STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	345193	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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
K 000	INITIAL COMMENTS This Life Safety Code(LSC) survey was conducted as per The Code of Federal Register at 42CFR 483.70(a); using the 2000 Existing Health Care section of the LSC and its referenced publications. This building is Type III(211) construction, one story, with a complete automatic sprinkler system. The facility is utilizing special locking arrangements. In the exit conference all deficiencies noted were discussed and acknowledged with administration. At time of survey the licensed bed capacity = 120 Total Certified Bed Count 120 NF Census 90 NF The deficiencies determined during the survey are as follows:	K 000		
K 012 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Building construction type and height meets one of the following: 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There are gaps between ceiling and wall behind range hood - gaps do not maintain required ratings of roof/ceiling assembly. NFPA 101, 19.1.6.2, 19.1.6.3, 19.1.6.4, 19.3.5.1 This deficiency affected one of two smoke	K 012	All gaps were filled with fire caulk by the Maintenance Supervisor on May 04, 2016. The Facility Services Director checked all the other facility fire walls; no other compliance issues were found. The Facility Services Director inserviced all maintenance staff about the need for all fire walls to be sealed with no gaps. The Maintenance Supervisor will add the sealed fire wall check to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial	5/6/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Electronically Signed | 05/19/2016

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K 012	Continued From page 1 compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 012	compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to smoke doors to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of sealed fire walls.	
K 038 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There is non-passage hardware on door to beauty shop, and physical therapy rooms - the doors are locked against egress and require special knowledge for releasing locking mechanism. NFPA 101, 19.2.1, 7.1 This deficiency affected two of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 038	The Maintenance Supervisor installed the passage hardware on the PT room and the beauty shop on May 16, 2016. The Facility Services Director checked all doors for passage hardware in the facility; all non-compliant doors were corrected with passage hardware. The Facility Services Director inserviced all maintenance staff about the need for passage hardware on all doors. The Maintenance Supervisor will add a door check for passage hardware to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified	5/16/16

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	345193	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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K 038	Continued From page 2	K 038	related to passage hardware to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of passage hardware on doors.	
K 051 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system is installed with systems and components approved for the purpose in accordance with NFPA 70, National Electric Code and NFPA 72, National Fire Alarm Code to provide effective warning of fire in any part of the building. Fire alarm system wiring or other transmission paths are monitored for integrity. Initiation of the fire alarm system is by manual means and by any required sprinkler system alarm, detection device, or detection system. Manual alarm boxes are provided in the path of egress near each required exit. Manual alarm boxes in patient sleeping areas shall not be required at exits if manual alarm boxes are located at all nurse's stations. Occupant notification is provided by audible and visual signals. In critical care areas, visual alarms are sufficient. The fire alarm system transmits the alarm automatically to notify emergency forces in the event of fire. The fire alarm automatically activates required control functions. System records are maintained and readily available. 18.3.4, 19.3.4, 9.6 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is	K 051	SimplexGrinnell will correct the electromagnetic locks on May 18, 2016 so they remain unlocked when fire alarm is in silence mode. The Facility Services Director checked all	5/18/16

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K 051	Continued From page 3 non-compliant, specific findings include: The electromagnetic locks failed to remain unlocked with the fire alarm system in the alarm silence mode. Note: Delayed egress feature did function for all electromagnetic locks and locks did release with activation of fire alarm system by smoke detectors. NFPA 101, 19.3.4, 9.6 This deficiency potentially affects all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 051	other electromagnetic locks in the facility; no other compliance issues were found. The Facility Services Director inserviced all maintenance staff about the need for electromagnetic locks to remain unlocked in silence mode. The Maintenance Supervisor will add an electromagnetic locks check to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to electromagnetic locks to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of the electromagnetic locks.	
K 062 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 062	The storage room was torn down and removed by the Maintenance Supervisor on May 09, 2016. The canopied smoking area was torn down and removed by the Maintenance Supervisor on May 11, 2016.	5/11/16

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	345193	A. BUILDING **01 - MAIN BUILDING 01** B. WING _____	**05/03/2016**

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K 062	Continued From page 4 1. The storage room beneath the noncombustible roof canopy is not equipped with sprinkler coverage - walls enclosing area are constructed of combustible material. Canopy area is located at eastside of facility. 2. The canopy over the exterior smoking area is constructed of pressure treated lumber and partly enclosed with plastic wall material - the area is not equipped with sprinkler coverage. NFPA 101, 19.7.6, 9.7.5, 4.6.12, NFPA 25, NFPA 13 This deficiency affected two of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 062	The Facility Services Director checked all other areas around the facility; no other compliance issues were found. The Facility Services Director inserviced all maintenance staff about add-ons not allowed next to the building. The Maintenance Supervisor will add the check for building add-ons not allowed to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to building add-ons not allowed to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of building add-ons not allowed.	
K 067 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 067	Reece Electric replaced the damaged wiring on May 18, 2016. The Facility Services Director hung proper signage by the switch on May 18, 2016 The Facility Services Director inserviced maintenance staff on checking for	5/18/16

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K 067	Continued From page 5 The emergency manual stop switch for air handlers are not labeled and did not eliminate power to roof top air handling units. NFPA 101, 19.5.2.1, NFPA 90A This deficiency potentially affects all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 067	damaged wiring. The Maintenance Supervisor will check the switch weekly to ensure it is working properly. The Maintenance Supervisor will add the check for damaged wiring and appropriate signage to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to damaged wiring and appropriate signage to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of damaged wiring and appropriate signage.	
K 070 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Portable space heating devices shall be prohibited in all health care occupancies. Except it shall be permitted to be used in non-sleeping staff and employee areas where the heating elements of such devices do not exceed 212 degrees F (100 degrees C). 18.7.8, 19.7.8 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include:	K 070	The Facility Services Director removed the heater from the bookkeeper□s office on May 03, 2016. The Facility Services Director checked all the other rooms for portable heating devices; no other compliance issues were	5/4/16

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K 070	Continued From page 6 There is a high-temperature portable space heater in bookkeeper office. The surface temperature of heating elements exceed 212 degrees Fahrenheit. NFPA 101, 19.7.8 This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 070	found. The Facility Services Director inserviced all maintenance staff about no portable heating devices are allowed in rooms. The Maintenance Supervisor will add the room check for portable heating devices to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to no portable heating devices allowed to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of portable heating devices.	
K 144 SS=E	NFPA 101 LIFE SAFETY CODE STANDARD Generators inspected weekly and exercised under load for 30 minutes per month and shall be in accordance with NFPA 99 and NFPA 110. 3-4.4.1 and 8-4.2 (NFPA 99), Chapter 6 (NFPA 110) This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: 1. There are no specific gravity readings and	K 144	The Facility Services Director will acquire the gauge to check gravity reading and electrolyte levels. The Maintenance Supervisor will do weekly checks of the gravity reading and electrolyte levels. Integrated Power System will install a remote Emergency Stop away from the	6/3/16

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K 144	Continued From page 7 electrolyte levels documented in accordance with NFPA 110, Chapter 6 for emergency generator weekly checks. 2. There is no emergency stop switch located at exterior enclosure of emergency generator. 3. EPS supplying load indicator, located on generator annunciator panel, did not function during test of emergency power system with ATS(automatic transfer switch) in emergency mode. NFPA 101, NFPA 99, NFPA 110 Chapter 6 This deficiency potentially affects all smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 144	main generator. The Maintenance Supervisor will check the remote Emergency Stop each quarter. Integrated Power System will troubleshoot system to identify the issue with the EPS load indicator and repair it on May 31, 2016. The Facility Services Director inserviced all maintenance staff about the use of gravity readings and electrolyte levels. The Facility Services Director inserviced all maintenance staff about the quarterly checks on the remote Emergency Stop. The Facility Services Director inserviced all maintenance staff about the EPS Load Indicator. The Maintenance Supervisor will add the gravity reading and electrolyte level check, the remote Emergency Stop, and the EPS Load Indicator to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to the gravity reading and electrolyte level check, the remote Emergency Stop and the EPS Load Indicator to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of the gravity reading and electrolyte level check, the remote Emergency Stop, and	

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K 144	Continued From page 8	K 144	the EPS Load Indicator.	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment shall be in accordance with National Electrical Code. 9-1.2 (NFPA 99) 18.9.1, 19.9.1 This STANDARD is not met as evidenced by: 42 CFR 483.70 (a) Based on observations, on May 3, 2016 at approximately 10:00 AM onward, the following deficiencies were noted: The standard is non-compliant, specific findings include: There are boxes and storage supplies located beneath an exposed bulb incandescent light fixture in the beauty shop. NFPA 101, 19.9.1, 9-1.2 This deficiency affected one of two smoke compartments. Failure to comply with minimum standards as referenced increases the risk of death or injury due to fire and/or smoke.	K 147	The Maintenance Supervisor removed the boxes on May 04, 2016. The Maintenance Supervisor removed the light fixture on May 04, 2016. The Facility Services Director checked all the other rooms in the facility; no other compliance issues were found. The Facility Services Director inserviced all maintenance staff on appropriate incandescent light fixtures and storage containers. The Maintenance Supervisor will add incandescent light fixtures and storage container check to the Preventative Maintenance monthly rounds checklist and provide the Administrator a copy of a log of the completed audits for compliance monitoring until substantial compliance is achieved and maintained as determined by the Quality Assurance Committee. The Facility Services Director will report audit findings including trends identified related to incandescent light fixtures and storage container check to the Quality Assurance Committee quarterly. Once substantial compliance is achieved and maintained the QA Committee may recommend discontinuation of its quarterly review of incandescent light fixtures and storage containers.	5/5/16

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