

STATEMENT OF DEFICIENCIES PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445273	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 10/08/2012
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NAME OF PROVIDER OR SUPPLIER COURT TERRACE NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 1710 BELCOURT AVENUE NASHVILLE, TN 37212
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4) 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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038 IS=D	NFPA 101 LIFE SAFETY CODE STANDARD Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to provide exits readily accessible at all times. The finding included: Observation of the exit discharge adjacent to room 4 on 10/8/12 at 11:06 AM, revealed the exit discharge did not have an all-weather surface to the public way. This finding was verified the maintenance director and acknowledged by the administrator during the exit conference on 10/8/12.	K 038	No resident was directly affected by the absence of an all-weather surface to the public way. Bids to build the sidewalk were immediately obtained and the work has been completed. Completion date 11/01/12	
K 147 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2 This STANDARD is not met as evidenced by: Based on observation, it was determined the facility failed to maintain the electrical wiring and equipment. The finding included:	K 147		

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REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>R. M. K. J.</i>	TITLE <i>Administrator</i>	(X6) DATE <i>10/26/2012</i>
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A deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that 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 following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued am participation.

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

FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES
PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

445273

(X2) MULTIPLE CONSTRUCTION
A. BUILDING 01 - MAIN BUILDING 01
B. WING _____

(X3) DATE SURVEY
COMPLETED

10/08/2012

NAME OF PROVIDER OR SUPPLIER

COURT TERRACE NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
1710 BELCOURT AVENUE
NASHVILLE, TN 37212

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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147	<p>Continued From page 1 Observation of the pantry on 10/8/12 at 11:14 AM, revealed the ground fault interrupt circuit at the counter was not functioning correctly. This finding was verified by the maintenance director and acknowledged by the administrator during the exit conference on 10/8/12.</p>	K 147	<p>No resident was directly affected by the faulty Ground Fault Interrupter device. The device was immediately replaced. All other GFIs were examined and found to be in good working order. The Maintenance Director will examine GFI devices monthly and report on their working condition at the monthly QA meeting for the next three months and quarterly for two quarters if one GFI is found to be faulty. Completion date: 11/01/12</p>	
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