

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1902	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/19/2014
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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) COMPLETE DATE
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N1405	<p>1200-8-6-.14(2)(a)1. Disaster Preparedness</p> <p>(2) Physical Facility and Community Emergency Plans.</p> <p>(a) Physical Facility (Internal Situations).</p> <p>1. Every nursing home shall have a current internal emergency plan, or plans, that provides for fires, bomb threats, severe weather, utility service failures, plus any local high risk situations such as floods, earthquakes, toxic fumes and chemical spills. The plan should consider the probability of the types of disasters which might occur, both natural and "man-made".</p> <p>This Rule is not met as evidenced by: Based on document review, it was determined the facility had no written disaster plans.</p> <p>The findings included:</p> <p>During document review the facility was unable to provide the surveyor with a current written disaster plan. The administrator confirmed this during the exit conference on 5/19/14.</p>	N1405	<p>I. Maintenance Director retrieved the Disaster Manual from the Nursing Station and a copy was placed in the Administrator's office.</p> <p>II. The Administrator and Maintenance Director have reviewed the Disaster Manual and information is current.</p> <p>III. The Administrator and Maintenance Director have been reeducated on Disaster Manual requirements. The Administrator has provided an education reminder for staff on the manual location.</p> <p>IV. The Maintenance Director will complete random audits of manual location monthly for three months. Results of the audits will be discussed at the Quality Assurance meetings as needed.</p> <p>V. Completion Date: June 10, 2014.</p>	
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Division of Health Care Facilities

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

TITLE

(X6) DATE

R. M. K. F.

Administrator

06/06/2014

STATE FORM

6899

WONX21

If continuation sheet 1 of 1

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JUN 10 2014