

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

PRINTED: 04/01/2015
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 03/11/2015
NAME OF PROVIDER OR SUPPLIER NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218	

(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 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exits.</p> <p>The findings included:</p> <p>Observations of the delay egress doors revealed there was no signage on the doors in the following locations:</p> <p>a. On 3/10/15 at 2:35 PM - B4 South stairwell. b. On 3/11/15 at 10:00 AM - B3 South, B3 West, B3 North, B2 South, B2 West and B2 North stairwells. National Fire Protection Association 101, 7.2.1.6.1 (c), 2000 Edition.</p> <p>These findings were verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.</p>	K 038	<p>DISCLAIMER:</p> <p>Nashville Community Care & Rehab @ Bordeaux does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	
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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____

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

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NAME OF PROVIDER OR SUPPLIER NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE		STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218	

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K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exits.</p> <p>The findings included:</p> <p>Observations of the delay egress doors revealed there was no signage on the doors in the following locations:</p> <p>a. On 3/10/15 at 2:35 PM - B4 South stairwell. b. On 3/11/15 at 10:00 AM - B3 South, B3 West, B3 North, B2 South, B2 West and B2 North stairwells. National Fire Protection Association 101, 7.2.1.6.1 (c), 2000 Edition.</p> <p>These findings were verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.</p>	K 038	<p>K 038 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>SS=E</p> <p>Requirements:</p> <p>The facility must ensure that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1.</p> <ol style="list-style-type: none"> On 3/13/15 the Plant Ops Director/designee added signage to the doors at B4 south, B3 South, B3 West, B3 North, B2 South, B2 West & B2 North stairwells for delayed egress. On 3/13/15 the Plant Ops Director/designee inspected other stairwell doors to ensure that signage for delayed egress was present. a. On 4/28/15 the Administrator conducted in-service training with the Plant Ops Director regarding appropriate signage for stairwell doors related to delayed egress. 	
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K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the exits.</p> <p>The findings included:</p> <p>Observations of the delay egress doors revealed there was no signage on the doors in the following locations:</p> <p>a. On 3/10/15 at 2:35 PM - B4 South stairwell. b. On 3/11/15 at 10:00 AM - B3 South, B3 West, B3 North, B2 South, B2 West and B2 North stairwells. National Fire Protection Association 101, 7.2.1.6.1 (c), 2000 Edition.</p> <p>These findings were verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.</p>	K 038	<p>b. The Plant Ops Director/designee will check stairwell doors for delayed egress signage weekly x 4 & then monthly thereafter. This will be documented in the TELS system.</p> <p>4. The Plant Ops Director will report audit findings at the QAPI committee meeting monthly ongoing.</p> <p>Compliance Date: 05/10/15</p>	

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K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke barrier.</p> <p>The findings included:</p> <p>Observations of the beauty shop on 3/10/15 at 10:15 AM, revealed missing ceiling tiles due to a water leak (water was leaking at time of observation).</p> <p>This finding was verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.</p>	K 025	<p>DISCLAIMER:</p> <p>Nashville Community Care & Rehab @ Bordeaux does not believe and does not admit that any deficiencies existed before, during or after the survey. The facility reserves all rights to contest the survey findings through informal dispute resolution formal appeal proceedings or any administrative or legal proceedings. This plan of correction is not meant to establish any standard of care, contract obligation or position and the facility reserves all rights to raise all possible contentions and defenses in any type of civil or criminal claim, action or proceeding. Nothing contained in this plan of correction should be considered as a waiver of any potentially applicable Peer Review, Quality Assurance or self-critical examination privilege which the facility does not waive and reserves the right to assert in any proceeding. The facility offers its response, credible allegations of compliance and plan of correction as part of its ongoing efforts to provide quality of care to residents.</p>	
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038		

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K 025 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>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</p> <p>This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke barrier.</p> <p>The findings included:</p> <p>Observations of the beauty shop on 3/10/15 at 10:15 AM, revealed missing ceiling tiles due to a water leak (water was leaking at time of observation).</p> <p>This finding was verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.</p>	K 025	<p>K 025 NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>SS=D</p> <p><u>Requirements:</u></p> <p>The facility must maintain smoke barriers which 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 panes 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, 19.1.6.2, 19.1.6.4</p>	
K 038 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1</p>	K 038		

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K 025 SS=D	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 This STANDARD is not met as evidenced by: Based on observations, the facility failed to maintain the smoke barrier. The findings included: Observations of the beauty shop on 3/10/15 at 10:15 AM, revealed missing ceiling tiles due to a water leak (water was leaking at time of observation). This finding was verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.	K 025	1. On 3/10/15 the Plant Ops Director/designee replaced missing tiles in the beauty shop & repaired the roof leak on 4/1/15. Ceiling tiles were inspected & stained tiles were replaced after repair on 4/1/15. 2. On 3/10/15 the Plant Ops Director/designee conducted walking rounds to inspect ceiling tiles & stained ceiling tiles were replaced as needed. 3. a. On 4/28/15 the Administrator conducted in-service training with the Plant Ops Director regarding changing of stained ceiling tiles to maintain smoke barrier. b. The Plant Ops Director/designee will check ceiling tiles for stains weekly x 4 & then monthly thereafter. This will be documented in the TELS system.	
K 038 SS=E	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	K 038	4. The Plant Ops Director will report audit findings at the QAPI committee meeting monthly ongoing.	

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K 038	Continued From page 1 This STANDARD is not met as evidenced by: Based on observations and testing, the facility to maintain the exits. The findings included: 1. Observation and testing of the R1 South emergency exit on 3/10/15 at 1:34 PM, revealed the door did not latch within the door frame. 2. Observations of the R1 East stairwell and the R1 North stairwell exits on 3/10/2015 at 2:25 PM, revealed there was not a walking surface leading to the public way that was slip resistant under inclement weather conditions. This finding was verified by the maintenance staff and acknowledge by the administrator during the exit conference on 3/11/15.	K 038	K 038 NFPA 101 LIFE SAFETY CODE STANDARD SS=E <u>Requirements:</u> The facility must ensure that exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1.19.2.1. 1. a. On 3/10/15 the Plant Ops Director/designee repaired the emergency exit door on R1 South & confirmed latch. b. On 3/13/15 the Plant Ops Director/designee contacted Regional Plant Ops Director about best steps to take to correct the finding (R1 East & R1 North do not have a walking surface that lead to a public way)—a concrete path is the solution. 2. a. On 3/13/15 the Plant Ops Director/designee inspected other emergency doors to ensure they were in good repair & confirmed latch.	

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Compliance Date: 05/10/15