STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253 SS=D	483.10(i)(2) HOUSEKEEPING & MAINTENANCE SERVICES (i)(2) Housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior; This REQUIREMENT is not met as evidenced by: Based on observations and staff interview the facility failed to label and properly store personal care items and personal hygiene products in 3 resident bathrooms on 2 of 4 halls of the facility. The findings included: 1. Observations of the bathroom shared by 2 residents in Room 142 made on 05/01/17 at 12:39 PM, 05/02/17 at 11:00 AM, 05/04/17 at 10:07 AM and 05/04/17 at 10:50 AM revealed an unlabeled ceramic mug sitting on the right side of the sink containing toothbrushes and toothpaste which were also unlabeled. There was an unlabeled emesis basin on the left side of the sink containing a denture cup, denture brush, toothbrush and toothpaste which were also unlabeled. An interview with the Director of Nursing (DON) on 05/04/17 at 10:50 AM in Room 142 revealed the items remained as noted above. The DON stated she expected personal hygiene items to be labeled or stored in a labeled container. An interview with Nurse Aide (NA) #3 on 05/04/17 at 10:51 AM revealed residents' personal care items should be labeled and/or stored in a labeled container. 2. Observations of the bathroom shared by 2 residents in Room 123 made on 05/02/17 at 7:59	F 253	On May 4, 2017, the ceramic mug, emesis basin, and denture cup in room 142 were labeled by a CNA with the resident□s name. The toothbrush was discarded and replaced with a new toothbrush in a toothbrush holder that was labeled by a CNA On May 4, 2017 the wash basins and bed pan in room 123 were discarded by a CNA. New wash basins were labeled by a CNA with the residents□ names and placed in the residents□ room. The new basins were stored separately, not stacked. The bedpan was not replaced because the affected resident no longer used it. On May 4, 2017 the bedpan in room 131 was discarded by a CNA. It was replaced with a new bedpan, labeled by a CNA with the resident□s name and stored in a plastic bag on the back of the commode. An audit of resident rooms, including bathrooms, was done by the ADON on May 5, 2017 for improper storage of wash basins and bedpans. Any wash basins found nesting or without names were discarded and replaced with properly labeled and stored wash basins by a CNA. Any bedpans found without names	6/1/17

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Electronically Signed
TITLE
(X6) DATE: 05/26/2017

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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F 253	Continued From page 1 AM, 05/02/17 at 4:03 PM, on 05/03/17 at 8:07 AM, on 05/03/17 at 10:07 AM, on 05/04/17 at 8:41 AM and on 05/04/17 at 10:45 AM revealed 2 unlabeled wash basins stored on the bathroom floor and nesting inside each other. An interview on 05/03/17 at 10:17 AM with Nurse Aide (NA) #1 revealed residents' wash basins should be labeled with resident's name and stored separately on the shelf in the appropriate resident's closet. NA #1 stated wash basins and bedpans should never be stored on the bathroom floor. An interview with the Director of Nursing (DON) on 05/04/17 at 10:45 AM in Room 123 revealed the items remained as noted above. The DON stated she expected wash basins to be labeled and stored in each resident's closet. 3. Observations of the bathroom shared by 2 residents in Room 131 made on 05/02/17 at 8:02 AM, 05/02/17 at 4:05 PM, 05/03/17 at 8:08 AM, 05/03/17 at 10:08 AM and 05/04/17 at 8:41 AM revealed 2 unlabeled wash basins stored on the bathroom floor and nesting inside each other. Also, stored on the bathroom floor was an unlabeled, unbagged bedpan. An interview on 05/03/17 at 10:17 AM with Nurse Aide (NA) #1 revealed residents' wash basins should be labeled with resident's name and stored on the shelf in the resident's closet. NA #1 stated bedpans should be labeled and stored on the back of the commode in a clear plastic bag. NA #1 stated wash basins and bedpans should never be stored on the bathroom floor. An interview with the Director of Nursing (DON)	F 253	or improperly stored were discarded and replaced by properly labeled and stored bedpans by a CNA. An audit of resident rooms, including bathrooms, was done by the ADON on May 5, 2017 to make sure all personal items were labeled with the resident□s name. Any personal items found without labels were labeled by the CNA. On May 30, 2017 all CNAs will be inserviced by the DON on the proper storage and labeling of wash basins and bedpans and the correct labeling of personal items. Make-up inservices will be provided by June 1, 2017. Any CNA on leave will be required to make-up the inservice prior to return to duty. All new CNAs will be oriented on the correct storage and labeling of wash basins, bedpans, and personal items. A reminder to label and store wash basins, bedpans, and other personal care items was placed in the front of all CNA flow sheet books by the DON and ADON on May 26, 2017. The DON, ADON, or the RN Supervisor will do random audits for improperly labeled or stored wash basins, bedpans, and personal items weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action by nursing staff as directed by the auditor. Any deficient	

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F 253	Continued From page 2 on 05/04/17 at 10:47 AM in Room 131 revealed the wash basins had been removed from the floor; however, the bedpan remained as noted above on the bathroom floor. The DON stated she expected bedpans to be labeled and stored in a plastic bag on the back of the commode. An interview on 05/04/17 at 10:48 AM with NA #2 revealed bedpans should be labeled and stored in a plastic bag on the back of the commode.	F 253	practices will be documented and corrected immediately. The Administrator will monitor for compliance. Any deficient practice will be documented and reported to the QA Committee and corrective action will be taken.	
F 278 SS=D	483.20(g)-(j) ASSESSMENT ACCURACY/COORDINATION/CERTIFIED (g) Accuracy of Assessments. The assessment must accurately reflect the resident's status. (h) Coordination A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals. (i) Certification (1) A registered nurse must sign and certify that the assessment is completed. (2) Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment. (j) Penalty for Falsification (1) Under Medicare and Medicaid, an individual who willfully and knowingly- (i) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or	F 278		5/18/17

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F 278	Continued From page 3 (ii) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment. (2) Clinical disagreement does not constitute a material and false statement. This REQUIREMENT is not met as evidenced by: Based on record review and staff interviews the facility failed to accurately code 1 of 1 sampled residents utilizing the Minimum Data Set (MDS) to reflect dialysis (Resident #51) and 1 of 1 sampled residents for death to reflect prognosis (Resident #31). Findings included: 1. a. Resident #51 was readmitted to the facility on 06/27/16 with diagnosis of end stage renal disease (ESRD). A review of the physician's signed monthly orders dated 09/28/16 to 10/31/16 indicated Resident #51 was to receive dialysis every Monday, Wednesday, and Friday. The annual Minimum Data Set (MDS) assessment dated 10/19/16 indicated Resident #51 had not been coded under Section O for Special Treatments, Procedures, and Programs as receiving dialysis care. On 05/03/17 at 9:23 AM an interview was conducted with the MDS Coordinator who stated she had completed Section O for Special Treatments, Procedures, and Programs and stated Resident #51 should have been coded as	F 278	On May 3, 2017, the annual MDS assessment, section 0 for special treatments, of October 19, 2016 for resident #51 was modified by the MDS Coordinator to reflect resident #51□s dialysis orders. The modified MDS was successfully submitted by the MDS Coordinator to CMS on May 3, 2017. On May 3, 2017, the quarterly MDS of January 13, 2017 was modified by the MDS Coordinator on resident #51□s section 0 for special treatments to reflect the resident□s dialysis order. The modified MDS was successfully submitted by the MDS Coordinator to CMS on May 3, 2017. On May 3, 2017, the quarterly MDS of April 14, 2017 was modified by the MDS Coordinator on resident #51□s section 0 for special treatments to reflect the resident□s dialysis order. The modified MDS was successfully submitted by the MDS Coordinator to CMS on May 3, 2017. On May 2, 2017, the MDS on resident #31, section J1400, Prognosis, was modified by the MDS Coordinator to	

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F 278

Continued From page 4

receiving dialysis. The MDS Coordinator stated Resident #51 had been receiving dialysis for a long time and was missed for coding on the annual MDS assessment. The MDS Coordinator stated she would immediately submit a correction to Resident #51's annual MDS assessment dated 10/19/16 to indicate dialysis care.

b. Resident #51 was readmitted to the facility on 06/27/16 with diagnosis of end stage renal disease (ESRD).

A review of the physician's signed monthly orders dated 12/31/16 to 01/31/17 indicated Resident #51 was to receive dialysis every Monday, Wednesday, and Friday.

The quarterly MDS assessment dated 01/13/17 indicated Resident #51 had not been coded under Section O for Special Treatments, Procedures, and Programs as receiving dialysis care.

On 05/03/17 at 9:33 AM an interview was conducted with the Assistant Director of Nursing (ADON) who stated she had completed Section O for Special Treatments, Procedures, and Programs and stated Resident #51 should have been coded as receiving dialysis. The ADON stated Resident #51 had been receiving dialysis for a long time and was missed for coding on the quarterly MDS assessment. The MDS Coordinator stated she would immediately submit a correction to Resident #51's quarterly MDS assessment dated 01/13/17 to reflect dialysis care.

c. Resident #51 was readmitted to the facility on 06/27/16 with diagnosis of end stage renal

F 278

reflect a life expectancy of less than 6 months. The modified MDS was successfully submitted by the MDS Coordinator to CMS on May 2, 2017.

An audit of section J1400 on the MDS was done by the MDS Coordinator on all hospice residents in the past 6 months for correct MDS coding. For any deficient practice found, the MDS was modified and submitted by the MDS Coordinator to CMS on May 3, 2017.

An audit of section O on the MDS was done by the MDS Coordinator for special treatments. For any deficient practice found, the MDS was modified and sent by the MDS Coordinator to CMS on May 2, 2017.

Prior to coding, the MDS Coordinator will check physician orders and review resident status for hospice and dialysis services.

MDS Coordinator/ADON will do random audits of the MDS for deficient practices weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action. For any deficient practice found, the MDS will be modified and sent to CMS by the MDS Coordinator.

The Administrator will monitor the audits for compliance. Any deficient practice will be documented and reported to the QA

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F 278	Continued From page 5 disease (ESRD). A review of the physician's signed monthly orders dated 03/29/17 to 04/30/17 indicated Resident #51 was to receive dialysis every Monday, Wednesday, and Friday. The quarterly MDS assessment dated 04/14/17 indicated Resident #51 had not been coded under Section O for Special Treatments, Procedures, and Programs as receiving dialysis care. On 05/03/17 at 9:23 AM an interview was conducted with the MDS Coordinator who stated she had completed Section O for Special Treatments, Procedures, and Programs and stated Resident #51 should have been coded as receiving dialysis. The MDS Coordinator stated Resident #51 had been receiving dialysis for a long time and was missed for coding on the quarterly MDS assessment. The MDS Coordinator stated she would immediately submit a correction to Resident #51's quarterly MDS assessment dated 04/14/17 to reflect dialysis care. On 05/03/17 at 9:39 AM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that the annual MDS assessment dated 10/19/16, quarterly MDS assessment dated 01/13/17, and the quarterly MDS assessment dated 04/14/17 would have been coded accurately to reflect Resident #51 was receiving dialysis. The DON stated Resident #51 had been on dialysis since admission to the facility and was missed for coding. The DON stated her expectation was that a correction would be completed for Resident #51's annual	F 278	Committee and corrective action will be taken.	

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F 278	Continued From page 6 MDS assessment dated 10/19/16, quarterly MDS assessment dated 01/13/17, and quarterly MDS assessment dated 04/14/17 and submitted to reflect dialysis. On 05/03/17 at 2:41 PM an interview was conducted with the Administrator who stated his expectation was that Resident #51's annual MDS assessment dated 10/19/16, quarterly MDS assessment dated 01/13/17, and quarterly MDS assessment dated 04/14/17 would have been accurately coded to reflect dialysis. The Administrator stated his expectation was that Resident #51's annual and quarterly MDS assessments would be corrected and submitted to reflect dialysis care. 2. Resident #31 was admitted to the facility on 01/03/17 with diagnosis of congestive heart failure. A review of a physician's order dated 01/05/17 indicated Resident #31 had a prognosis of less than 6 months related to diagnosis of congestive heart failure. A review of a hospice progress note dated 01/05/17 indicated Resident #31 had a prognosis of less than 6 months related to diagnosis of congestive heart failure. A review of Resident #31's admission Minimum Data Set (MDS) assessment dated 01/10/17 indicated Resident #31 had been coded under section J1400 Prognosis as not having a condition or chronic disease that could result in a life expectancy of less than 6 months. On 05/02/17 at 3:08 PM an interview was conducted with the MDS Coordinator who stated	F 278		

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F 278	Continued From page 7	F 278		

she coded Section J1400 Prognosis and stated Resident #31 should have been coded as having a life expectancy of less than 6 months. The MDS Coordinator stated she missed reading the physician's order and hospice progress note dated 01/05/17 that indicated Resident #31 had a prognosis of less than 6 months related to diagnosis of congestive heart failure. The MDS Coordinator stated she would immediately submit a correction to Resident #31's admission MDS assessment dated 01/10/17 to reflect a life expectancy of less than 6 months.

On 05/02/17 at 3:36 PM an interview was conducted with the Director of Nursing (DON) who stated her expectation was that Resident #31's admission MDS assessment dated 01/10/17 would have been accurately coded to reflect Resident #31 had a life expectancy of less than 6 months. The DON stated her expectation was that the MDS Coordinator would have reviewed the physician's order and hospice note dated 01/05/17 prior to coding Resident #31's admission MDS assessment. The DON stated her expectation was that the admission MDS assessment dated 01/10/17 would be corrected and submitted to reflect Resident #31 had a life expectancy of less than 6 months.

On 05/02/17 at 3:52 PM an interview was conducted with the Administrator who stated his expectation was that the admission MDS assessment dated 01/10/17 would have been accurately coded to reflect Resident #31 had a life expectancy of less than 6 months. The Administrator stated his expectation was that the admission MDS assessment dated 01/10/17 would be corrected and submitted to reflect Resident #31 had a life expectancy of less than 6

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F 278	Continued From page 8 months.	F 278		
F 282 SS=D	483.21(b)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN (b)(3) Comprehensive Care Plans The services provided or arranged by the facility, as outlined by the comprehensive care plan, must- (ii) Be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to follow the care plan for 2 of 14 residents (Resident #94 and #2) dependent on staff for incontinence care. The findings included: 1. Resident #94 was admitted to the facility on 11/21/16 with diagnoses which included non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 02/17/17 indicated Resident #94 required extensive assistance with transfers, bed mobility, hygiene, and toileting. The MDS also indicated Resident #94 was occasionally incontinent of urine. The MDS further indicated Resident #94 had a care plan including approaches to manage his urinary incontinence that included "check resident at least every 2 hours for urinary incontinence care." During a continuous observation of Resident #94 on 05/04/17 from 9:22 AM to 12:06 PM, Resident #94 was not offered or assisted with urinary incontinence care.	F 282	On May 4, 2017, resident #2 was provided incontinence care at 12:48 pm by a CNA. Resident #2 will be cued for toileting every 2 hours thereafter as outlined in the care plan. On May 4, 2017, resident #94 was provided incontinence care at 12:06 pm by a CNA. Resident #94 will be checked and every 2 hours by a CNA as outlined in the care plan. On May 4, 2017, CNA #1 and CNA #2 were counseled by the DON about following the plan of care for residents. The ADON and RN Supervisor conducted rounds on May 5, 2017 of all other residents to identify residents in need of incontinence care or toileting cues as outlined in their care plans. Any issues found were brought to the attention of the CNA for immediate correction.	6/1/17

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F 282	Continued From page 9 On 05/04/17 at 9:41 AM, Nurse Aide (NA) #1 was observed in the dining room asking Resident #94 if he wanted to go down to his room. Resident #94 responded "no" and NA #1 said "all right" and NA #1 left the room. Resident #94 was not checked for urinary incontinence and he was not offered assistance with incontinence care. On 05/04/17 at 9:46 AM, NA #2 was observed walking up to Resident #94 in the hallway and helped him to his room where he was assisted to be seated in a chair. Resident #94 was not checked for urinary incontinence and he was not offered assistance with incontinence care. On 05/04/17 at 10:07 AM, Resident #94 was observed using his call light and calling out "hello" repeatedly. On 05/04/17 at 10:09 AM, NA #2 was observed walking into the room of Resident #94 and asked if he needed something. Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 to the side and pulled up the bedside table and offered the beverage that was sitting on the bedside table to Resident #94. Resident #94 was not checked for urinary incontinence and he was not offered assistance with incontinence care. On 05/04/17 at 10:14 AM, the Activity Director (AD) was observed walking into the room of Resident #94 and made reference to the television (TV) and a show that was on. On 05/04/17 at 10:23 AM, the housekeeper was observed walking into the room of Resident #94. The housekeeper took the trash out of the room.	F 282	On May 30, 2017, the DON will inservice all CNAs on incontinence care and cueing residents for toileting as outlined in their care plan. Make-up inservices will be provided by June 1, 2017. Any CNA on leave will be required to make-up the inservice prior to return to duty. All newly hired CNAs will be oriented on incontinence care and following the care plan by RN Supervisor. Incontinence care and following the care plan has been added to the skills check list for new hires. Licensed nurses will be responsible for monitor that residents under their direct supervision are receiving incontinence care and toilet cueing as outlined in the residents□ care plans. Any discrepancies identified will receive immediate corrective action. A random audit of residents will be conducted by the DON, ADON, or Nursing Supervisor for incontinence care and cueing to toilet as outlined in residents□ care plans weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action by nursing staff as directed by the auditor. The DON will monitor for compliance and report results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with supervision from the	

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F 282	Continued From page 10 On 05/04/17 at 10:36 AM, the housekeeper was observed walking into the room of Resident #94. The housekeeper swept and mopped the room. During an interview on 05/04/17 at 11:53 AM, NA #2 stated Resident #94 was usually checked every 2 hours but this had been a crazy day because she had to take another resident for a whirlpool bath off the unit and was gone for about 35 minutes. NA #2 stated she had not assisted Resident #94 with incontinence care but she knew it should have been done. During an interview on 05/04/17 at 12:01 PM, NA #1 stated she had assisted Resident #94 with transfers, dressing and urinary incontinence care at 7:15 AM. NA #1 stated she also asked Resident #94 about toileting after breakfast and Resident #94 denied having to go to the bathroom. NA #1 also stated the nurse aides tried to check all the residents every 2 hours but she had gotten busy and forgot to check on Resident #94 since after breakfast. On 05/04/17 at 12:06 PM, NA #1 and NA #2 assisted Resident #94 with incontinence care. Resident #94 was noted to have on a brief that was visibly wet with yellow urine. Resident #94 was also noted to have slightly pinkish colored skin across his lower buttocks but had no evidence of skin breakdown. During an interview on 05/04/17 at 1:21 PM, the Director of Nursing (DON) stated the NA's were trained to check on the residents every 2 hours for incontinence care. The DON also stated her expectations were for the NA's to check on residents every 2 hours and follow their care	F 282	DON as necessary when trends and/or patterns are identified.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 282	Continued From page 11	F 282		

plans.

2. Resident #2 was admitted to the facility 01/22/08 with diagnoses which included aphasia, CVA (stroke), and hemiplegia or hemiparesis.

Review of the care plan dated 01/11/17 focused on incontinence of bladder and required cueing to toilet per schedule. The intervention in place was for direct care staff to cue Resident #2 to void every 2 hours while awake.

A review of the quarterly Minimum Data Set (MDS) dated 04/11/17 indicated Resident #2 had moderately impaired cognition with poor decision making and required supervision and cues. The MDS also indicated Resident #2 needed extensive assistance with toileting and was frequently incontinent of bladder. The MDS indicated Resident #2 had rejection of care behaviors that had occurred 1-3 days.

The Care Area Assessment of the MDS dated 04/11/17 for urinary incontinence described Resident #2 to have bladder incontinent episodes, remained on a toileting program and staff were to cue him to toilet every 2 hours and assist as needed.

A continuous observation of Resident #2 made on 05/04/17 at 9:48 AM thru 05/04/17 at 12:26 PM revealed Resident #2 was alert and awake and had not been cued for toileting needs. There were no negative behaviors noted during the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

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F 282	Continued From page 12 continuous observation. During an interview on 05/04/17 at 12:48 PM with the Nurse Aide (NA) #4 she revealed Resident #2 had not been cued for toileting needs for a period of more than 2 hours. During an interview on 05/04/17 at 1:04 PM with Nurse #2 it was revealed she had not checked to ensure Resident #2 was cued for toileting needs. During an interview on 05/04/17 at 2:56 PM with the Administrator it was revealed his expectation was for direct care staff to provide care every 2 hours and follow Resident #2's plan of care.	F 282		
F 312 SS=D	483.24(a)(2) ADL CARE PROVIDED FOR DEPENDENT RESIDENTS (a)(2) 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. This REQUIREMENT is not met as evidenced by: Based on observations, record review, and staff interviews the facility failed to check for incontinence for 2 of 4 sampled residents who were dependent upon staff for toileting and incontinence care (Residents #2 and #94). 1. Resident #2 was admitted to the facility 01/22/08 with the diagnoses of aphasia, CVA (stroke), and hemiplegia or hemiparesis. Review of the care plan for Resident #2 dated 01/11/17 focused on incontinence of the bladder and cue to toilet per schedule. The interventions in place for direct care staff was to cue Resident	F 312	On May 4, 2017, resident #2 was provided incontinence care at 12:48 pm by a CNA. Resident #2 will be cued for toileting by a CNA every 2 hours. On May 4, 2017, resident #94 was provided incontinence care at 12:06 pm by a CNA. Resident #94 will be provided incontinence care every 2 hours by a CNA. On May 4, 2017, CNA #1 and CNA #2 were counseled by the DON on providing incontinence care to dependent residents.	6/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 13 #2 to void every 2 hours while awake and assist with toileting as needed. A review of the quarterly Minimum Data Set (MDS) dated 04/11/17 indicated Resident #2 had moderately impaired cognition with poor decision making and required supervision and cues. The MDS also indicated Resident #2 needed extensive assistance with toileting and was frequently incontinent of bladder. The MDS showed Resident #2 had rejection of care behaviors that had occurred 1-3 days. The Care Area Assessment of the MDS dated 04/11/17 for urinary incontinence described Resident #2 to continue to have bladder incontinent episodes and remained on a toileting program and staff were cue him to toilet every 2 hours and assist as needed. Observation of Resident #2 made on 05/04/17 at 9:48 AM revealed him lying in bed alert and watching television. The final observation made on 05/04/17 at 12:26 PM revealed Resident #2 was alert and lying in bed with a strong odor of urine and a yellow ring surrounding a large wet area on the bed sheets. There were no negative behaviors noted during the observations. Resident #2 was observed wearing pants with an area of wetness surrounding the perineal and buttocks area. During an interview on 05/04/17 at 12:48 PM with the Nursing Aide (NA) #4 she confirmed the bed linens were wet and stained with a yellow ring. She also confirmed Resident #2's pants were wet at perineal and buttocks area. She was unable to explain why she had not cued or checked for incontinence for more than 2 hours. She	F 312	The ADON and RN Supervisor conducted rounds on May 5, 2017 of all other dependent residents to identify residents in need of incontinence care or toileting cues as outlined in their care plans. On May 30, 2017, the DON will inservice all CNAs on incontinence care for dependent residents. Make-up inservices will be provided by June 1, 2017. Any CNA on leave will be required to make-up the inservice prior to return to duty. All newly hired CNAs will be oriented on incontinence care for residents by the RN Supervisor. Incontinence care has been added to the skills check list for new hires. Licensed nurses will be responsible for monitor that residents under their direct supervision are receiving incontinence care and toilet cueing as outlined in the residents□ care plans. Any discrepancies identified during audit will receive corrective action by nursing staff as directed by the auditor. A random audit of residents will be conducted by the DON, ADON, or Nursing Supervisor for incontinence care and cueing to toilet weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action. The DON will monitor for compliance and	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 312

Continued From page 14

confirmed Resident #2 was on a toileting program and was to be checked 3 to 4 times each eight hour shift.

During an interview on 05/04/17 at 1:04 PM with Nurse #2 she confirmed she had not checked if Resident #2 was being provided cues for toileting or incontinence care.

During an interview on 05/04/17 at 2:39 PM with Director of Nursing it was revealed her expectation was for direct care staff to check Resident #2 every 2 hours and provide incontinence care as needed.

During an interview on 05/04/17 at 2:56 PM with the Administrator it was revealed his expectation was for direct care staff to provide care every 2 hours and follow Resident #2's plan of care.

2. Resident #94 was admitted to the facility on 11/21/16 with diagnoses which included non-Alzheimer's dementia. The quarterly Minimum Data Set (MDS) dated 02/17/17 indicated Resident #94 had short and long term memory problems and required extensive assistance with transfers, bed mobility, hygiene, and toileting. The MDS also indicated Resident #94 was occasionally incontinent of urine. The MDS further indicated Resident #94 had a care plan including approaches to manage his urinary incontinence that included "check resident at

F 312

report results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with supervision from the DON as necessary when trends and/or patterns are identified.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 15	F 312		

least every 2 hours for urinary incontinence care."

During a continuous observation of Resident #94 on 05/04/17 from 9:41 AM to 12:06 PM, Resident #94 was not checked for incontinence.

On 05/04/17 at 9:41 AM, Nurse Aide (NA) #1 was observed in the dining room asking Resident #94 if he wanted to go down to his room. Resident #94 responded "no" and NA #1 said "all right" and NA #1 left the room.

On 05/04/17 at 9:46 AM, NA #2 was observed walking up to Resident #94 in the hallway and helped him to his room where he was assisted to be seated in a chair. Resident #94 was not checked for urinary incontinence.

On 05/04/17 at 10:07 AM, Resident #94 was observed using his call light and calling out "hello" repeatedly.

On 05/04/17 at 10:09 AM, NA #2 was observed walking into the room of Resident #94 and asked if he needed something. Resident #94 was unable to tell NA #2 what he needed. NA #2 moved the rolling walker of Resident #94 to the side and pulled up the bedside table and offered the beverage that was sitting on the bedside table to Resident #94. Resident #94 was not checked for urinary incontinence.

During an interview on 05/04/17 at 11:53 AM, NA #2 stated Resident #94 was usually checked every 2 hours but this had been a crazy day because she had to take another resident for a whirlpool bath off the unit and was gone for about 35 minutes. NA #2 stated she had not assisted Resident #94 with incontinence care but she

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 312	Continued From page 16 knew it should have been done. During an interview on 05/04/17 at 12:01 PM, NA #1 stated she had assisted Resident #94 with transfers, dressing and urinary incontinence care at 7:15 AM. NA #1 stated she also asked Resident #94 about toileting after breakfast and Resident #94 denied having to go to the bathroom. NA #1 also stated the nurse aides tried to check all the residents every 2 hours but she had gotten busy and forgot to check on Resident #94 since after breakfast. On 05/04/17 at 12:06 PM, NA #1 and NA #2 assisted Resident #94 with incontinence care. Resident #94 was noted to have on a brief that was visibly wet with yellow urine. Resident #94 was also noted to have slightly pinkish colored skin across his lower buttocks but had no evidence of skin breakdown. During an interview on 05/04/17 at 1:21 PM, the Director of Nursing (DON) stated the NA's are trained to check on the residents every 2 hours for incontinence care. The DON also stated her expectations were for the NAs to check on residents every 2 hours and follow their care plans.	F 312		
F 323 SS=D	483.25(d)(1)(2)(n)(1)-(3) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES (d) Accidents. The facility must ensure that - (1) The resident environment remains as free from accident hazards as is possible; and (2) Each resident receives adequate supervision	F 323		6/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 323 Continued From page 17
and assistance devices to prevent accidents.

(n) - Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements.

(1) Assess the resident for risk of entrapment from bed rails prior to installation.

(2) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(3) Ensure that the bed's dimensions are appropriate for the resident's size and weight.
This REQUIREMENT is not met as evidenced by:
Based on observations, record review, and staff interviews the facility failed to provide a hazard free environment by leaving a bottle of fingernail polish remover in the bathroom on the secure unit for 1 of 1 residents reviewed (Resident #97).

Findings included:

Resident #97 was admitted to the facility on 08/31/16 with diagnoses including dementia, Alzheimer's, and anxiety disorder. The most recent quarterly Minimum Data Set (MDS) dated 03/01/17 indicated Resident #97 had moderately impaired cognition and disorganized thinking. The MDS also indicated Resident #97 had trouble concentrating for 2 to 6 days with no behaviors or wandering and was ambulatory within the secure unit.

F 323

On May 1, 2017, the bottle of polish remover was removed from resident #97s room by the DON.

On May 1, 2017, all rooms and bathrooms on the secure unit were checked by CNAs for any chemicals. No other chemicals were found on the secure unit.

On May 30, 2017 an inservice will be given by the DON for all staff on the proper storage of chemicals. Make-up inservices will be provided by June 1, 2017. Any CNA on leave will be required to make-up the inservice prior to return to duty. All new staff will be oriented when hired on the proper storage of chemicals by the RN Supervisor.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 18 The Care Area Assessment (CAA) summary of the MDS revealed Resident #97 had previous wandering behaviors and was moved to the secure unit for safety. An observation of the secure unit made on 05/01/17 at 2:41 PM revealed a bottle of fingernail polish remover was sitting on the back of the toilet in the shared bathroom of Resident #97. An observation of the secure unit with the Director of Nursing (DON) on 05/01/17 at 5:15 PM confirmed the fingernail polish remover was sitting on the back of the toilet in Resident #97's bathroom. During an interview with the DON on 05/01/17 at 5:15 PM she revealed the bottle of fingernail polish or chemicals shouldn't be available to residents and she removed the nail polish. During an observation of the secure unit on 05/03/17 at 3:40 PM it was revealed a wandering resident was seen entering Resident #97's room. During an interview on 05/04/17 at 2:46 PM the DON revealed it was her expectation for hazardous chemicals to never be within reach of residents on the secure unit. During an interview on 05/04/17 at 2:54 PM the Administrator revealed it was his expectation for fingernail polish and chemicals to be stored in a locked area and out of the reach Residents.	F 323	A reminder to check rooms for inappropriately stored chemicals was put in the front of all CNA flow sheet books by the DON and ADON on May 26, 2017. On May 26, 2017, the Social Worker sent a letter to responsible parties notifying them of the need to check personal items including chemicals in with the nurse on duty for the safety of all residents. On May 26, 2017, the Admissions Coordinator added the notification of acceptable and non-acceptable personal items to the admission packet. The DON or the ADON will do random audits for improperly stored chemicals weekly for 4 weeks or longer until substantial compliance is maintained as determined by the QA Committee. Any discrepancies identified during audit will receive corrective action. Any deficient practices will be documented and corrected immediately. The Administrator will monitor for compliance. Any deficient practice will be documented and reported to the QA Committee and corrective action will be taken.	
F 332 SS=E	483.45(f)(1) FREE OF MEDICATION ERROR RATES OF 5% OR MORE (f) Medication Errors. The facility must ensure	F 332		6/1/17

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 19 that its- (1) Medication error rates are not 5 percent or greater; This REQUIREMENT is not met as evidenced by: Based on observations, record review, staff and physician interviews, the facility medication administration error rate was greater than 5% as evidenced by 5 medication errors out of 26 opportunities, resulting in a medication error rate of 19.23% for 2 of 7 residents observed during medication pass (Residents #15 and #47). The findings included: 1. Resident #15 was readmitted to the facility on 12/31/16 with diagnoses which included anxiety, chronic lung disease and hypophosphatemia (low phosphate level in blood). A review of the medical record for Resident #15 revealed a physician's order for the following medications: a. Lorazepam - give 0.5 milligram tablet three times daily for anxiety with a start date of 03/06/17 - designated administration times were 8:00 AM, 2:00 PM, and 8:00 PM b. Spiriva - inhale contents of 1 capsule every day for chronic lung disease with a start date of 03/03/17 - designated administration time was 8:00 AM c. Phos-Nak concentrated powder - give 2 packets by mouth with meals for hypophosphatemia with a start date of 03/03/17 - designated administration times were 7:30 AM,	F 332	The doctor was notified by a licensed nurse on May 3, 2017 that resident #15 had not received his medications at the designated administration times, resident had missed his Spiriva dose, and Phos-Nak powder was not given with a meal as ordered. The doctor gave orders to a licensed nurse to administer the missed Spiriva dose and to continue the same administration times for the remainder of May 3, 2017 and orders were implemented by a licensed nurse. Resident #15 was notified of these orders. The doctor was notified by a licensed nurse on May 3, 2017 the resident #47 had not received his medications at the designated administration time. The doctor gave orders to a licensed nurse to continue the same administration times for the remainder of May 3, 2017 and orders were implemented by a licensed nurse. Resident #47 and the responsible family member were notified of these orders. The ADON and RN Supervisor did an audit on May 4, 2017 on all residents for medications ordered to be given with meals. A list of residents with medications ordered to be given with meals was put in the front of all Medication Administration Records (MAR) and all licensed nurses	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	**410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713**

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 332 Continued From page 20
11:30 AM, and 4:30 PM.

An interview was conducted with Nurse #1 on 05/03/17 starting at 9:33 AM. Nurse #1 was observed administering Lorazepam to Resident #15 at 9:54 AM. Nurse #1 stated she could give medications an hour before or an hour after the designated administration time. Nurse #1 also stated she did not call the physician if a medication was administered late, but would call the physician if a resident refused to take a medication.

A second interview was conducted with Nurse #1 on 05/03/17 at 10:00 AM. Nurse #1 was observed administering Phos-Nak to Resident #15 at 9:58 AM. Nurse #1 stated the medication Phos-Nak was supposed to be given with a meal, but the resident had eaten at 8:00 AM and it was still okay to give it. Nurse #1 acknowledged the medication was due to be given at 7:30 AM that morning.

A third interview was conducted with Nurse #1 on 05/03/17 at 10:29 AM. Nurse #1 did not administer Spiriva during her medication administration to Resident #15. Nurse #1 acknowledged she had forgotten to administer Spiriva to Resident #15 and it had been due at 8:00 AM.

An interview was conducted with the Director of Nursing (DON) on 05/03/17 at 10:33 AM. The DON stated her expectations were for medications to be given per the physician's order and for the physician to be notified if medications were given late. The DON further stated she would speak with Nurse #1 and have her contact the physician (MD) about the late medications

F 332

were informed. The list of residents will be reviewed and updated weekly by ADON and returned to the front of the MAR's.

Medication administration times were reviewed by ADON and RN Supervisor. Physician orders were given to a licensed nurse to change some residents' administration times to better achieve the designated administration times. The MAR's were changed by a licensed nurse to reflect these orders on May 17, 2017.

On May 3, 2017 the Director of Nursing counseled nurse #1 on proper medication administration what to do if medication is given later than the designated time. Nurse #1 was also counseled to call the doctor and report to the resident and the responsible party if the medication was not given at the designated time. The Director of Nursing or their designee will observe Nurse #1 during med-pass to monitor that medications are given at the designated times weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any deficient practice will be brought to the nurse's attention and immediately documented. Audits will be reviewed by the QA Committee.

On May 29, 2017 the DON will inservice all licensed nurses on medications being given within designated times, with meals as ordered, and notification of the doctor, resident, and responsible party if not given

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE

F 332 Continued From page 21

that had been given.

An interview was conducted with the physician (MD) on 05/04/17 at 1:39 PM. The MD stated he had been notified about several medication variances at the facility yesterday. The MD stated he always expected to be called anytime there was any type of variance with medications and especially if the medication was a controlled substance. The MD stated he didn't think having a shorter time between administration of the scheduled doses of Lorazepam for Resident #15 had a potential for causing an adverse effect. The MD stated he didn't have a concern about an isolated missed dose of Spiriva for Resident #15 unless the resident was in respiratory distress. The MD stated he didn't think a single episode of giving Resident #15 Phos-Nak on an empty stomach had the potential for causing an adverse effect but it did have the potential for causing esophageal irritation.

2. Resident #47 was admitted to the facility on 03/28/17 with diagnoses which included diabetes with neuropathy (nerve damage often causing burning and pain in the lower legs and feet), chronic lung disease with chronic respiratory failure and continuous oxygen, and chronic venous ulcers (wounds on the lower legs caused by poor circulation).

A review of the medical record for Resident #47 revealed a physician's order for the following medications:

a. Oxycodone 10 milligram (mg) tablet - give one tablet by mouth every 4 hours for pain - start date of 03/30/17 - designated administration times of 8:00 AM, 12:00 PM, 4:00 PM and 8:00

F 332

as ordered. Make-up inservices will be provided by June 1, 2017. Any nurse on leave will be required to make-up the inservice prior to return to duty. All new licensed nurses will be oriented on correct medication administration procedures by the RN Supervisor.

DON/ADON will randomly monitor licensed nurses for timely administration of medication and medication administered per physician's order with meals weekly for 4 weeks or longer until substantial compliance is achieved and maintained as determined by the QA Committee. Any deficient practice observed will be addressed immediately, the nurse will be educated by the DON or ADON, and the deficient practice will be brought to the attention of the administrator. The QA Committee will discuss any deficient practices found and whether corrective action is necessary including the use of disciplinary procedures.

A prompt of acceptable medication administration time variations was placed in the front of all MAR charts by the ADON on May 25, 2017.

The Administrator will monitor for compliance and report results to the QA Committee. The QA Committee will review audit findings and monitor for any trends or patterns. The QA Committee will direct and institute corrective action with supervision from the Administrator as necessary when trends and/or patterns

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING ______ B. WING ______	05/04/2017

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
MOUNTAIN VIEW MANOR NURSING CE	410 BUCKNER BRANCH ROAD BRYSON CITY, NC 28713

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 332	Continued From page 22	F 332		

PM

b. Lorazepam 0.5 mg tablet - give one tablet by mouth 4 times a day - start date of 04/12/17 - designated administration times of 8:00 AM, 12:00 PM, 4:00 PM and 8:00 PM.

An interview was conducted with Nurse #1 on 05/03/17 starting at 9:33 AM. Nurse #1 was observed administering Lorazepam and Oxycodone to Resident #47 at 9:40 AM. Nurse #1 stated she could give medications an hour before or an hour after the designated administration time. Nurse #1 also stated she did not call the physician if a medication was administered late, but would call the physician if a resident refused to take a medication.

An interview was conducted with the Director of Nursing (DON) on 05/03/17 at 10:33 AM. The DON stated her expectations were for medications to be given per the physician's order and for the physician to be notified if medications were given late. The DON further stated she would speak with Nurse #1 and have her contact the physician (MD) about the late medications that had been given.

An interview was conducted with the physician (MD) on 05/04/17 at 1:39 PM. The MD stated he had been notified about several medication variances at the facility yesterday. The MD stated he always expected to be called anytime there was any type of variance with medications and especially if the medication was a controlled substance. The MD stated he didn't think having a shorter time between administration of the scheduled doses of Lorazepam or Oxycodone for Resident #47 had a potential for causing an

Plan of correction (F 332): are identified.

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F 332	Continued From page 23 adverse effect.	F 332		
F 520 SS=D	483.75(g)(1)(i)-(iii)(2)(i)(ii)(h)(i) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS (g) Quality assessment and assurance. (1) A facility must maintain a quality assessment and assurance committee consisting at a minimum of: (i) The director of nursing services; (ii) The Medical Director or his/her designee; (iii) At least three other members of the facility's staff, at least one of who must be the administrator, owner, a board member or other individual in a leadership role; and (g)(2) The quality assessment and assurance committee must : (i) Meet at least quarterly and as needed to coordinate and evaluate activities such as identifying issues with respect to which quality assessment and assurance activities are necessary; and (ii) Develop and implement appropriate plans of action to correct identified quality deficiencies; (h) Disclosure of information. A State or the Secretary may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee with the requirements of this section.	F 520		5/31/17

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	345193	A. BUILDING ______ B. WING ______	05/04/2017

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F 520	Continued From page 24 (i) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, and staff interviews the facility's Quality Assessment and Assurance Committee failed to maintain procedures and monitor the interventions put in place by the committee from the annual recertification survey on 4/14/16 regarding Provide Assistance with Activities of Daily Living (ADL). The deficiency for ADLs was cited again during the recertification survey of 5/4/17. The continued failure of the facility during two federal surveys of record show a pattern of the facilities inability to sustain an effective Quality Assurance Program. Findings Included: This tag is cross referenced to: F312: Provide Assistance with ADLs: Based on observations, record review, and staff interviews the facility failed to check for incontinence for 2 of 4 sampled residents who were dependent upon staff for toileting and incontinence care (Residents #2 and #94). During the recertification survey of April 2016 the facility was cited for failure to provide grooming, fingernail care and shaving to residents. On the present recertification survey the facility failed to check for and provide incontinence care.	F 520	Mountain View Manor Nursing Center currently holds and will continue to hold regularly scheduled QA Committee meetings a minimum of quarterly. The QA committee has established a Care Practices subcommittee to do weekly facility rounds. The subcommittee will consist of 4 members of the QA Committee, at least one member will be a nurse; members will be rotated quarterly. The rounds will include random audits of ADLs. Any deficient practice will be brought to the attention of the charge nurse and corrected immediately by nursing staff. The Care Practices subcommittee will report the results of the rounds to the QA Committee a minimum of quarterly. The QA Committee will discuss any deficient practices found these results and whether corrective action is necessary including the use of disciplinary procedures. The Administrator will review the activities and findings of the subcommittee rounds quarterly. The Administrator will be responsible for identifying issues addressed by utilizing this new system to ensure corrective actions are taken to achieve and maintain compliance.	

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	345193	A. BUILDING ______ B. WING ______	**05/04/2017**

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F 520	Continued From page 25 During an interview on 05/04/17 at 3:17 PM the Director of Nursing revealed weekly audits had been done for dependent residents who received ADL care. She also revealed the facility had stopped the audits and indicated there had been an improvement in the ADL care for dependent residents. She recommended the facility should have continued the weekly audits to ensure ADL care was provided by direct care staff.	F 520		