

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445237	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 05/05/2025
NAME OF PROVIDER OR SUPPLIER Church Hill Post-Acute and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 701 West Main Blvd Church Hill, TN 37642	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
<p>F 0657</p> <p>Level of Harm - Minimal harm or potential for actual harm</p> <p>Residents Affected - Few</p>	<p>Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 37078</p> <p>Based on facility documentation review, medical record review, and interview the facility failed to have the minimum required disciplines attend the Interdisciplinary (IDT) care plan meetings for 1 (Resident #1) of 4 residents reviewed for care plan timing and revision.</p> <p>The findings include:</p> <p>Review of the facility policy titled, Care Planning - Interdisciplinary Team, revised 3/2022, revealed .The interdisciplinary team is responsible for the development of resident care plans .The IDT includes but is not limited to .the residents attending physician .a registered nurse .a nursing assistant .a member of the food and nutrition services .resident and or the resident's representative .other staff as appropriate .</p> <p>Review of the medical record revealed Resident #1 was admitted to the facility on [DATE] and readmitted on [DATE] with diagnoses including Hepatic Encephalopathy, Alcoholic Cirrhosis of Liver with Ascites, Dependence on Renal Dialysis, and Esophageal Varices. Resident #1 was discharged to the hospital on 4/29/2025.</p> <p>Review of the comprehensive Minimum Data Set (MDS) assessment dated [DATE] revealed Resident #1 scored a 14 on the Brief Interview of Mental Status (BIMS) assessment which indicated the resident was cognitively intact. The resident required assistance of 1 or more staff persons with activities of daily living (ADL's).</p> <p>Review of 3 facility documents titled, INTERDISCIPLINARY TEAM CARE CONFERENCE NOTE/CARE PLANNING PROCESS, for the care plan meeting documentation dated 2/25/2025, 3/11/2025, and 4/16/2025 for Resident #1 revealed the resident or a resident representative, the Social Services Director (SSD), and the Dietary Manager attended all three meetings, no other disciplines were in attendance.</p> <p>During an interview on 4/30/2025 at 1:00 PM, the Director of Nursing (DON) stated .no we did not have the full IDT staff at those care plan meetings .no nurse or doctor was at those meetings for [Resident #1] .</p> <p>During an interview on 5 /1/2025 at 8:30 AM, The Social Services Director (SSD) stated .I [SSD] set the care plan meetings up it was just me and the dietary manager there was no other staff .those meetings did not have the full team together everybody was just tied up .</p>

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.

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