

MAY 20 2010

PRINTED, WORKED TO  
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - STATE BUILDING B. WING: _____	(X3) DATE SURVEY COMPLETED  04/26/2010
NAME OF PROVIDER OR SUPPLIER  BELCOURT TERRACE NURSING HOME		STREET ADDRESS, CITY, STATE, ZIP CODE 1710 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) COMPLETE DATE
N 901	<p>1200-8-6-.09(1) Life Safety</p> <p>(1) Any nursing home which complies with the required applicable building and fire safety regulations at the time the board adopts new codes or regulations will, so long as such compliance is maintained (either with or without waivers of specific provisions), be considered to be in compliance with the requirements of the new codes or regulations.</p> <p>This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to comply with the applicable building and fire safety regulations as required.</p> <p>The findings included:</p> <p>Observations in resident rooms 19 and 34 on 4/26/10 between 9:15 PM and 10:05 PM, revealed the night lights were not working. Tennessee Department Of Health 1200-8-6-09(1).</p> <p>This deficiency was verified by the Maintenance Director and later acknowledged by the Administrator during the exit interview on 4/26/10.</p>	N 901	<p>N901=</p> <ol style="list-style-type: none"> <li>I. Night Lights have been replaced.</li> <li>II. Other Night Lights were checked and are in working order</li> <li>III. Maintenance Director/Designee will check night lights weekly</li> <li>IV. Night Lights will be monitored by Maintenance/Designee and will be reviewed through QA process for revisions as needed.</li> <li>V. Completion Date</li> </ol>	5/14/10

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Administrator*

(X6) DATE

5/19/10

STATE FORM

6892

OK8H21

If continuation sheet 1 of 1