

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  445483	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01  B. WING _____	(X3) DATE SURVEY COMPLETED  05/23/2016
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NAME OF PROVIDER OR SUPPLIER  APPALACHIAN CHRISTIAN VILLAGE	STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601
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(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 029 SS=D	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>One hour fire rated construction (with 0 hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observation, the facility failed to provide self-closing doors and walls that are smoke resistant in hazardous rooms.</p> <p>The findings include:</p> <p>Observation on 5/23/16 at 11:30 AM and 11:53 AM revealed the <u>storage room by resident room 515</u> was over 50 sq. ft. with combustible storage and the <u>door closer arm</u> was missing. The <u>upper level housekeeping closet by the elevators</u> was over 50 sq. ft. with combustible storage and the <u>door</u> was not self-closing and the <u>wall adjoining the shower room</u> is not smoke resistant by a transfer opening.</p> <p>These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/23/16.</p>	K 029	<p>1. The storage room by resident room 515 with combustible storage that had the door closer arm missing will have a new fire rated door installed with a self-closer by Trimble Door Company by 7/7/16. The upper level housekeeping closet by the elevators with combustible storage will have a new door installed with a self-closing apparatus and also the wall in this room that adjoins with the shower that is not smoke resistant by a transfer opening will be fixed with 5/8 inch sheet rock to ensure that it is smoke resistant by our maintenance dept by 7/7/16.</p> <p>2. All other self-closing doors in health care were checked to ensure they were closing properly and there was a functioning arm to accomplish this procedure. All walls in storage closets with combustible storage were also checked to ensure smoke resistance and no other breaches.</p> <p style="text-align: right;">Cont.</p>	7/7/16
K 052 SS=F	<p><b>NFPA 101 LIFE SAFETY CODE STANDARD</b></p> <p>A fire alarm system required for life safety shall be tested, and maintained in accordance with NFPA 70 National Electric Code and NFPA 72 National Fire Alarm Code and records kept readily available. The system shall have an approved</p>	K 052	<p>1. The smoke detector sensitivity testing that was noted to be past due during survey was completed by East TN Fire Alarm Co. on 6/1/16 to correct this standard breach.</p> <p style="text-align: right;">cont.</p>	7/7/16

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE 6/7/16

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.

## K 029 SS-D. Cont.

for these two standards were found.

3. A systematic approach to ensure these two breaches do not reoccur will be for the Administrator to educate all maintenance staff that all self-closing doors must have a functioning arm for self-closure and all walls in storage areas with combustibles will have a smoke resistant wall. An audit will be put in place to ensure these two breaches does not reoccur.

4. The Quality Staff and/or Maintenance Director will maintain an audit on a monthly bases to ensure that all self-closing doors must have a functioning arm for self-closure and all walls in storage areas with combustibles will have a smoke resistant wall. The results of the audit will be presented at the monthly Quality Assurance meeting.

## K 052 SS-F Cont.

2. All other required smoke detecting required procedures were reviewed to ensure they had been completed timely and none were found to be in breach of the required standards

3. A systematic approach to ensure these this breach does not reoccur will be for the Administrator to educate all maintenance staff that all smoke detecting required procedures including the smoke sensitivity testing must be completed on a timely bases. An audit will be put in place to ensure these this breach does not reoccur.

4. The Quality Staff and/or Maintenance Director will maintain an audit on a monthly bases to ensure that for all smoke detecting required procedures must be completed on a timely bases. The results of the audit will be presented at the monthly Quality Assurance meeting.

## CENTERS FOR MEDICARE &amp; MEDICAID SERVICES

OMB NO. 0938-0391

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K 052	Continued From page 1 maintenance and testing program complying with applicable requirement of NFPA 70 and 72. 9.6.1.4, 9.6.1.7, This STANDARD is not met as evidenced by: Based on record review, the facility failed to maintain the fire alarm system.  The findings include:  Record review on 5/23/16 at 10:34 AM revealed the smoke detector sensitivity testing is past due.  This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/23/16. NFPA 101 2000 Edition - NFPA 101 19.3.4.1 - NFPA 101 9.6 - NFPA 72 7-3.2.1	K 052			
K 130 SS=F	NFPA 101 MISCELLANEOUS  OTHER LSC DEFICIENCY NOT ON 2786 This STANDARD is not met as evidenced by: Based on observation, the facility failed to maintain fire doors.  The findings include:  Observation on 5/23/16 between 11:45 AM and 2:08PM revealed the following: 1. 90 minute double egress cross corridor fire doors by room 515 does not have a lower latching mechanism. 2. 90 minute fire doors entering the stairwell by room 524, the lower latch has been removed. 3. 90 minute fire door of wound care is damaged and delaminated. 4. 90 minute fire doors entering the stairwell by room 609 have no floor strike for the bottom latch.	K 130	1. The Fire Doors noted during survey to have the following breaches: 90 minute double egress cross corridor fire doors by room 515 that does not have a lower latching mechanism, 90 minute fire doors entering the stairwell by room 524 with lower latch removed, 90 minute fire door of wound care office that is damaged and delaminated, and 90 minute fire doors entering the stairwell by room 609 that has no strike for the bottom will all be repaired by Trimble Door Company by 7/7/16. 2. All other Fire Doors in the health care center were inspected to	7/7/16	

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K 130	Continued From page 2  These findings were verified by the maintenance director and acknowledged by the administrator during the exit conference on 5/23/16. NFPA 80 1999 Edition 1-9.3 In this standard, builders hardware is applied only to swinging doors and consists of the items specified in Tables 2-4.3.1 and 2-4.4.3 (see Figures B-20 through B-28). These include hinges (full mortise, half mortise, half surface, full surface, olive knuckle, paumelle, or spring); single-, two-, or three-point locks and latches; top and bottom bolts (flush, surface, or concealed); and door closers. This type of hardware shall not be required to be shipped from the factory with the fire doors. Fire exit hardware consists of exit devices that have been labeled for both fire and panic protection. (See Figures B-24 and B-25.) 2-5.2 Manufacturers' Instructions. All components shall be installed in accordance with the manufacturers' installation instructions and shall be adjusted to function as described in the listing. 15-2.5.2 Any breaks in the face covering of doors shall be repaired immediately. 15-2.5.3 Where a fire door, frame, or any part of its appurtenances is damaged to the extent that it could impair the door's proper emergency function, it shall be repaired with parts obtained from the door's manufacturer. Upon completion of the repairs, the door shall be tested to ensure emergency operation and closing.	K 130	ensure proper function and were found to be in compliance with the required standards. 3. A systematic approach to ensure compliance with fire door required standards will be for the Administrator to educate the Maintenance Supervisory and maintenance Staff on proper fire door function and requirements. An audit will be maintained to ensure compliance 4. The Quality Assurance Staff will maintain an audit on a monthly bases to ensure fire door requirements are being met. The results of the audit will be presented at the monthly Quality Assurance meeting.		