

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 05/19/2014

FORM APPROVED
OMB NO. 0938-0391

45th 6/2/14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445483	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 05/07/2014
NAME OF PROVIDER OR SUPPLIER APPALACHIAN CHRISTIAN VILLAGE			STREET ADDRESS, CITY, STATE, ZIP CODE 2012 SHERWOOD DRIVE JOHNSON CITY, TN 37601	
(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 000	INITIAL COMMENTS A recertification survey and complaint investigation #32826 were completed at Appalachian Christian Village on May 5 - 7, 2014. No deficiencies were cited related to complaint investigation #32826 under 42 CFR Part 483, Requirements for Long Term Care Facilities.			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation and interview, the facility failed to ensure the facility was free of odors on one of five halls. The findings included: Observation on May 5, 2014, at 3:00 p.m., May 6, 2014, at 9:00 a.m. and 4:00 p.m., and May 7, 2014, at 8:00 a.m. and 10:40 a.m., revealed a strong urine odor on the 516 to 525 hall. Continued observation revealed a strong urine odor in room #524. Interview with the Licensed Practical Nurse Minimum Data Set Coordinator #1 on May 7, 2014, at 10:40 a.m., confirmed the presence of the strong urine odor.	F 253	This Plan of Correction is submitted as required under State and federal law. The submission of this Plan of Correction does not constitute an admission on the part of Appalachian Christian Village to the accuracy of the surveyor findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute deficiency or that the scope and severity regarding any of the deficiencies cited are correctly supplied. 1. Rooms #516 thru #525 were cleaned by housekeeping staff. One resident in room #524 had their catheter changed and lab work completed on May 7, 2014. 2. A 100% audit for odors of the building was conducted by the Facility Administrator on May 7, 2014. 3. The Facility Administrator and/or Director of Environmental Services in-serviced all housekeeping staff on the Policy and Procedure of maintaining a sanitary, orderly and free-of-odor facility on May 7, 2014. 4. The Facility Administrator, Director of Social Services, Dietary Director, Director of Admissions, Business Office Manager, Assistant Director of Nursing, Director of Environmental Services,	06/02/2014

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *Jennifer Deegan, MPH, LNHA* TITLE Administrator / Dir. of Health Services (X6) DATE 6/3/14

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 278	Continued From page 2 This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to ensure a Minimum Data Set (MDS) assessment was accurate for one (#21) resident of twenty-nine residents reviewed. The findings included: Resident #21 was admitted to the facility on October 8, 2011, with diagnoses including Urinary Tract Infection, Hypertension, Hypothyroidism, Anxiety, and Depression. Medical record review of the care plan dated April 8, 2014, revealed "...Limitations in ROM (range of motion) to bilateral hands r/t (related to) Arthritis...Provide ROM daily during care as tolerated..." Medical record review of the Annual MDS assessment dated October 4, 2013, revealed no impairment in range of motion. Medical record review of the Quarterly MDS assessment dated April 4, 2014, revealed no impairment in range of motion. Observation on May 7, 2014, at 9:50 a.m., revealed the resident lying on the bed. Interview with Licensed Practical Nurse MDS Coordinator #1 on May 5, 2014, at 2:05 p.m., in the MDS office confirmed the MDS assessment for range of motion was inaccurate.	F 278	Continued From page 2 Committee quarterly. Members of the Committee are: Facility Administrator, Director of Nursing, Quality Assurance Nurse, Medical Director, Director of Maintenance, Director of Admissions, Director of Dietary and Director of Environmental Services.		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment.	F 280	This Plan of Correction is submitted as required under State and federal law. The submission of this Plan of Correction does not constitute an admission on the part of Appalachian Christian Village to the accuracy of the surveyor findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility	06/02/2014	

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F 280	<p>Continued From page 3</p> <p>A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review and interview, the facility failed to revise a comprehensive care plan to reflect interventions placed after falls for two residents (#2, #105) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was readmitted to the facility on February 11, 2014, with diagnoses including Hypertension, Osteoporosis, and Malignant Neoplasm of the Breast.</p> <p>Medical record review of a fall investigation dated May 3, 2014, revealed resident #2 had a fall without injury while ambulating to the bathroom with a Certified Nursing Assistant.</p> <p>Medical record review of the Care Plan dated February 21, 2014, revealed interventions placed after the resident fall were not listed on the Care Plan.</p> <p>Interview with the Interim Director of Nursing (IDON) and Minimum Data Set (MDS) Coordinator #1 on May 7, 2014, at 9:57 a.m., in the facility conference room confirmed the facility failed to revise the care plan to reflect interventions placed after the fall.</p>	F 280	<p>Continued From page 3</p> <p>that the findings cited are accurate, that the findings constitute deficiency or that the scope and severity regarding any of the deficiencies cited are correctly supplied.</p> <ol style="list-style-type: none"> Care Plans for Residents #2 and #105 were immediately updated to include interventions to prevent falls on May 7, 2014 by the Minimum Data Set Nurse. A 100% audit of care plans for all falls in the facility from April 7 - May 7, 2014 was completed on May 8, 2014 by the Minimum Data Set Nurses and was updated appropriately for interventions. All Minimum Data Set Nurses were in-serviced by the Director of Nursing on May 7, 2014 on the Policy and Procedure of Falls Protocol and fall prevention care planning. The Assistant Director of Nursing, RN Supervisor and/or the Director of Nursing will audit daily for four weeks, then five times a week for eight weeks, and/or 100% compliance for care plan interventions related to fall prevention. Results of the audit will be reported to the Quality Assurance Committee quarterly. Members of the Committee are: Facility Administrator, Director of Nursing, Quality Assurance Nurse, Medical Director, Director of Maintenance, Director of Admissions, Director of Dietary and Director of Environmental Services. 	

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F 280	Continued From page 4 Resident #105 was admitted to the facility on November 9, 2013, with admitting diagnoses of Modular Prostate without Urinary Obstruction, Psychosis, and Screening Examination of Pulmonary Tuberculosis. Review of the facility's Report for Quality and Safety Review report for falls without injury, on December 7, 2013, December 18, 2013, December 26, 2013, February 10, 2014, and April 19, 2014, revealed interventions to prevent further falls were not updated on the resident's care plan for fall prevention. Review of facility policy, Falls Protocol, (no date) revealed the protocol required the staff to update the care plan with fall prevention interventions. Interview with the Assistant Director of Nursing on May 6, 2014, at 2:35 p.m., in the conference room confirmed the care plan had not been updated with interventions to prevent falls.			
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by:	F 315	This Plan of Correction is submitted as required under State and federal law. The submission of this Plan of Correction does not constitute an admission on the part of Appalachian Christian Village to the accuracy of the surveyor findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute deficiency or that the scope and severity regarding any of the deficiencies cited are correctly supplied. 1. Residents # 21, #41 and #58 were immediately assessed by the Medical Director on May 7, 2014. No adverse outcomes were identified. 2. On May 7, 2014, all residents that have a catheter were audited. New orders were written, including the diagnosis, specific size, frequency	06/02/2014

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F 315	<p>Continued From page 5</p> <p>Based on medical record review, facility policy review, and interview, the facility failed to complete a bladder assessment and develop an individualized toileting plan for one resident (#41) with a known decline in bowel and bladder, failed to ensure orders for size of urinary catheters for two residents (#21, #58), and failed to ensure a urinary catheter change was completed monthly for one resident (#58) of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #41 was admitted to the facility on November 7, 2013, with diagnoses including Hyperglycemia, Type 2 Diabetes Mellitus, and Coronary Artery Disease.</p> <p>Medical record review of the admission Minimum Data Set (MDS) dated November 14, 2013, revealed no limitations on making self understood, no limitations on understanding others, and was occasionally incontinent of bowel and urine.</p> <p>Medical record review of a MDS dated December 4, 2013, revealed no limitations on making self understood, no limitations on understanding others and was frequently incontinent of bowel and urine.</p> <p>Interview with Charge Nurse #1 on May 6, 2014, at 1:46 p.m., at the downstairs nurse's station confirmed the resident had not been assessed for a bowel and bladder program and an individualized toileting program had not been developed.</p> <p>Resident #58 was admitted to the facility on July 27, 2012, with diagnoses including Rheumatoid Arthritis Dementia with Behavioral Disturbances, Pulmonary Embolism, Neurogenic Bladder, and Congestive Heart Failure.</p> <p>Medical record review of physician orders dated March 2014 revealed, "change...(indwelling urinary) catheter every month and PRN (as needed) due 3/25/14." Continued review revealed</p>	F 315	<p>Continued From page 5</p> <p>in which to change catheter and type of catheter care to be provided. All residents were assessed for Bowel and Bladder and individualized toileting program by the RN Supervisor, Director of Nursing and/or Assistant Director of Nursing.</p> <p>3. All licensed staff were in-serviced on the Policy and Procedure for Bowel and Bladder program, Individualized toileting program and Physician's Orders by the Director of Nursing, Assistant Director of Nursing and/or RN Supervisors from May 9 - May 12, 2014.</p> <p>4. The Assistant Director of Nursing, RN Supervisor and/or the Director of Nursing will audit Physician Orders and Bowel and Bladder Assessments daily for four weeks, then five times a week for eight weeks, and/or 100% compliance. Results of the audit will be reported to the Quality Assurance Committee quarterly. Members of the Committee are: Facility Administrator, Director of Nursing, Quality Assurance Nurse, Medical Director, Director of Maintenance, Director of Admissions, Director of Dietary and Director of Environmental Services.</p>	

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F 315	<p>Continued From page 6</p> <p>no orders for the size or the type of catheter care needed.</p> <p>Medical record review of the Care Plan updated on January 17, 2014 and last updated on April 17, 2014, revealed the problem of neurogenic bladder requiring the indwelling urinary catheter with approaches of change catheter every thirty days and as needed.</p> <p>Review of facility policy, Medication Orders, revealed "Physician's orders must be signed by the physician and dated when such order was signed...Current list of orders must be maintained in the clinical record of each resident and are necessary...When recording orders for a... (indwelling urinary) catheter specify...The size of the catheter needed...The frequency of change...The type of catheter care needed."</p> <p>Medical record review revealed the indwelling urinary catheter was changed on February 25, 2014, and April 27, 2014, with no documentation the catheter was changed in March 2014.</p> <p>Interview with Registered Nurse Supervisor #1 at the 500 Nursing Station on May 6, 2014, at 3:30 p.m., confirmed no documentation the resident's catheter had been changed in March 2014.</p> <p>Interview with the Assistant Director of Nursing in the Director of Nursing's office on May 6, 2014, at 3:20 p.m., confirmed the resident entered the facility with a catheter, had a history of having the catheter for many years, and there were no physician's orders for the size of the catheter needed or the type of catheter care needed.</p> <p>Interview with Licensed Practical Nurse (LPN) #2 on May 7, 2014, at 12:15 p.m., confirmed the resident had an indwelling urinary catheter size 20 fr (french)/30 cc (cubic centimeters) in place.</p>			

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F 315	<p>Continued From page 7</p> <p>Resident #21 was admitted to the facility on October 6, 2011, with diagnoses including Urinary Tract Infection, Hypertension, Hypothyroidism, Anxiety, and Depression.</p> <p>Medical record review of the Physician's Recapitulation Orders dated May 1, 2014 through May 31, 2014, revealed "... (change) (indwelling) cath Q (every) month (and) pm..."</p> <p>Medical record review of the Interdisciplinary Notes dated March 26, 2014, revealed... (Indwelling) catheter changed using #20 fr/30cc... Immediate urine return noted. Resident tolerated procedure well..."</p> <p>Medical record review of the Interdisciplinary Notes dated April 21, 2014, revealed "... removed (indwelling) cath d/t (due to) leaking reinserted 16 f (indwelling) cath with 20 cc bulb syringe using sterile tech (technique)..."</p> <p>Review of facility policy, (Indwelling) Catheter, revealed "... When recording orders for a (indwelling) catheter, specify: a. If prn, why it is needed... The size of the catheter needed (#18 Fr. (indwelling) cath. (catheter) to straight drain.)... The frequency of change..."</p> <p>Observation on May 6, 2014, at 2:00 p.m., revealed the resident lying on the bed with the indwelling catheter in a privacy bag.</p> <p>Interview with the Assistant Director of Nursing on May 6, 2014, at 1:45 p.m., in the Director of Nursing's office confirmed there was no physician's order for the size of the indwelling catheter.</p>			

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F 323 SS=D	<p>483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES</p> <p>The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents.</p> <p>This REQUIREMENT is not met as evidenced by:</p> <p>Based on medical record review, review of facility policy, and interview, the facility failed to develop interventions to prevent falls, for one resident (#105) of four residents reviewed for falls of twenty-nine residents reviewed.</p> <p>The findings included:</p> <p>Resident #105 was admitted to the facility on November 9, 2013, with admitting diagnoses of Modular Prostate without Urinary Obstruction, Psychosis, and Screening Examination of Pulmonary Tuberculosis.</p> <p>Medical record review of the facility's Report for Quality and Safety Review for falls without injury, on December 26, 2013, revealed "...the resident was found in room lying on right side, skin tear to right arm, steristrips applied, sent to ER (Emergency room) for eval (evaluation) and sent back to the facility...on February 7, 2014, when the resident fell attempting to get out of a chair in the dining room...hlp hurt...was x-rayed with negative results...on February 24, 2014, when the resident was found sitting in the floor with the sentry alarm sounding...complained of right leg pain...x-ray negative for fracture...and on April 19, 2014, the resident was observed in floor in front of bed...complained of right hip pain, bruise to right hip...x-ray negative for fracture..." Continued review revealed interventions to prevent further falls were not developed.</p> <p>Medical record review of a Fall Risk assessment (no date), revealed a score of ten (high risk for falls).</p>	F 323	<p>This Plan of Correction is submitted as required under State and federal law. The submission of this Plan of Correction does not constitute an admission on the part of Appalachian Christian Village to the accuracy of the surveyor findings nor the conclusions drawn therefrom. The facility's submission of the Plan of Correction does not constitute an admission on the part of the facility that the findings cited are accurate, that the findings constitute deficiency or that the scope and severity regarding any of the deficiencies cited are correctly supplied.</p> <ol style="list-style-type: none"> Interventions to prevent falls for Resident #105 Care Plans were immediately implemented on May 7, 2014 by the Minimum Data Set Nurse. Residents that had experienced a fall from April 7 - May 7, 2014 were 100% audited on May 8, 2014 by the Minimum Data Set Nurses to ensure interventions were implemented to prevent further falls. All licensed staff were in-serviced by the Director of Nursing, Assistant Director of Nursing and/or RN Supervisors from May 9 - May 12, 2014 on the Policy and Procedure of Fall Protocol and Fall Prevention Intervention. The Assistant Director of Nursing, RN Supervisor and/or the Director of Nursing will audit daily for four weeks, then five times a week for eight weeks, and/or 100% compliance for the implementation of fall interventions related to fall prevention. Results of the audit will be reported to the Quality Assurance Committee quarterly. Members of the Committee are: Facility Administrator, Director of Nursing, Quality Assurance Nurse, Medical Director, Director of Maintenance, Director of Admissions, Director of Dietary and Director of Environmental Services. 	06/02/2014

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F 323	Continued From page 9 Interview with the Assistant Director of Nursing on May 6, 2014, at 2:35 p.m. in the conference room confirmed the facility had failed to develop interventions to prevent further falls.				