08/30/19. T Administrator may choose to decrease	the	
	record revealed the la	7's electronic medical ast transmitted MDS was assessment with an ARD of			frequency of the meetings to weekly at one month, based on the recommendations of the QAPI commit if timely completion and transmission of the MDS assessments are occurring p	tee, of	
	Further review of Resident #7's electronic medical record revealed a quarterly MDS assessment with an ARD of 08/06/19. The status of this assessment was "in progress" which indicated it had not been completed as of 08/29/19.				RAI guidelines. The Administrator will review the result the audits and the weekly compliance meetings with MDS Coordinator for timeliness of completion and submission for any trends or patterns and report to	s of	
	Coordinator confirme completing and transfirme MDS Coordinato been on completing a assessments that we annual recertification still behind on completing assessments that we annual recertification the MDS assessments	/19 at 12:20 PM. The MDS d she was responsible for mitting MDS assessments. r explained her focus had and transmitting MDS re late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS re due after the facility's date. She acknowledged to dated 08/06/19 for and not completed within ime.			the Quality Assurance Performance Improvement Committee. The QAPI Committee consists of the Administrate Director of Nursing, Medical Director, at least 3 other staff members and meat a minimum of quarterly. The QAPI Committee will review the results of the weekly reviews of MDS timeliness of completion and submissions and directorrective action as necessary. The QAPI Committee may approve changes in the frequency of the audits and/or discontitute audits once the new system has be deemed effective to maintain substantic compliance. Completion date 09/18/19	end ets t API ne nue een	
	Administrator on 08/2 Administrator stated a	ducted with the 19/19 at 3:51 PM. The 19/19 at 3:51 PM. The 19/19 after the facility's annual 19/19 on 06/27/19, he was under					

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII	IPLE CONSTRUCTION NG		DATE SURVEY COMPLETED
		345193	B. WING _			C 08/29/2019
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP CO 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	DE	00/23/2013
(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 CO ((EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY	N SHOULD BE E APPROPRIATE	(X5) COMPLETION DATE
F 640	completed and trans timeframe based on compliance audits. was unaware there wexpected MDS asset transmitted within the 4. Resident #8 was 08/07/19. Review of Resident are record revealed an expected and expected with 08/28/19. An interview was concoordinator on 08/28/19. An interview was concompleting and trans The MDS Coordinator confirmed completing and trans that we annual recertification still behind on completing assessments that we annual recertification date. assessment dated 00 late and not transmit timeframe. An interview was concadministrator on 08/28/19.	assessments were being mitted within the required the results of the facility's The Administrator stated he was still an issue and assments to be completed and a regulatory timeframe. The administrator stated he was still an issue and assments to be completed and a regulatory timeframe. The admitted to the facility on the status of this assessment as transmission date of the status of this assessment as transmission date of the status of the sassessment as transmission date of the status of the sassessments. The admitted to the facility on the status of this assessment as transmission date of the status of the sassessments. The administrator stated he was responsible for a smitting MDS assessments. The survey on 06/27/19 but was the survey of the sassessment the same stated within the regulatory the same stated here.	F	540		
	the impression MDS completed and trans	assessments were being mitted within the required the results of the facility's				

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	l ` ′	PLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		345193	B. WING		,	C 08/29/2019	
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP COD 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713		06/29/2019	
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	I SHOULD BE	(X5) COMPLETION DATE	
F 640	was unaware there wexpected MDS asset transmitted within the 5. Resident #9 was 06/15/18. Review of Resident record revealed a dewith an ARD of 07/2 assessment was "exdate of 08/28/19. An interview was concoordinator on 08/28 Coordinator confirmed completing and transmitted been on completing assessments that we annual recertification still behind on completing assessments that we recertification date. tracking record dated was late and not transmitted recertification survey the impression MDS completed and transmitted rame based on compliance audits. was unaware there we was concompliance audits.	The Administrator stated he was still an issue and ssments to be completed and e regulatory timeframe. #9's electronic medical eath in facility tracking record 8/19. The status of this exported" with a transmission and transmission with the MDS 9/19 at 12:20 PM. The MDS ed she was responsible for smitting MDS assessments. For explained her focus had and transmitting MDS are late prior to the facility's in survey on 06/27/19 but was eting and transmitting MDS ere due after the She acknowledged the MDS d 07/28/19 for Resident #9 insmitted within the regulatory	F 64	40			

	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:				(X3) DATE COMP	SURVEY LETED
	345193	B. WING _				C 29/2019
	IG CE		410 BUCKNER BRANG	CH ROAD	1 00/	23/2013
(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL	ID PREFIX TAG	(EACH CO	RRECTIVE ACTION SHOULD E	3E	(X5) COMPLETION DATE
Continued From page	e 13	F 6	40			
transmitted within the	regulatory timeframe.					
6. Resident #10 was 07/04/19.	readmitted to the facility on					
record revealed a dea with an ARD of 08/11	ath in facility tracking record /19. The status of this					
Coordinator on 08/29 Coordinator confirme completing and trans The MDS Coordinato been on completing a assessments that we annual recertification still behind on comple assessments that we recertification date. S tracking record dated	/19 at 12:20 PM. The MDS d she was responsible for mitting MDS assessments. r explained her focus had and transmitting MDS re late prior to the facility's survey on 06/27/19 but was eting and transmitting MDS re due after the She acknowledged the MDS 08/11/19 for Resident #10					
Administrator on 08/2 Administrator stated a recertification survey the impression MDS completed and transr timeframe based on t compliance audits. T was unaware there w expected MDS asses transmitted within the	29/19 at 3:51 PM. The after the facility's annual on 06/27/19, he was under assessments were being mitted within the required the results of the facility's the Administrator stated he was still an issue and asments to be completed and a regulatory timeframe.	Fé	56			9/18/19
	SUMMARY ST. (EACH DEFICIENCE REGULATORY OR IT. Continued From page transmitted within the 6. Resident #10 was 07/04/19. Review of Resident # record revealed a dea with an ARD of 08/11 assessment was "exp date of 08/28/19. An interview was con Coordinator on 08/29 Coordinator confirme completing and trans. The MDS Coordinator been on completing a assessments that we annual recertification still behind on comple assessments that we recertification date. Stracking record dated was late and not transtimeframe. An interview was con Administrator on 08/2 Administrator stated a recertification survey the impression MDS completed and transr timeframe based on to compliance audits. Twas unaware there we expected MDS assess transmitted within the	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 13 transmitted within the regulatory timeframe. 6. Resident #10 was readmitted to the facility on 07/04/19. Review of Resident #10's electronic medical record revealed a death in facility tracking record with an ARD of 08/11/19. The status of this assessment was "exported" with a transmission date of 08/28/19. An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were late prior to the facility's annual recertification survey on 06/27/19 but was still behind on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record dated 08/11/19 for Resident #10 was late and not transmitted within the regulatory timeframe. 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ROWIDER OR SUPPLIER N VIEW MANOR NURSING CE SUMMANY STATEMENT OF DEFICIENCES (EACH DESCIDENCY OR LSC IDENTIFYING INFORMATION) Continued From page 13 transmitted within the regulatory timeframe. 6. Resident #10 was readmitted to the facility on 07/04/19. Review of Resident #10's electronic medical record revealed a death in facility tracking record with an ARD of 08/11/19. The status of this assessment was "exported" with a transmission date of 08/28/19. An interview was conducted with the MDS Coordinator on 08/29/19 at 12:20 PM. The MDS Coordinator explained her focus had been on completing and transmitting MDS assessments that were due after the recertification date. She acknowledged the MDS tracking record date do 8/11/19 for Resident #10 was late and not transmitted within the regulatory timeframe. 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WING STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713 SUMMARY STATEMENT OF DEFICIENCES (EACH DEPICEINCNY SUMMARY STATEMENT OF DEFICIENCES) (EACH DEPICEINCNY SHOULD BE CROSS-REPERENCED TO THE APPROPRIATE DEFICIENCY) Continued From page 13 transmitted within the regulatory timeframe. 6. Resident #10" was readmitted to the facility on 07704/19. Review of Resident #10"s electronic medical record revealed a death in facility tracking record with an ARD of 08/11/19. The status of this assessment was "exported" with a transmission date of 08/28/19 at 12:20 PM. The MDS Coordinator on 08/28/19 at 12:20 PM. The MDS Coordinator confirmed she was responsible for completing and transmitting MDS assessments. 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STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT A. BUILDII	TIPLE CONSTRUCTION NG	(X3) DATE SURVEY COMPLETED	
		345193	B. WING _		08/29/2019
	ROVIDER OR SUPPLIER	NG CE		STREET ADDRESS, CITY, STATE, ZIP C 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	•
(X4) ID PREFIX TAG			ID PREFI) TAG	PROVIDER'S PLAN OF X (EACH CORRECTIVE ACT CROSS-REFERENCED TO DEFICIENCE	TION SHOULD BE COMPLETION THE APPROPRIATE
F 656	Continued From pag	e 14	F 6	356	
SS=D	CFR(s): 483.21(b)(1)				
	implement a comprecare plan for each reresident rights set for §483.10(c)(3), that in objectives and timefred medical, nursing, and needs that are identificated assessment. The condescribe the followin (i) The services that or maintain the reside physical, mental, and required under §483 (ii) Any services that under §483.24, §483 provided due to the resident under §483.10, inclustreatment under §48 (iii) Any specialized sere abilitative service provide as a result or recommendations. If findings of the PASA rationale in the reside (iv) In consultation wire resident's representation (A) The resident's profuture discharge. Fact whether the resident community was asset	cility must develop and hensive person-centered sident, consistent with the rith at §483.10(c)(2) and icludes measurable ames to meet a resident's dimental and psychosocial fied in the comprehensive imprehensive care plan must grare to be furnished to attain ent's highest practicable dipsychosocial well-being as 24, §483.25 or §483.40; and would otherwise be required 6.25 or §483.40 but are not resident's exercise of rights ding the right to refuse 3.10(c)(6). Services or specialized is the nursing facility will for PASARR a facility disagrees with the RR, it must indicate its ent's medical record. It the resident and the ative(s)-bals for admission and reference and potential for collities must document is desire to return to the resident and reference and any referrals to the sessed and any referrals to the sessed and any referrals to the sessed and or other appropriate			

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 8/ 29/2019
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	10 113211 011 001 1 2.2.1			410 BUCKNER BRANCH ROAD	,_	
MOUNTAI	N VIEW MANOR NURSIN	IG CE		BRYSON CITY, NC 28713		
(X4) ID	SUMMARY ST	ATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CO	DRRECTION	(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG		N SHOULD BE E APPROPRIATE	COMPLETION DATE
F 656	Continued From page	e 15	F 6	56		
	(C) Discharge plans i	n the comprehensive care				
	plan, as appropriate,	in accordance with the				
	requirements set fortl section.	h in paragraph (c) of this				
	This REQUIREMENT by:	is not met as evidenced				
	Based on interviews	, record reviews, and		The care plan of Resident #	1 and	
		ity failed to develop a		Resident # 4 was updated or	ı 08/29/19 by	
		plan for falls to include the		the MDS Coordinator. Resid	ent # 1 and	
	-	pelt for 2 of 2 residents		Resident # 4 will continue to		
	reviewed for restraint	s (Resident #1 and #4).		plan that reflects the use of a	-	
				long as the physician □s orde	r for the lap	
	The findings included	:		belt is in place.		
	4 5 11 1/14			All residents who use a lap b		
		admitted to the facility on		wheelchair are at risk to be a	-	
	03/16/2018 with an a			same practice. A care plan a		
		a, anxiety disorder, muscle		completed by an RN for those who use a lap belt in the whe		
	Falls.	id arthritis, and a history of		verify that care plan is in place		
	i alis.			the lap belt. The care plan au		
	The quarterly Minimu	m Data Set (MDS) dated		completed by 09/18/19. Corre		
	07/01/2019 revealed			will be taken by the RN comp		
		t in cognition, she also had a		audit for any resident who do	-	
	short-term and long-t			a care plan in place for the us		
	_	of 1 staff with bed mobility		belt.	·	
	and transfers. Reside	ent #1 used a wheelchair for		The DON provided education	ı to the care	
	mobility. The MDS als	so revealed she had no falls		plan team which consists of t	he MDS	
	coded for this assess	ment.		Coordinator, the Activities Dir	ector, the	
				Director of Social Services, a		
		#1 care plans revealed that		Dietary Manager on 08/29/19		
		initiated on 10/10/16 and		to include a lap belt on the re	sident⊡s	
		07/01/2019 with a notation		comprehensive plan of care.		
	of no falls and to conf			A licensed nurse receiving a		
		erventions in place for falls		order for a lap belt will update		
	-	the lowest position, remind		resident ☐s care plan to reflect		
		get up without assistance,		a lap belt. The MDS Coording		
		will be in wheelchair, fall it side of bed up against the		designated RN will review tel orders weekly for newly orde	•	
		each, back wheels on the		and verify that the lap belt ha		
	wan, can ngut witilli i	Caori, Daok Wilcold Oll till		and voing that the lap belt ha	0 00011	1

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` '		CONSTRUCTION	(X3) DATE COMP	SURVEY PLETED
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		345193	B. WING				29/2019
NAME OF P	ROVIDER OR SUPPLIER		_	S	TREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	20/2010
				4	10 BUCKNER BRANCH ROAD		
MOUNTAI	N VIEW MANOR NURSIN	NG CE			BRYSON CITY, NC 28713		
(X4) ID	SUMMARY ST	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	(EACH DEFICIENC	Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFI TAG	X	(EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		COMPLETION DATE
F 656	Continued From page	e 16	F	656			
	wheelchair are lower	ed by occupational staff to			added to the plan of care. If the lap bel	t	
		g, and bolsters on mattress.			has not been added to the plan of care		
	-	an intervention for a lap belt.			the MDS Coordinator or designated RN		
	•	·			will update the plan of care at that time		
	An observation on 08	3/28/2019 at 09:07 AM			reflect the use of the lap belt. This		
	revealed Resident #1	sitting in her wheelchair in			process was implemented on 08/29/19		
	the front lobby comm	on area with a lap belt			Care plan audits will be completed wee		
	around her waist.				beginning on 08/29/19 by an RN to ver	ify	
					that residents who utilize lap belts have	a a	
	An interview was con	ducted on 08/28/2019 at			care plan to address the use of the lap		
		g Assistant (NA) # 3 revealed			belt for four weeks at a minimum or lor		
		ays had a lap belt on her			until substantial compliance is achieved	t	
		wheelchair, and that she			and maintained as determined by the		
	could unfasten it hers	self.			QAPI Committee. Corrective action wil		
					taken by the MDS Coordinator and/or I		
		ducted on 08/29/2019 at			for any resident who uses a lap belt that	IΤ	
		S Nurse revealed that a lap er and should have been on			does not have a care plan in place to		
					address the use of the belt.	d	
	the care plan. The M	the lap belt to deter her from			The Director of Nursing (DON) provide inservice education to the licensed and		
	getting up unassisted				non-licensed nursing staff on 09/10/19		
		aled she was responsible for			The training reviewed the updated		
	updating care plans.	alca one was responsible for			restraint guidelines. A posttest to acces	SS	
	apaamig care plane.				learning and promote competency was		
	An interview was con	iducted on 08/29/2019 at			given. Mandatory make-up inservices v		
	1:45 PM with the Dire	ector of Nursing (DON)			be provided by 09/18/19. Any licensed		
	revealed that a lap be	elt required a doctor's order			staff and non-licensed staff on leave w	II	
	and it should be on the	ne resident's care plan. She			be required to make-up the inservice p	rior	
	further revealed that				to return to duty.		
		nave a doctor's order or why			Care plan audits will be completed wee	-	
		e plan. The DON revealed			beginning 08/29/19 by an RN to verify		
		r position and does not know			residents who utilize lap belts have a c		
	if there was a system	in place for lap belts.			plan to address the use of the lap belt		
		2/20/10 10 51 51 111 11			four weeks at a minimum or longer unt		
		9/2019 at 3:51 PM with the			substantial compliance is achieved and		
		ed that he had no idea that			maintained as determined by the QAPI		
	·	belts did not have a doctor's			Committee. Corrective action will be ta		
		o revealed that it was his			by the MDS Coordinator and/or RN for		
	expectation that the I	MDS nurse would have	1		any resident who uses a lap belt that d	oes	1

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION		TE SURVEY MPLETED
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		345193	B. WING			8/29/2019
NAME OF P	ROVIDER OR SUPPLIER	•		STREET ADDRESS, CITY, STATE, ZIP CO	DDE	
MOLINTAL	N VIEW MANOR NU	DSING CE		410 BUCKNER BRANCH ROAD		
WIOONIA	IN VIEW MANOR NO	COING CE		BRYSON CITY, NC 28713		
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F 656	Continued From p	page 17	F 65	56		
		elt on the resident's care plan.		not have a care plan in place	e to address	
	2. Resident #4 wa 11/02/2019 with a vascular demention history of falls.	as admitted to the facility on n admitting diagnosis of a, abnormal posture, and a		the use of the belt. The DON will review the res weekly care plan audits for a patterns and report to the QACOMMITTEE. The QAPI Committee. The Administrator	ults of the any trends or API mittee -, Director of	
	revealed that Res impaired cognition and short-term me for all activities of	rterly MDS dated 06/18/2019 ident #4 had moderately n and deficits with her long-term emory. She was a total assist daily living with 1-2 staff IDS revealed no falls coded for		Nursing, Medical Director, a other staff members and me minimum of quarterly. The Committee will review the reaudits and direct corrective a necessary. The QAPI Comm	ets at a QAPI esults of the action as	
	this assessment. A review of Resid 11/02/2015 and la a notation of no fa and interventions. falls included: kee remind her as nee assistance, when wheelchair, fall mup against the wa	ent #4 fall care plan initiated on lest updated 06/18/2019 revealed alls, and to continue with goals. The interventions in place for up bed in the lowest position, eded to not get up without out of bed she will be in leats next to bed, Left side of bed ll, and the call light within reach. e plan intervention for a lap belt.		approve changes in the freq audits and/or discontinue the the new system has been de effective to maintain substar compliance. Completion date 09/18/19	uency of the e audits once eemed	
	2:30 PM revealed wheelchair and had an interview was 2:35 PM with NA had always had a and when she wa	Resident #4 on 08/29/2019 at she was sitting in her ad a lap belt around her waist. conducted on 08/29/2019 at #4 revealed that Resident #2 lap belt since her admission, s up in her wheelchair it was orther revealed that Resident #4 e lap belt.				
		conducted on 08/29/2019 at #1 revealed that Resident #4				

	DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G	(X3) DATE SURVEY COMPLETED
		345193	B. WING		C 08/29/2019
	ROVIDER OR SUPPLIER	I NG CE		STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	00/25/2013
(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 CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE COMPLETION
F 656	and when she was up always on. She further could unfasten the late of the care plan. The MD belt needed and order the care plan. The MD Resident #4 needed getting up unassisted interview further revealed that a lap be and it should be on the further revealed that Resident #1 did not he it was not on the care that she was new in the could under the care that she was new in the could under the care that she was new in the could under the care that she was new in the could under the care that she was new in the could under the care that she was new in the could under the care that she was new in the could under the care that th	belt since her admission, on the wheelchair it was er revealed that Resident #4 polet. ducted on 08/29/2019 at Son Nurse revealed that a laper and should have been on DS Nurse stated that the lap belt to deter her from the lato avoid injury. The alled she was responsible for ducted on 08/29/2019 at ector of Nursing (DON) elt required a doctor's order ne resident's care plan. She	F 65	56	
F 867 SS=D	Administrator revealed the residents with lap order for use. He also expectations that the included the lap belt (QAPI/QAA Improvem CFR(s): 483.75(g)(2) §483.75(g) Quality as §483.75(g)(2) The quassurance committee	(ii) ssessment and assurance. lality assessment and	F 86	37	9/18/19

PRINTED: 09/30/2019 FORM APPROVED OMB NO. 0938-0391

	OF DEFICIENCIES CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	PLE CONSTRUCTION G		E SURVEY MPLETED
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		345193	B. WING _		•	8/29/2019
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CO	·DE	
MOLINTAL	N VIEW MANOR NUR	PSING CE		410 BUCKNER BRANCH ROAD		
MOUNTAI	N VILW MANOK NON	COING CE		BRYSON CITY, NC 28713		
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F 867	Continued From p		F 8	67		
	This REQUIREME	dentified quality deficiencies; ENT is not met as evidenced				
	by:	review and staff interviews, the		Resident #1 removed the sh	heet that had	
		ssessment and Assurance		been tied around her wheeld		
		failed to maintain implemented		the sheet over her head acc		
		onitor interventions that the		interviews conducted by the		
	·	eviously put into place following		Service Director (SSD) on 0		
		ication survey of 06/27/19.		The sheet was not reapplied		
		ecited deficiency that was		resident by the nursing staff.		
		June of 2019 and subsequently		displayed no signs or sympto		
	, ,	ent revisit and complaint		distress or discomfort per sta		
		3/29/19. The recited deficiency		conducted by the SSD on 06		
		Encoding/Transmitting		Resident # 1 will continue to		
		nents. The continued failure of		wheelchair when out of bed	and will not	
	the facility during t	two federal surveys of record		have a restraint applied to he	er without a	
	show a pattern of	the facility's inability to sustain		medical symptom as assess	ed by a	
	an effective Qualit	y Assurance Program.		Registered Nurse (RN) and	a physician□s	
				order for use.		
	Findings included:			The Minimum Data Set (MD	S) of	
				Resident # 5 with the Assess	sment	
	This tag is cross re	eferenced to:		Reference Date (ARD) date	of 8/7/19 was	
				completed in the electronic h	nealth record	
	F-640 Encoding/T	ransmitting Resident		on 9/10/19 by the RN/MDS (
		sed on record review and staff		The MDS assessment was s	successfully	
	interviews, the fac	ility failed to complete one		submitted and accepted in the	ne Quality	
	admission, one an	nnual and one quarterly		Improvement and Evaluation		
		t (MDS) assessments within 14		(QIES) on 9/10/19 by the RN	1/MDS	
	days of the Assess	sment Reference Date (ARD)		Coordinator.		
		mit one entry and 2 death in the				
		cords within 14 days of the MDS		The MDS of Resident # 6 wi		
	•	or 6 of 10 residents reviewed for		date of 8/5/19 was complete		
		nents (Residents #5, #6, #7, #8,		electronic health record on 9	•	
	#9, and #10).			RN/MDS Coordinator. The N		
				assessment was successful	•	
		recertification survey of		and accepted in the QIES or	n 9/06/19 by	
		ty was cited for failure to		the RN/MDS Coordinator.		
		smit discharge, significant				
	change and annua	al MDS assessments within the		The MDS of Resident # 7 wi	th the ARD	

Facility ID: 923363

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDII		CONSTRUCTION	(X3) DATE COMP	SURVEY
		345193	B. WING _			1	C 29/2019
	ROVIDER OR SUPPLIER N VIEW MANOR NURSIN			41	REET ADDRESS, CITY, STATE, ZIP CODE 10 BUCKNER BRANCH ROAD RYSON CITY, NC 28713	1 007	23/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFII TAG	x	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		(X5) COMPLETION DATE
F 867	Administrator explain annual recertification Quality Assessment a committee met to rev concern and systems correct the deficiencies stated he was under assessments were be transmitted within the on the results of the f The Administrator fur there was still an issu concern would be rev	n 08/29/19 at 3:51 PM, the ed that after the facility's survey on 06/27/19, the and Assurance (QAA) iew the identified areas of were put into place to es cited. The Administrator the impression MDS	F	867	date of 8/6/19 was completed in the electronic health record on 8/20/19 by RN/MDS Coordinator. The MDS assessment was successfully submitte and accepted in the QIES on 9/06/19 by the RN/MDS Coordinator. The MDS of Resident# 8 with the ARD date of 8/7/19 was transmitted into the QIES system on 8/29/19 by the RN/MD Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 9 with the ARD date of 7/28/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. The MDS assessment was successfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the AR date of 8/11/19 was transmitted into the QIES system on 8/29/19 by the RN/MDS Coordinator. The MDS of Resident # 10 with the AR date of 8/11/19 was transmitted into the QIES on 8/29/19 by the RN/MDS Coordinator. Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessment was uccessfully submitted and accepted in the QIES on 8/29/19 by the RN/MDS Coordinator. Residents # 5, #6, #7, #8, #9, and # 10 will continue to have timely assessment completed in the electronic health record by the Interdisciplinary Team (IDT) and transmitted by the MDS Coordinator in the QIES system per Resident Assessment Instrument (RAI) guideline The care plan of Resident # 1 and	d by OS s n O e S s n O ts rd I to	

, ,	VIDER/SUPPLIER/CLIA TIFICATION NUMBER:	, ,	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	245402	D WING		С
NAME OF PROVIDED OF CURRUES	345193	B. WING	OTDEET ADDRESS SITV STATE ZID SODE	08/29/2019
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 SUMMARY STATEMENT (PREFIX (EACH DEFICIENCY MUST BE TAG REGULATORY OR LSC IDENTI	PRECEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD B CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	DATE.
F 867 Continued From page 21		F 867	<u>'</u>	or election or election an oelt on is election is election.

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULT A. BUILDIN	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED
		345193	B. WING			C 08/29/2019
	ROVIDER OR SUPPLIER			STREET ADDRESS, CIT 410 BUCKNER BRANC BRYSON CITY, NC	CH ROAD	1 00/23/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFI) TAG	(EACH CO	DER'S PLAN OF CORRECTION PRECTIVE ACTION SHOULD E ERENCED TO THE APPROPRI DEFICIENCY)	BE COMPLETION
F 867	Continued From pag	e 22	F	orientation perion Weekly staff into sheet as a restrict the SSD, AA, or of four weeks. Will be initiated through 09/26/2 conducted rand RN Supervisor resident is inappered four weeks or look compliance is a as determined as discrepancies and transmission on 09/05/19 and minimum of four committee has compliance has system has been MDS Coordinated Administrator and Administrator and Administrator and the electronic howere initiated on Administrator mand the discrepancies of the commendation of the electronic home month, bas recommendation timely completic	terviews related to use of raints will be completed or designated RN for a to The weekly staff interview on 09/05/19 and run 19. Weekly rounds will be domly by the DON and/of on all shifts to identify its propriately restrained from the QAPI Committee ands by the QAPI Committee ands by the DON and/or e initiated on 09/06/19. Will receive immediate on by a licensed nurse. In plete weekly audits of the ents reviewing completion dates. The audits be and will continue at a cur weeks or until the QA deemed substantial is been reached and the endeemed effective. The tor will meet with the and/or Assistant at a minimum of two times are completion and the fine MDS assessments are completion and the modern of the MDS assessments are completion and the modern of the MDS assessments are completed on 08/30/19. The may choose to decrease e meetings to weekly at	I by otal ews be or fa or de. RN Any the on gan API e he es a sin ings e the fter e, if the

	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	` ′	E CONSTRUCTION	(X3) DATE SURVEY COMPLETED
		345193	B. WING		C
	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713	08/29/2019
(X4) ID PREFIX TAG	(EACH DEFICIENC	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	BE COMPLETION
F 867	Continued From pag	e 23	F 867	The MDS Coordinator will meet with the Administrator and/or Assistant Administrator at a minimum of two time week beginning 08/30/19 to review completion and transmission of the MI assessments in the electronic health record. The Administrator may choose decrease the frequency of the meeting weekly after one month, based on the recommendations of the QAPI commit if timely completion and transmission the MDS assessments are occurring provided the MDS assessments are occurring provided to the MDS assessments in the electron health record for the QAPI reporting period. Care plan audits will be completed we by an RN for a total of four weeks to we that residents who utilize lap belts have care plan to address the use of the lap belt. The care plan audits will begin on 08/29/19 and run thru 09/19/19. Corrective action will be taken by the lap for any resident who uses a lap belt the does not have a care plan in place to address the use of the belt. The Administrator, AA, SSD, or DON review the results of their audits, round and/or interviews for any trends or patterns and report to the Quality Assurance Performance Improvement (QAPI) Committee. The QAPI Committees of the Administrator, Director Nursing, Medical Director, and at least other staff members and meets at a minimum of quarterly. The QAPI	es a DS e to gs to ttee, of per sion pnic ekly erify re a o n RN pat will ds ettee of

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	1 ' '	PLE CONSTRUCTION G		(X3) DATE SURVEY COMPLETED	
		345193	B. WING		1	C / 29/2019	
NAME OF P	ROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE	1 00/	123/2013	
				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 CORRECTION (EACH CORRECTIVE ACTION SHOUL) CROSS-REFERENCED TO THE APPROF DEFICIENCY)) BE	(X5) COMPLETION DATE	
F 867	Continued From page	÷ 24	F 86	Committee will review the results of audits and direct correct action as necessary. The QAPI Committee ma approve changes in the frequency of audits and/or discontinue the audits/interviews once the new system has been deemed effective to maints substantial compliance. Completion date 09/18/19	ay the em		