

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN1920	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 08/16/2012
NAME OF PROVIDER OR SUPPLIER BORDEAUX LONG TERM CARE		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) COMPLETE DATE
N 002	1200-8-6 No Deficiencies This Rule is not met as evidenced by: ... An annual licensure survey was conducted on 8/13/12 through 8/16/12. Bordeaux Long Term Care is in substantial compliance with the state licensure regulations for health.	N 002	

Division of Health Care Facilities

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

STATE FORM

[Handwritten Signature]

TITLE

Administrative

(X6) DATE

8-30-12

6598

TT0611

If continuation sheet 1 of 1