

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

PRINTED: 09/29/2011
FORM APPROVED
OMB NO. 0938-0391

45th 11/12/11

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 09/28/2011
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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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F 221 SS:D	<p>483.13(a) RIGHT TO BE FREE FROM PHYSICAL RESTRAINTS</p> <p>The resident has the right to be free from any physical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, and interview, the facility failed to assess for the use of a restraint prior to use for two residents (#2, #8) of eighteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on September 24, 2010, with diagnoses including Heart Disease, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of a physical restraint assessment dated September 9, 2011, revealed "No restraint used at this time..."</p> <p>Observation on September 26, 2011, at 9:42 a.m., revealed the resident self-propelling in a wheelchair. Continued observation revealed the resident rolled up to this surveyor and asked for assistance. Further observation and interview at this time with the Physical Therapy Assistant #1 (PTA) present, revealed "I need help getting this off" pointing to the self-release belt around the resident's waist and attached to the wheelchair.</p> <p>Interview with Certified Nurse Assistant (CNA) #1 on September 26, 2011, at 1:30 p.m., with the Director of Nursing (DON) present, in the resident</p>	F 221	<p>F 221: all residents will continue to be assessed for need of physical restraints as policy indicates. The ADON will review and maintain the list of residents who have been assessed to need any physical restraint, and will ensure the list remains current and properly distributed to staff members. New assessments completed which determine the need for restraints will be added to the list and updated as completed.</p> <p>Daily rounds by supervisory staff and rounds made at shift change time will include the observation of all residents and any restraints used. Supervisors will compare any restraints to the current list to ensure proper utilization of restraints.</p> <p>Results of monitoring will be reported to the Director of Nursing, who will check on her rounds to ensure proper use and documentation is being carried out.</p> <p>Results of DONs checks and the supervisors' monitoring process will be reported to the Quality Assurance Committee and will be reviewed by the Medical Advisory Committee at least quarterly.</p>	11-01-11 u/h/c
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Brian Neil Deason, NHA</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/11/11</i>
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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 221	<p>Continued From page 1</p> <p>room, confirmed "The resident has had the belt in place, and as far as I know should have it." Continued interview at this time with CNA #1 confirmed CNA #1 had placed the resident in the restraint this morning.</p> <p>Resident #8 was admitted to the facility on October 8, 2008, with diagnoses including Chronic Obstructive Pulmonary Disease, Depression, and Anxiety.</p> <p>Medical record review of Side Rail Assessments dated January 10, 2009, through June 20, 2011, revealed "...Continues to use SR (side rail) x (times) 1 (one side) to aid in positioning and mobility..."</p> <p>Medical record review of the Minimum Data Set (MDS) dated July 29, 2011, revealed the resident scored 7 out of 15 on the Brief Interview for Mental Status (BIMS), indicating severe cognitive impairment.</p> <p>Observation on September 26, 2011, at 9:39 a.m., and September 27, 2011, at 8:31 a.m., revealed the resident in bed, eyes closed, with full side rails up on both sides of the bed.</p> <p>Observation and interview on September 27, 2011, at 8:48 a.m., with the Assistant Director of Nursing (ADON) in the resident's room, revealed full side rails were in use on both sides of the bed. Continued interview at this time revealed the resident had severe cognitive impairment and used only one rail for positioning.</p> <p>Interview with the Director of Nursing and the</p>	F 221			

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F 221	Continued From page 2 Assistant Director of Nursing on September 27, 2011, at 8:49 a.m., at the downstairs nursing station, confirmed the residents (#2 and #8) had not been assessed for restraint use prior to being placed in the restraints.	F 221		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4). This REQUIREMENT is not met as evidenced by: Based on medical record review, observation, facility policy review, and interview the facility failed to revise the care plans to include intravenous access care and maintenance for two residents (#2, #10) of eighteen residents reviewed.	F 279	F 279: the care plans for residents # 2 and # 10 were updated. All care plans for active residents will be reviewed to ensure all have current and or updated information. This will be completed by the MDS nurses. MDS nurses and staff nurses have been in serviced regarding the proper completion of interim care plans and working care plans, to contain current, correct and complete information. The RN MDS coordinator will complete weekly reviews of care plans and interim care plans to ensure they contain correct, current information. The Quality Assurance review nurse will review care plans periodically and will report the results of these audits to the Quality Assurance Committee.	9-28-11 11-01-11 09-30-11 11-01-11

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F 279	<p>Continued From page 3</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on September 24, 2010, with diagnoses including Heart Disease, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of the Physician's Telephone Order dated September 23, 2011, revealed "...Gentamycin IV (intravenous antibiotics) 90 mg (milligrams) q (every) 24 (twenty-four hours) x (times) 10 days..."</p> <p>Review of the resident's care plan and interview with the Director of Nursing on September 27, 2011, at 2:12 p.m., in the conference room confirmed the care plan had not been revised to include the use of intravenous antibiotics.</p> <p>Resident #10 was admitted to the facility August 23, 2011, with diagnoses including: Deep Vein Thrombosis, Pulmonary Embolism, Right Femur Fracture, Atrial Fibrillation, and Congestive Heart Failure.</p> <p>Medical record review of the nurse's admission note dated August 23, 2011, at 6:15 p.m., revealed "...PICC (peripherally inserted central catheter used for administration of intravenous medication) line intact to R (right) arm..."</p> <p>Medical record review of the Interim Admission Care Plan dated August 23, 2011, revealed care and monitoring of the resident's PICC line were not addressed.</p> <p>Medical record review of the Care Plan dated September 2, 2011, revealed care and monitoring of the resident's PICC line were not addressed.</p>	F 279		

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F 279	Continued From page 4	F 279			
F 281 SS=D	<p>Interview with the DON (Director of Nursing) on September 28, 2011, at 8:00 a.m., in the conference room, confirmed care and monitoring of the resident's PICC line were not addressed in the care plan.</p> <p>483.20(k)(3)(i) SERVICES PROVIDED MEET PROFESSIONAL STANDARDS</p> <p>The services provided or arranged by the facility must meet professional standards of quality.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to discontinue a PICC line (peripherally inserted central catheter, used for the administration of intravenous medication) as ordered for one resident (#10) of eighteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #10 was admitted to the facility August 23, 2011, with diagnoses including Deep Vein Thrombosis, Pulmonary Embolism, Right Femur Fracture, Atrial Fibrillation, and Congestive Heart Failure.</p> <p>Medical record review of the Transfer Summary and Long Term Care Physician Orders dated August 23, 2011, revealed "...D/C (discontinue) PICC line 8/30/2011..."</p> <p>Medical record review of the nurse's note dated September 15, 2011, at 9:00 a.m., revealed "...PICC line was removed per order..."</p>	F 281	<p>F 281: the Nursing supervisor notified resident # 10's physician of the delayed response to the order, with no new orders or comment received from the physician, as no harm was suffered by the resident.</p> <p>Nursing staff, including the Quality Assurance nurse, reviewed all orders when checking the monthly recertifications to ensure all treatment and care to be correct and consistent with current orders. 09-30-11</p> <p>The Quality Assurance nurse and/or ADON will review all new admissions' orders and any new orders received to ensure they are promptly carried out. The new order review will be carried out by the QA nurse weekly during chart audits, to ensure all orders are completed and will report any deficient practice immediately to the DON.</p> <p>The QA nurse will report results of audits to the Quality Assurance committee for their review and approval. 11-01-11</p>		

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F 281	Continued From page 5	F 281		
F 505 SS-D	<p>Interview with the DON (Director of Nursing) September 28, 2011, at 8:00 a.m., in the conference room, confirmed the Transfer Summary and Long Term Care order to remove the PICC line on August 30, 2011, was not removed until September 15, 2011, resulting in a sixteen day delay of care for the resident.</p> <p>483.75(j)(2)(ii) PROMPTLY NOTIFY PHYSICIAN OF LAB RESULTS</p> <p>The facility must promptly notify the attending physician of the findings.</p> <p>This REQUIREMENT is not met as evidenced by: Based on medical record review and interview the facility failed to report a laboratory result timely for one resident (#2) of eighteen residents reviewed.</p> <p>The findings included:</p> <p>Resident #2 was admitted to the facility on September 24, 2010, with diagnoses including Heart Disease, Atrial Fibrillation, and Dementia.</p> <p>Medical record review of a Physician's Telephone Order dated September 18, 2011, revealed "...Obtain UA (urinalysis) / (with) C&S (culture and sensitivity) for C/O (complains of) dysuria (difficulty urinating) and foul smelling urine..."</p> <p>Medical record review of the final laboratory results for the urinalysis dated September 21, 2011, revealed the urine specimen was positive for Proteus Mirabilis (bacteria). Continued review</p>	F 505	<p>F 505: the charge nurse received an order for antibiotics and followed the procedure for procuring the medication from the pharmacy. The antibiotics have been administered to the resident.</p> <p>09-23-11</p> <p>Nursing supervisor has reviewed the lab log and compared the entries to the lab results sheets to ensure all labs have been reported to the physician. All labs have been reported to the residents' attending physician.</p> <p>09-30-11</p> <p>All nursing staff have been re-in-serviced as to the proper procedure for reporting all lab results.</p> <p>The nursing supervisor will review the lab log draws and collections to compare against the lab results sheets and will report to the physician the lab results on a daily basis.</p> <p>09-30-11</p> <p>The Quality Assurance Nurse will do weekly audits to ensure any deficit practice does not occur. Results of audits will be reported to the QA committee at least on a quarterly basis.</p> <p>11-01-11</p>	

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F 505	<p>Continued From page 6</p> <p>revealed the laboratory results had not been reported to the Nurse Practitioner (NP) until September 23, 2011. Continued review revealed the NP issued orders at this time for intravenous antibiotics for ten days.</p> <p>Interview with the Director of Nursing and the Quality Assurance Nurse in the conference room on September 27, 2011, at 2:12 p.m., confirmed the laboratory results had been received on September 21, 2011, and had not been reported to the Physician until September 23, 2011 (2 days later).</p>	F 505		
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