

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

PRINTED: 02/17/2009
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 03 BIRMINGHAM B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2009
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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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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K 025 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
Smoke barriers are constructed to provide at least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4

K 025 Prefix tag K025 SS=F

A

- Penetrations on the 2nd, 3rd, and 4th floors above fire doors, stairwell exit doors, elevator lobbies and electrical rooms will be sealed by 3/6/09 using 3M Fire Stop.

B

- All patients could be affected by this practice. No residents were harmed

C

- Penetrations will be checked during the quarterly preventive maintenance program for the inspection and repair of smoke and fire partitions.

D

- Documentation will be kept on file in the Facilities Management Office and reviewed by the Facilities Management Director or Supervisor and a standing report made to the Safety Committee which in turn reports to the Quality Improvement Committee.

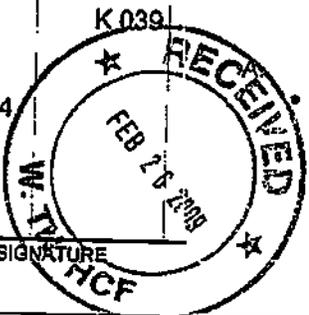
2/10/09

This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoke barriers.

The findings included:
Observations during the facility tour on 2/2/09, revealed the following:
a. The 2nd, 3rd, and 4th floors had penetrations in the smoke walls located above the fire doors.
b. The 1st, 2nd, 3rd, and 4th floors elevator lobbies had penetrations in the fire walls.
c. The 2nd and 3rd 4th floors electrical rooms ceiling conduit ends were not sealed.
The maintenance staff verified these findings as noted above.

K 039 SS=F NFPA 101 LIFE SAFETY CODE STANDARD
Width of aisles or corridors (clear and unobstructed) serving as exit access is at least 4 feet. 19.2.3.3

K-039



On 2/2/09 the equipment found to be in corridors of Birmingham 2, 3 or 4 was relocated to their respective storage areas by the Nursing staff on each unit.

3/10/09

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	FILE	(X6) DATE
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* 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 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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K 039	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to ensure the corridors were clear and unobstructed. The findings included: Observations during the facility tour on 2/2/09, revealed the 2nd, 3rd, and 4th floor corridors had chairs, carts, and lift equipment stored in the corridors. The maintenance staff member verified the 2nd, 3rd, and 4th floor corridors had chairs, carts, and lift equipment stored in the corridors.	K 039	B. <ul style="list-style-type: none">All residents could have been effected by this practice in the Birmingham building, but none were harmed. C. <ul style="list-style-type: none">On 2/25/09 a policy was developed and implemented addressing the Life Safety Requirement of proper storage of equipment on the respective units. If the equipment is stored on the corridor or is in use on the coridor it must be moved every 30 minutes by the staff on that hallway. An in-service on the new policy will be conducted by the Clinical Educator, Nursing Supervisor, PCM and Charge Nurse beginning 2/25/09 with completion by 2/27/09. D. <ul style="list-style-type: none">The PCM and the Environmental Services Director will monitor this during the Environmental rounds on each unit. If deficiencies are found it will be corrected at the time and reported in the Risk Management and Safety Committee monthly meeting.		
K 052 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the fire alarm system. The findings included: Observations of the 4th floor's fire alarm pull station, located across room 412, on 2/2/09	K 052			

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K 039 Continued From page 1

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to ensure the corridors were clear and unobstructed.

The findings included:

Observations during the facility tour on 2/2/09, revealed the 2nd, 3rd, and 4th floor corridors had chairs, carts, and lift equipment stored in the corridors. The maintenance staff member verified the 2nd, 3rd, and 4th floor corridors had chairs, carts, and lift equipment stored in the corridors.

K 052 SS=D
NFWA 101 LIFE SAFETY CODE STANDARD

A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the fire alarm system.

The findings included:

Observations of the 4th floor's fire alarm pull station, located across room 412, on 2/2/09

K 039

K 052 Prefix tag K052 SS=D

A

- The items that blocked the pull station across from room 412 were removed on 2/2/09.

B

- All patients could be affected by this practice. No residents were harmed

C

- The Facility Management Director and staff will check pull stations to ensure they are free from obstruction during their monthly PM checks and weekly rounds.

D

- Documentation will be kept on file in the Facilities Management Director and reviewed by the Facilities Management Director or Supervisor.

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K 052	Continued From page 2 revealed the pull station was blocked with a chair. The maintenance staff member verified the chair was blocking the pull station.	K 052		
K 067 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 19.5.2.1, 9.2, NFPA 90A, 19.5.2.2 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the sprinkler system. The findings included: Observations during the facility tour on 2/2/09, revealed the following: a. Resident rooms 330, 402, 404, 413, and 415 sprinklers were dirty with lint. b The kitchen's loading dock revealed the sprinklers were corroded. These sprinklers must be replaced not cleaned. c. The kitchen and dish washing area sprinklers were corroded. These sprinklers must be replaced not cleaned. The maintenance staff member verified the sprinkler heads were covered in lint or corroded as noted above.	K 067	Prefix tag K 067 SS=F A <ul style="list-style-type: none"> Dusty sprinkler heads in rooms 330, 402, 04, 413, and 415 were cleaned on 2/2/09. Corroded sprinkler heads on Loading Dock will be replaced by 3/6/09 Corroded sprinkler heads in Kitchen will be replaced by 3/6/09 B <ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed. C <ul style="list-style-type: none"> Facilities staff will continue to monitor corroded or dirty sprinkler heads during their monthly preventative maintenance rounds and will also be checked quarterly by Fire Sprinkler LLC during their quarterly inspections. D <ul style="list-style-type: none"> Documentation of monthly and quarterly inspections will be kept on file in the Facilities Management department and reviewed by the Facilities Management Director or Supervisor. 	3/10/09
K 147 SS=F	NFPA 101 LIFE SAFETY CODE STANDARD Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2	K 147		

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K 147 Continued From page 3

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the electrical equipment.

The findings included:

Observations during the tour of the kitchen on 2/2/09, revealed the cover on a ground fault circuit interrupter located next to the plate warmer was missing. The maintenance staff member verified the ground fault circuit interrupter located next to the plate warmer was missing.

K 211 SS=E
NFPA 101 LIFE SAFETY CODE STANDARD

Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
o The corridor is at least 6 feet wide
o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
o The dispensers have a minimum spacing of 4 ft from each other
o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
o Dispensers are not installed over or adjacent to an ignition source.
o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the alcohol based hand rub dispensers.

K 147 Prefix tag K 147 SS=F

3/10/09

- A
 - The GFCI cover in the kitchen next to the plate warmer was repaired on 2/20/09
- B
 - All residents could be affected by this practice. No residents were harmed
- C
 - Facilities staff will continue to monitor all electrical outlets during their monthly preventative maintenance rounds
- D
 - Documentation will be kept on file in the Facilities Management department and reviewed by the Facilities Management Director or Supervisor.

K 211 Prefix tag K 211 SS=E

3/10/09

- A
 - The alcohol hand dispensers in the 4th floor exam room were moved at least three feet away from any light switch or electrical outlet.

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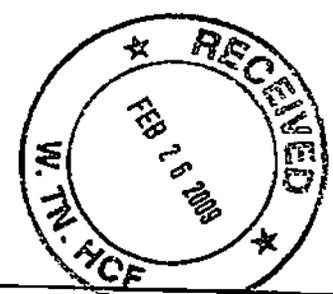
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K 211	<p>Continued From page 4</p> <p>The findings included:</p> <p>Observations of the 4th floor exam room on 2/2/09 revealed the alcohol based hand rub dispenser was installed adjacent to the light's on/off switch. The maintenance staff member verified the alcohol based hand rub dispenser was installed adjacent to the light's on/off switch.</p>	K 211	<p>B</p> <ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed. The Facilities Management staff will look at all alcohol dispensers in the facility and will move any that are not in compliance by 3/6/09. <p>C</p> <ul style="list-style-type: none"> Facilities staff will continue to monitor alcohol dispensers during their monthly preventative maintenance rounds and will ensure that any new dispensers will be mounted at least three feet away from any electrical device. <p>D</p> <ul style="list-style-type: none"> Documentation will be kept on file in the Facilities Management department and reviewed by the Facilities Management Director or Supervisor. 	
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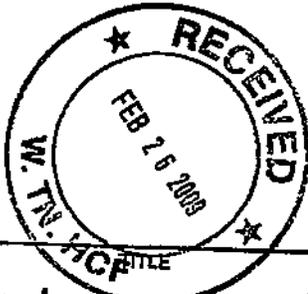
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K 018 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Doors protecting corridor openings in other than required enclosures of vertical openings, exits, or hazardous areas are substantial doors, such as those constructed of 1 1/4 inch solid-bonded core wood, or capable of resisting fire for at least 20 minutes. Doors in sprinklered buildings are only required to resist the passage of smoke. There is no impediment to the closing of the doors. Doors are provided with a means suitable for keeping the door closed. Dutch doors meeting 19.3.6.3.6 are permitted. 19.3.6.3</p> <p>Roller latches are prohibited by CMS regulations in all health care facilities.</p> <p>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the doors protecting the corridors.</p> <p>The findings included:</p> <p>Observations during the facility tour of the 4th floor on 2/2/09, revealed the door to resident room 407 did not have a latch. The maintenance staff member verified the door did not have a latch.</p>	K 018	<p>The plan of corrections is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations.</p> <p>Prefix tag K 018</p> <p>A</p> <ul style="list-style-type: none"> The door latch in room 407 was repaired on 2/3/09. <p>B</p> <ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed. <p>C</p> <ul style="list-style-type: none"> Door latches will be monitored during Facilities Management's monthly preventative maintenance rounds <p>D.</p> <ul style="list-style-type: none"> Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. 	3/10/09
K 025 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Smoke barriers are constructed to provide at</p>	K 025		



ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Randee Morrison</i>	TITLE <i>Administrative</i>	(X6) DATE 2/25/09
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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 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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K 025	<p>Continued From page 1</p> <p>least a one half hour fire resistance rating in accordance with 8.3. Smoke barriers may terminate at an atrium wall. Windows are protected by fire-rated glazing or by wired glass panels and steel frames. A minimum of two separate compartments are provided on each floor. Dampers are not required in duct penetrations of smoke barriers in fully ducted heating, ventilating, and air conditioning systems. 19.3.7.3, 19.3.7.5, 19.1.6.3, 19.1.6.4</p> <p>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the smoke barriers.</p> <p>The findings included:</p> <p>Observations during the facility tour on 2/2/09, revealed the following:</p> <p>a. The 1st, 2nd, 3rd, and 4th floors had penetrations in the smoke walls located above the fire doors.</p> <p>b. The 1st, 2nd, 3rd, and 4th floors had penetrations in the fire walls located above the stairwell exit doors (corridor side).</p> <p>c. The 1st, 2nd, 3rd, and 4th floors elevator lobbies had penetrations in the fire walls.</p> <p>d. The 1st and 4th floors electrical rooms had penetrations in the walls and ceiling.</p> <p>The maintenance staff member verified the presence of the penetrations as noted on the 1st, 2nd, 3rd and 4th floors.</p>	K 025	<p>Prefix tag K025 SS=F</p> <p>A</p> <ul style="list-style-type: none"> Penetrations on the 1st, 2nd, 3rd, and 4th floors above fire doors, stairwell exit doors, elevator lobbies and electrical rooms will be sealed by 3/6/09 using 3M Fire Stop. <p>B</p> <ul style="list-style-type: none"> All patients could be affected by this practice. No residents were harmed <p>C</p> <ul style="list-style-type: none"> Penetrations will be checked during the quarterly preventive maintenance program for the inspection and repair of smoke and fire partitions. <p>D</p> <ul style="list-style-type: none"> Documentation will be kept on file in the Facilities Management Office and reviewed by the Facilities Management Director or Supervisor and a standing report made to the Safety Committee which in turn reports to the Quality Improvement Committee. 	3/10/09
K 050 SS=F	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Fire drills are held at unexpected times under varying conditions, at least quarterly on each shift.</p>	K 050		

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K 050	<p>Continued From page 2</p> <p>The staff is familiar with procedures and is aware that drills are part of established routine. Responsibility for planning and conducting drills is assigned only to competent persons who are qualified to exercise leadership. Where drills are conducted between 9 PM and 6 AM a coded announcement may be used instead of audible alarms. 19.7.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility staff member responding to the fire drill announced the wrong location of the fire.</p> <p>The findings included:</p> <p>Observations during the fire drill on 2/9/09, the staff member selected to react to the drill announced the wrong location (room number) of the fire.</p>	K 050	<p>Prefix tag K 050 SS=F</p> <p>A</p> <ul style="list-style-type: none"> Follow up fire drills will be performed in area of non compliance. <p>B</p> <ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed. <p>C</p> <ul style="list-style-type: none"> Facilities Management Director will perform one drill per shift per month to ensure staff are trained and prepared in the event of a fire. In the event the fire drill does not go well the Facilities Management Director will stop the drill and perform within next seven business days and immediate in-service and will perform a follow up drill for that area. 	3/10/09
K 147 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Electrical wiring and equipment is in accordance with NFPA 70, National Electrical Code. 9.1.2</p> <p>This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the electrical equipment.</p> <p>The findings included:</p> <p>Observations during the facility tour on 2/2/09, revealed the following:</p> <p>a. The 4th floor tub room had a ground fault circuit interrupter that was loose in the wall.</p>	K 147	<p>D</p> <ul style="list-style-type: none"> Documentation will be kept on file in the Facilities Management Department and a summary report of all drills will be presented and reviewed by the Safety Committee each month. <p>Prefix tag K 147 SS=E</p> <p>A</p> <ul style="list-style-type: none"> The GFCI in the 4th floor tub room and 3rd floor soiled utility room was repaired on 2/4/09 	3/10/09

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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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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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K 147 Continued From page 3
b. The 3rd floor soiled utility room had an electrical outlet that was loose from the wall. The maintenance staff member verified the 4th floor tub room had a ground fault circuit interrupter that was loose in the wall and the 3rd floor soiled utility room had an electrical outlet that was loose from the wall.

K 211 SS=E NFPA 101 LIFE SAFETY CODE STANDARD
Where Alcohol Based Hand Rub (ABHR) dispensers are installed in a corridor:
o The corridor is at least 6 feet wide
o The maximum individual fluid dispenser capacity shall be 1.2 liters (2 liters in suites of rooms)
o The dispensers have a minimum spacing of 4 ft from each other
o Not more than 10 gallons are used in a single smoke compartment outside a storage cabinet.
o Dispensers are not installed over or adjacent to an Ignition source.
o If the floor is carpeted, the building is fully sprinklered. 19.3.2.7, CFR 403.744, 418.100, 460.72, 482.41, 483.70, 483.623, 485.623

This STANDARD is not met as evidenced by:
Based on observations, it was determined the facility failed to maintain the alcohol based hand rub dispensers.

The findings included:
Observations during the facility tour on 2/2/09, revealed the following:
a. The 4th floor soiled linen and medicine rooms

K 147	B	<ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed
K 211	C	<ul style="list-style-type: none"> Facilities staff will continue to monitor all electrical outlets during their monthly preventative maintenance rounds
	D	<ul style="list-style-type: none"> Documentation will be kept on file in the Facilities Management department and reviewed by the Facilities Management Director or Supervisor.
		Prefix tag K 211 SS=E
	A	<ul style="list-style-type: none"> The alcohol had dispensers in the 4th floor soiled linen and medication rooms were moved at least three feet away from any light switch or electrical outlet on 2/12/09.
	B	<ul style="list-style-type: none"> All residents could be affected by this practice. No residents were harmed. The Facilities Management staff will look at all alcohol dispensers in the facility and will move any that are not in compliance by 3/6/09.

3/10/09

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

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OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - RIBEIRO B. WING _____	(X3) DATE SURVEY COMPLETED 02/02/2009
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NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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K 211 Continued From page 4
had alcohol based hand rub dispensers installed adjacent to the light's on/off switch. The maintenance staff member verified the 4th floor soiled linen and medicine rooms had alcohol based hand rub dispensers installed adjacent to the light's on/off switch.

K 211

C

- Facilities staff will continue to monitor alcohol dispensers during their monthly preventative maintenance rounds and will ensure that any new dispensers will be mounted at least three feet away from any electrical device.

D

- Documentation will be kept on file in the Facilities Management department and reviewed by the Facilities Management Director or Supervisor.

