

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

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

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  09/26/2011
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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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(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 064 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Portable fire extinguishers are provided in all health care occupancies in accordance with 9.7.4.1, 19.3.5.6, NFPA 10</p> <p>This STANDARD is not met as evidenced by: Based on observation the facility failed to assure fire extinguisher cabinets were provided as per NFPA 10.</p> <p>The findings included:</p> <p>Observation on September 26, 2011 at 10:30 a.m. revealed the fire extinguisher cabinets located at the nurse stations on first and second floor were provided with inoperable handles.</p>	K 064	<p>K 064: The handles on the fire extinguisher cabinet doors at the upper and lower floor nurses stations have been repaired.</p> <p>09-30-11</p> <p>All fire extinguisher cabinets have been checked to ensure all handles are in good working order.</p> <p>The Maintenance supervisor has made the checking of the cabinet door handles a specific item on the monthly preventative maintenance schedule.</p> <p>The Maintenance supervisor will periodically 'spot' check behind the maintenance personnel to ensure all equipment and fixtures are in good working order and being maintained correctly.</p> <p>10-01-11</p>	10/11/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE <i>Administrator</i>	(X6) DATE 10/11/11
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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.