

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 280 SS=D	<p>483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP</p> <p>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.</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: Based policy review, medical record review and interview, it was determined the facility failed to revise the comprehensive care plan to address pain for 1 of 10 (Resident #6) sampled residents.</p> <p>The findings included: Review of the facility's "Care Plan Goals and Objectives" policy documented, "...The purpose of this procedure is to complete care plans while incorporating measurable goals and objectives that assist in leading to the resident's optimal</p>	F 280	<p>Preparation and/or execution of this plan of correction does not constitute admission or agreement by this provider of the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and/or state law. This plan of correction constitutes our credible allegation of compliance.</p>	8-17-11
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*Acceptable Pol
 by GAT 7/25/11
 Standalone*

Acceptable Pol 7/25/11 Standalone A-1002

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>[Signature]</i>	TITLE Administrator	(X6) DATE 8/4/11
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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.

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F 280	<p>Continued From page 1</p> <p>level of functioning... 1. Care plan goals and objectives are defined as the desired outcome for a specific resident problem..."</p> <p>Medical record review for Resident #6 documented an admission date of 6/23/11 with diagnoses of Pain, End Stage Renal Disease, Type 2 Diabetes Mellitus, Neurogenic Bladder, Hypertension and Psychosis. Review of the physician's orders dated 7/4/11 documented, "...Duragesic-100 (fentanyl) - Schedule II film, extended release; 100mcg [micrograms]/ [per] hr [hour]; transdermal once a day every 3 days... Roxanol (morphine) - Schedule II concentrate; 20mg [milligrams]/ml [milliliters]; amt [amount]; 0.25- [to] 1ml; oral every 4 hours - PRN [as needed]..." Review of the care plan dated 7/12/11 revealed no documentation to address pain.</p> <p>During an interview in the Minimum Data Systems (MDS) coordinator's office on 7/19/11 at 8:00 AM, the MDS coordinator was asked to review Resident #6's care plan for pain therapy. The MDS coordinator stated, "...I don't see pain addressed on the care plan or a pain care plan..."</p>	F 280	<p>F- 280 s/s=D</p> <p>I. Resident #6 has a care plan in place to address pain.</p> <p>II. Residents have been assessed for pain and have a care plan in place to address pain management where needed.</p> <p>III. Licensed nursing have been re-educated on revising care plans to reflect resident current needs.</p> <p>IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits of care plans for pain management 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions where needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11
F 282 SS=D	<p>483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN</p> <p>The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, medical record review, observation and interview, it was determined the</p>	F 282		

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F 282	<p>Continued From page 2</p> <p>facility failed to follow the care plan intervention for a chair alarm for 1 of 9 (Resident #3) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Care Plan Goals and Objectives" policy documented, "...4. Goals and objectives are entered on the resident's care plan so that the disciplines have access to such information and are able to report whether or not the desired outcomes are being achieved..."</p> <p>Medical record review for Resident #3 documented an admission date of 5/8/08 with diagnoses of Diabetes Mellitus, Blindness, Hypercholesterolemia, Depressive Disorder and Hypertension. The comprehensive care plan dated 6/7/11 documented, "...Problem Start Date: 7/23/2008 At risk for falls... Approach Start Date: 10/29/2008 Sensor alarm to bed and to chair... Problem Start Date: 8/5/2008 Self care deficit related to cognitive deficits... Approach Start Date: 10/29/2008 Sensor alarm to bed and chair to alert staff of attempts to arise unassisted..." The physician's orders dated 7/4/11 documented, "...Body alarm when up in W/C (wheelchair) to remind resident not to self transfer, Check placement and function every shift..."</p> <p>Observations in the side 1 hallway on 7/18/11 at 10:35 AM, revealed Resident #3 sitting in a w/c without a chair alarm in place as care planned.</p> <p>Observations in the dining room on 7/18/11 at 3:20 PM and 5:35 PM and on 7/20/11 at 12:15 PM, revealed Resident #3 sitting in a w/c without a chair alarm in place as care planned.</p>	F 282	<p>F-282 s/s=D</p> <p>I. Resident #3 is using the chair alarm as per the plan of care.</p> <p>II. Residents with chair alarms have been assessed and are in place as per plans of care.</p> <p>III. Nursing staff has been re-educated on placement and monitoring of chair alarms. Nursing staff has been re-educated on following resident's plan of care.</p> <p>IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits of residents with chair alarms 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions where needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11
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F 282	Continued From page 3	F 282			
F 283 SS=D	<p>Observations in Resident #3's room on 7/19/11 at 7:45 AM and on 7/20/11 at 10:25 AM, revealed Resident #3 sitting in a w/c without a chair alarm in place as care planned.</p> <p>During an interview in the dining room on 7/20/11 at 12:15 PM, the Assistant Director of Nursing was asked if Resident #3 had a chair alarm on. The ADON stated, "...no chair alarm on the wheelchair, not on... yes, there is an order for a chair alarm..."</p> <p>483.20(l)(1)&(2) ANTICIPATE DISCHARGE: RECAP STAY/FINAL STATUS</p> <p>When the facility anticipates discharge a resident must have a discharge summary that includes a recapitulation of the resident's stay; and a final summary of the resident's status to include items in paragraph (b)(2) of this section, at the time of the discharge that is available for release to authorized persons and agencies, with the consent of the resident or legal representative.</p> <p>This REQUIREMENT is not met as evidenced by: Based on closed medical record review and interview, it was determined the facility failed to develop a recapitulation of the resident's stay for 1 of 1 (Resident #10) sampled resident who was discharged.</p> <p>The findings included: Closed medical record review for Resident #10 documented an admission date of 1/17/11 with diagnoses of Cellulitis/Abcess, Dysfunction</p>	F 283	<p>F-283 s/s=D</p> <p>I. The recapitulation for Closed Record #10 has been completed.</p> <p>II. Closed records have been audited and have recapitulation of stays completed.</p> <p>III. Medical Record Coordinator and Licensed nurses have been re-educated on completing the recapitulation of resident stays for closed records.</p> <p>IV. The Director of Nursing, Medical Record Coordinator and/or Designee will complete weekly audits for 4 weeks then monthly audits for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11	

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F 283	Continued From page 4 Sinatrial Node, Hemiplegia Nondominant Lower Extremity Side, Venous Thrombosis, and Hypertension. Review of the "Discharge & [and] Transfer-Discharge Plan of Care" dated 4/23/11 documented, "...Discharge Date 4/23/11..." The facility was unable to provide documentation of a recapitulation of Resident #10's stay in the facility.	F 283			
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on medical record review, observation and interview, it was determined the facility failed to follow physician's orders for a chair alarm for 1 of 9 (Resident #4) sampled residents. The findings included: Medical record review for Resident #4 documented an admission date of 3/17/11 with diagnoses of Depression, Congestive Heart	F 309	F-309 s/s=D I. Resident #4 is using the chair alarm as per orders. II. Residents with chair alarms have been assessed and are in place as per orders. III. Nursing staff has been re-educated on placement and monitoring of chair alarms. Nursing staff has been re-educated on following resident orders. IV. The Director of Nursing, MDS Coordinator and/or Designee will complete random audits of residents with chair alarms 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions where needed. V. Completion Date: August 17, 2011	8-17-11	

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F 309	<p>Continued From page 5</p> <p>Failure, Hypertension and Dementia. Review of a physician's order dated 7/4/11 documented, "...chair alarm on while up in w/c [wheelchair] Q [every] Shift..."</p> <p>Observations in side 1 hallway beside the nurses' station on 7/19/11 at 7:10 AM, revealed Resident #4 sitting in a w/c with no chair alarm in place as ordered.</p> <p>Observations in Resident #4's room on 7/19/11 at 10:30 AM, revealed Resident #4 sitting in a w/c with no chair alarm in place as ordered.</p> <p>Observations in the hallway outside Resident #4's room on 7/20/11 at 7:30 AM, revealed Resident #4 sitting in a w/c with no chair alarm in place as ordered.</p> <p>During an interview in side 1 hallway on 7/20/11 at 7:30 AM, Nurse #1 confirmed there was no chair alarm on Resident #4. Nurse #1 stated, "...No chair alarm on w/c..."</p>	F 309		
F 315 SS=D	<p>483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER</p> <p>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.</p>	F 315		

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F 315	<p>Continued From page 6</p> <p>This REQUIREMENT is not met as evidenced by: Based on review of Sorenson and Luckmann's Basic Nursing A Psychophysilogic Approach textbook, medical record review, and observation, it was determined the facility failed to provide appropriate Foley catheter care and treatment for 1 of 2 (Resident #7) sampled residents observed with a catheter and a history of Urinary Tract Infections (UTI).</p> <p>The findings included:</p> <p>Review of "Sorenson and Luckmann's Basic Nursing A Psychophysilogic Approach, Third Edition," page 1187, documented "...the bag (Foley catheter bag) and tubing must never touch the floor... These actions increase the chances for bacteria in the drainage bag to ascend the tubing and possibly to enter the bladder. Bacteria in the drainage bag can lead to UTI and subsequent increased mucus production..."</p> <p>Medical record review for Resident #7 documented an admission date of 1/19/08 with diagnoses of Spina Bifida, Neurogenic Bladder, Renal Failure and Urinary Tract Infection. Review of a physician's order dated 7/6/11 documented, "Foley catheter # [number] 20 French with 30 cc [cubic centimeters]; change monthly and pm [as needed]..."</p> <p>Observations in the dining room on 7/18/11 at 5:30 PM and on 7/20/11 at 7:15 AM, revealed Resident #7 seated in a wheelchair (w/c) with the Foley catheter tubing laying on the floor under the w/c.</p>	F 315	<p>F-315 s/s=D</p> <p>I. Resident #7's foley catheter tubing is being secured under wheel chair when up, and not touching the floor.</p> <p>II. Residents with foley catheters have been checked and tubing is being secured and not touching the floor.</p> <p>III. Nursing staff have been re-educated on foley catheter tubing placement.</p> <p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of residents with foley catheters/tubing placement 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions where needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11	

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F 315	Continued From page 7 During an interview in the Director of Nursing's (DON) office on 7/20/11 at 2:00 PM, the DON stated, "...that is unacceptable [Foley catheter tubing laying on the floor]..."	F 315			
F 371 SS=E	483.35(j) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to serve food under sanitary conditions as evidence of a dirty grease trap, utensils hanging over the 3 compartment sink, carbon buildup on pans, not enough sanitizer in a sanitizer bucket, back splash on the ice machine, brown substance on the tea holder, splatter spots on the tray carts, chicken thawing in the sink, a staff member failed to wash his hands or ensure fried chicken was served at 135 degrees Fahrenheit (F) or above. The findings included: 1. Observations during the initial tour of the kitchen on 7/18/11 at 7:30 AM, revealed the following: a. Carrots and cabbage were in the cooler and	F 371	F- 371 s/s=E L. The bag of carrots/cabbage was discarded. The grease trap on the stove is clean. The carbon from pans was removed and/or pans replaced where needed. The sanitizer bucket is being used with correct sanitizer amount to meet strip testing. The back splash on the ice machine is clean. The tea holder container is clean. The tray carts have been cleaned. The chicken is being thawed per FDA food code guidelines for thawing meat. Fried chicken on the steam table is meeting food temperature guidelines. The identified dietary employee is washing their hands per recommended guidelines.	8-17-11	

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F 371	<p>Continued From page 8</p> <p>had brown areas all over them.</p> <p>b. A grease trap under the stove had a moderate amount brown crusted material present.</p> <p>c. A meat fork and three spoons were hanging above the 3 compartment sink.</p> <p>d. There was a moderate amount of carbon build-up noted on all the pans being used.</p> <p>e. The sanitizer bucket contained a liquid that did not change the color of the litmus strip.</p> <p>f. The back splash on the ice machine in the dining room had a gross amount of splatter designed clear substance.</p> <p>g. The tea holder in the dining room had a moderate amount of brown substance on the base of the container.</p> <p>2. Review of facility's "FOOD SAFETY" policy documented, "...cooked poultry breasts should be maintained at a temperature of 170 degrees... Cook foods to a safe temperature to kill microorganisms..."</p> <p>Observations in the kitchen on 7/19/11 beginning at 11:45 AM, revealed the following:</p> <p>a. Tray carts had a moderate amount of scattered beige colored substances on all four sides on the inside and outside.</p> <p>b. Chicken was thawing in the sanitizer part of the 3 compartment sink.</p> <p>c. The sanitizer bucket contained a liquid that did not change the color of the litmus paper.</p> <p>d. The fried chicken breast was noted to have a temperature on the tray line of 128 degrees F.</p> <p>e. A dietary employee pulled off his gloves, went outside the kitchen, came back in, and began meal tray prep on the tray line without washing his hands.</p>	F 371	<p>II. The refrigerators have been checked and produce is monitored and discarded as needed.</p> <p>Grease trap is monitored for cleaning needs.</p> <p>Cooking pans and baking pans have been checked and cleaned when needed.</p> <p>Sanitizer buckets are checked and meet sanitation strips readings.</p> <p>Ice machines have been checked and are clean.</p> <p>Tea Machine has been checked and is clean.</p> <p>Tray service carts have been checked and are clean.</p> <p>Chicken is being thawed per FDA food code guidelines for thawing meat.</p> <p>Meat items are checked and meeting temperature guidelines.</p> <p>Dietary employees are washing their hands as per recommended guidelines.</p> <p>III. Dietary staff has been re-education on kitchen sanitation/cleaning requirements, food handling, temperature for foods on steam table, thawing foods and hand washing.</p>		

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F 371	Continued From page 9 3. During an interview in the kitchen on 7/18/11 at 8:10 AM, the Dietary Manager (DM) was asked about the vegetables and the sanitizer. The DM stated, "...we cut off the bad parts and must have not had enough sanitizer in the bucket."	F 371	IV. The Administrator, Dietary Manager and/or Designee will complete random sanitation checks 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.	8-17-11
F 441 SS=D	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if	F 441	V. Completion Date: August 17, 2011 F-441 s/s=D I. Employee #1 is washing their hands as per recommended guidelines. Sanitizer is being used in the washing machines. II. Employees are being monitored and are washing their hands as per recommended guidelines. Washers are checked and sanitizer is being added to washing machines. III. Nursing and facility staff have been re-educated on hand washing guidelines. Laundry staff has been re-educated on use of sanitizer in the washers.	8-17-11

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 07/20/2011
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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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
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F 441	<p>Continued From page 10 direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice.</p> <p>(c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.</p> <p>This REQUIREMENT is not met as evidenced by: Based on policy review, observation and interview, it was determined the facility failed to ensure 1 of 7 Certified Nursing Assistants (CNA #1) prevented the potential spread of infection by not washing hands when setting up trays and touching the environment during dining observations. The facility failed to provide proper sanitation for the residents personal clothing by not having 1 of 3 washing machines at the proper temperature and without sanitizer in the water.</p> <p>The findings included:</p> <p>1. Review of the facility's "HANDWASHING" policy documented, "...WHEN TO WASH HANDS... 5. After having prolonged contact with a resident... 6. After handling used dressings, specimen containers, contaminated linens, linen..."</p> <p>Observations during the supper meal pass on side 1 hallway on 7/18/11 at 6:10 PM, CNA #1 entered room #10 and set-up the meal tray, left</p>	F 441	<p>IV. The Director of Nursing, Assistant Director of Nursing and/or Designee will complete random audits of staff and hand washing 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. The Administrator, Housekeeping Supervisor and/or Designee will complete random audits of washing machine use for sanitizer 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11
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DEPARTMENT OF HEALTH AND HUMAN SERVICES
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FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 07/20/2011
NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1740 BELCOURT AVENUE NASHVILLE, TN 37212		
(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 441	Continued From page 11 the room and obtained water for room #4, pulled the meal cart down the hall, took a tray off the cart to room #13, set-up the tray in room #13, left the room, pulled the cart down the hall and went to the kitchen to obtain utensils for a resident's tray. CNA #1 never washed her hands. During an interview in the Director of Nursing's (DON) office on 7/20/11 at 2:00 PM, the DON was asked about the handwashing. The DON stated, "...it is not acceptable, we have alcohol dispensers and bottles of alcohol gel..." 2. Observations in the washer room on 7/19/11 at 9:00 AM, revealed a low temperature washer with a temperature of 118.4 degrees without a sanitizer being used. During an interview in the washer room on 7/19/11 at 9:00 AM, the Environmental Services (ES) Manager was asked what was the low temperature washer used for and does it have a sanitizer. The ES Manager stated, "...We wash [residents'] personal clothes, bibs and mop heads in this washer [low temperature]..." During an interview in the Social Services office on 7/20/11 at 10:30 AM, the ES Manager stated, "...it [low temperature washer] did not have a sanitizer..."	F 441			
F 465 SS=E	483.70(h) SAFE/FUNCTIONAL/SANITARY/COMFORTABLE ENVIRON The facility must provide a safe, functional, sanitary, and comfortable environment for residents, staff and the public.	F 465			

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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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F 465	<p>Continued From page 12</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation and interview, it was determined the facility failed to ensure the environment was clean and sanitary as evidenced by black and white substances on shower chairs, presence of hair, greenish/black substance on a hoier lift, brown, black and green substances on a stretcher and yellow/brown substances on toilet seats in 2 of 2 (side 1 and side 2 shower rooms).</p> <p>The findings included:</p> <p>1. Observations in the side 1 shower room on 7/18/11 at 5:45 PM, revealed eight black hairs in the sink, a mauve color mesh back shower chair with a large amount of white substance on the mesh part of the chair back and smears of a black substance under the toilet seat and on the polyvinyl chloride (PVC) pipe. An Invacare Reliant 450 hoier lift with a large amount of green/black substance in a clump and smeared on the left lift hook that holds the sling. A maroon color gerichair with a brown substance on the right side of the handrail. A green color mesh back shower chair with hairs in a yellow/brown color substance under the toilet seat and green/black substance under the seat and PVC pipe, and a seat belt on the left side with brown substance. A stretcher along the PVC pipe on the top left side near the foam pad with three black hairs and along the top side of the bottom left side with smeared black/green substances.</p> <p>Observations in the side 1 hall shower room on 7/19/11 at 3:15 PM, revealed a mauve color</p>	F 465	<p>F-465 s/s=E</p> <p>I. The sink in the shower room has been cleaned. The mesh back, belt and toilet seat on the mauve and green shower chairs have been cleaned. The hoier lift and maroon geri chair have been cleaned. The stretcher has been cleaned.</p> <p>II. Shower rooms and equipment have been checked and cleaned.</p> <p>III. Nursing staff and Housekeeping staff have been re-educated on equipment cleaning procedures.</p> <p>IV. The Director of Nursing, Assistant Director of Nursing, Housekeeping Supervisor and/or Designee will complete random audits of equipment for sanitation 2 times a week for 4 weeks, weekly for 4 weeks, then monthly for 2 months. Results of the audits will be reviewed at the Quality Assurance meetings for revisions as needed.</p> <p>V. Completion Date: August 17, 2011</p>	8-17-11
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NAME OF PROVIDER OR SUPPLIER BELCOURT TERRACE NURSING HOME			STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212		
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F 465	<p>Continued From page 13</p> <p>mesh back shower chair with a large amount of white substance on the mesh part of the chair back and smears of a black substance under the toilet seat and on the PVC pipe. A maroon color gerichair with a brown substance on the right side of the handrail. A green color mesh back shower chair with hairs in a yellow/brown color substance under the toilet seat and green/black substance under the seat and PVC pipe, and a seat belt on the left side with brown substance. A stretcher along the PVC pipe on the top left side near the foam pad three black hairs and along the top bottom left side smeared black/green substances.</p> <p>2. Observations in the side 2 shower room on 7/18/11 at 5:40 PM, revealed a mauve color mesh back shower chair with green/black substances under the toilet seat and PVC pipe connector. The shower chair also had a large area of white substance on the mesh back.</p> <p>Observations in the side 2 hall shower room on 7/19/11 at 3:15 PM, revealed an Invacare Reilant 450 hoier lift with a large amount of green/black substance in a clump and smeared on the left lift hook that holds the sling. A mauve color mesh back shower chair with green/black substances under the toilet seat and PVC pipe connector. The chair also had a large area of white substance on the mesh back.</p> <p>3. During an interview in the side 1 hall shower room on 7/19/11 at 3:30 PM, the Director of Nursing (DON) confirmed the findings of unsanitary equipment in side 1 and side 2 shower rooms. The DON stated, "...yes, I see it..."</p>	F 465			

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