STATEMENT OF ISOLATED DEFICIENCIES WHICH CAUSE NO HARM WITH ONLY A POTENTIAL FOR MINIMAL HARM FOR SNFs AND NFs	PROVIDER #	MULTIPLE CONSTRUCTION	DATE SURVEY COMPLETE:
	345193	A. BUILDING: _____ B. WING _____	10/31/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH RD PO BOX 2344 BRYSON CITY, NC

ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES
F 514	483.75(l)(1) RES RECORDS-COMPLETE/ACCURATE/ACCESSIBLE

The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized.

The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes.

This REQUIREMENT is not met as evidenced by:
Based on record review and staff interviews the facility failed to ensure nurse ' s notes dated 1/17/13 contained accurate documentation regarding the location of a resident found unresponsive for 1 of 1 sampled resident. (Resident #115)

Findings include:

Resident #115 was originally admitted on 10/22/12 and re-admitted to the facility on 1/4/13.
Diagnosis included Osteomyelitis L 3-4, Atrial Fibrillation, Congestive heart Failure, Chronic obstructive pulmonary disease, Coagulopathy, Renal insufficiency, Deep Vein Thrombosis- right lower extremity and Anemia.

A review of the facility form titled 'Resident Data Collection' dated 1/4/13 revealed resident #115 was partial weight bearing, required assistance for dressing, grooming and oral hygiene.

A review of the re-admit Minimum Data Set dated 1/11/13 revealed resident #115's brief interview for mental status score was 15, indicating the resident was cognitively intact with no memory problems.

A review of resident #115's medical record revealed that physical therapy and occupational therapy was working with the resident to strengthen his muscle due to decline in medical condition.

A review of a nurse's note dated 1/17/13 at 1:55am stated "Walked into room to hang IV (intravenous) antibiotic. The patient was assessed and found to have no response to painful stimulation 0 spontaneous respiration, no palpable carotid or femoral pulses, apical pulse is absent no audible or palpable blood pressure. The pupils are fixed and dilated no breath sounds or heart sounds heard on auscultation. The patient is therefore pronounced dead by - ------ --- (nurse #1).

A telephone interview was conducted with NA#1 on 10/30/13 at 1:46pm. The NA stated she was working the night resident #115 was found dead. "She remembers he was sitting on the floor at the end of the bed. The NA stated the nurse and 2 other NA's and herself picked the resident up and placed him in his bed. She also stated that the other NA's told her not to say anything about him being on the floor.

The above isolated deficiencies pose no actual harm to the residents

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A telephone interview with NA#2 was conducted on 10/31/13 at 9:31am. When the NA was asked what she remembered about resident #115 and she stated "my nurse found him and she came and got me. The other NA's and I cleaned him up. When I first saw him he was lying in bed.

On 10/31/13 at 10:13am an interview conducted with nurse #1 provided the following information. On 1/7/13 nurse #1 remembers entering resident #115's room to administer IV antibiotic, when entering the room she saw the resident lying on his side the floor. "His head was on a pillow at the foot of the bed and his feet were beside the bed near the head of the bed. I did an assessment of him on the floor. I assessed his apical femur and radial pulses; he had none. I got NA #1, #2 and #3 and we picked him up and placed him in his bed. I finished the assessment for any bruises and there were none. It looked like he had gotten up to go to the bathroom and then he lay down on the pillow on the floor. He was non-compliant with using the call light. The call light was on the bed. He was awake at about 11:00pm and we talked. He was alert and talked about looking forward to getting stronger and going home. On my first round he told me the physician had told him that he was dying. I know he was awake at 11:30pm when NA #2 was with him." Nurse #1 was asked why the documentation did not state the resident was found on the floor. The nurse responded that she "thought she had put it in the nurse ' s note. Normally I would do an incident form when someone falls or is found on the floor. I do not remember fixing an incident report."

On 10/31/13 at 10:15am an interview with NA#3 was conducted. When asked what she remembered about Resident #115 she provided the following information. The night he died we (NA#2) took vitals about 11:30pm and 12:00am. The resident seemed to be fine then but agitated. The NA was asked to define agitated; she responded "he was like fidgety not like he would normally be. I do remember he was on some kind of medicine. The nurse found him somewhere around 2ish she came and said he had passed and we(NA#1 & #2 along with nurse #1) went down to get him ready for the funeral home. He was in the bed we cleaned him up and put a clean gown on him. The NA was asked if the resident was found on the floor as that information had been provided by other staff; she responded "It is a little odd for someone to say that he was found on the floor. I did not assist any one putting him back to bed.

On 10/31/13 at 100:18am an interview with the administrator revealed that he was unaware that Resident #115 was found on the floor. The administrator stated an investigation of a death would occur when there was suspicion regarding the death. Further discussion revealed that he was unaware of any incident reports completed regarding Resident #115; he stated the physicians had told the resident that nothing more could be done for him. The administrator referred to the DON (Director of Nursing) to check her records regarding an incident report.

On 10/31/13 at 10:20am the information regarding differences of finding resident on the floor was shared with the DON she had no information that resident was found on floor. The DON reviewed her incident report log and showed it to me and resident was not listed. The DON looked up schedule and on 1/16/13 and confirmed nurse #1 and NA#1, #2, and #3 were working that 11:00pm to 7:00am shift. Further discussion revealed that the facility policy was that an incident report is completed for all falls witnessed or unwitnessed.

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