

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

The plan of corrections is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations.

PRINTED: 08/21/2012
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 01 - RIBEIRO B. WING _____		(X3) DATE SURVEY COMPLETED 08/13/2012
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) COMPLETION DATE	
K 038 SS=D	<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: Ribeiro building</p> <p>Based on observations, it was determined the facility failed to ensure the exits did not impede the means of egress during in inclement weather.</p> <p>The findings included:</p> <ol style="list-style-type: none"> Observations of the exit discharge by the chapel on 8/13/12 at 11:51 AM, revealed the exit did not have all-weather hard surface to the public way. Observations of the exit discharge from the Accounts and Records Management on 8/13/12 at 11:55 AM, revealed the exit did not have all-weather hard surface to the public way. <p>These findings were acknowledged by the Director of Facilities Management, the Assistant Administrator, and the Interim Administrator during the exit conference on 8/13/12.</p>	K 038	<p>K 38 SS=D</p> <p>A. A letter is attached requesting a permanent waiver through CMS to not have to construct a walkway to an all-weather hard surface due to the exits not utilized by residents and are in corridors that previously lead to a building that was demolished ten years ago, 2002. (See Attachment I)</p>	9/14/12	
K 062 SS=E	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA</p>	K 062			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE *K. Mishra* TITLE *Administrator* (X6) DATE *8/31/12*

A 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 program participation.

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K 062	Continued From page 1 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the automatic sprinkler system. The findings included: 1. Observations of the speech audiology office, room 203, room 207, room 209, room 213, room 220, room 214, room 226, room 113 and room 130 on 8/13/12 beginning at 12:03 PM, revealed debris on the sprinklers. 2. Observations in room 403 and the exam room on the fourth floor on 8/13/12 at 12:04 PM, revealed the escutcheon plates on the sprinklers were not secured properly. 3. Observations of the R2 electrical closet on 8/13/12 at 12:34 PM, revealed the sprinkler was not in a level position. 4. Observations of the soiled utility room on the first floor on 8/13/12 at 1:07 PM, revealed the escutcheon plate was missing on the sprinkler. These findings were acknowledged by the Director of Facilities Management, the Assistant Administrator, and the Interim Administrator during the exit conference on 8/13/12.	K 062	K 62 SS=E - 1 A. Debris found on Sprinkler heads in Speech Audiology Office, 203, 207, 209, 213, 220, 214, 226, 113, and 130 was cleaned on 8/27/12 B. All residents could be affected by this practice. No residents were harmed C. The Facilities Management staff will monitor during their monthly preventive maintenance checks. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. K 62 SS=E - 2 A. Sprinkler escutcheon ring in 403 and 4 th Floor Exam Room will be replaced by 9/12/12 B. All residents could be affected by this practice. No residents were harmed C. The Facilities Management staff will monitor during their monthly preventive maintenance checks. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor.	9/14/12
K 066 SS=D	NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 066		

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K 062	Continued From page 1 25, 9.7.5 This STANDARD is not met as evidenced by: Based on observations, it was determined the facility failed to maintain the automatic sprinkler system. The findings included: 1. Observations of the speech audiology office, room 203, room 207, room 209, room 213, room 220, room 214, room 226, room 113 and room 130 on 8/13/12 beginning at 12:03 PM, revealed debris on the sprinklers. 2. Observations in room 403 and the exam room on the fourth floor on 8/13/12 at 12:04 PM, revealed the escutcheon plates on the sprinklers were not secured properly. 3. Observations of the R2 electrical closet on 8/13/12 at 12:34 PM, revealed the sprinkler was not in a level position. 4. Observations of the soiled utility room on the first floor on 8/13/12 at 1:07 PM, revealed the escutcheon plate was missing on the sprinkler. These findings were acknowledged by the Director of Facilities Management, the Assistant Administrator, and the Interim Administrator during the exit conference on 8/13/12. NFPA 101 LIFE SAFETY CODE STANDARD Smoking regulations are adopted and include no less than the following provisions:	K 062	K 62 SS=E - 3 A. Sprinkler unlevel in R-2 Electrical closet will be replaced by 9/12/12 B. All residents could be affected by this practice. No residents were harmed C. The Facilities Management staff will monitor during their monthly preventive maintenance checks. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. K 62 SS=E - 4 A. Sprinkler escutcheon in Soiled Utility Room on the 1 st Floor will be replaced by 9/12/12 B. All residents could be affected by this practice. No residents were harmed C. The Facilities Management staff will monitor during their monthly preventive maintenance checks. D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor.	9/14/12 9/14/12
K 066 SS=D		K 066		

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K 066	<p>Continued From page 2</p> <p>(1) Smoking is prohibited in any room, ward, or compartment where flammable liquids, combustible gases, or oxygen is used or stored and in any other hazardous location, and such area is posted with signs that read NO SMOKING or with the international symbol for no smoking.</p> <p>(2) Smoking by patients classified as not responsible is prohibited, except when under direct supervision.</p> <p>(3) Ashtrays of noncombustible material and safe design are provided in all areas where smoking is permitted.</p> <p>(4) Metal containers with self-closing cover devices into which ashtrays can be emptied are readily available to all areas where smoking is permitted. 19.7.4</p> <p>This STANDARD is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide the required equipment in the smoking area.</p> <p>The finding included:</p> <p>Observations of the smoking area on 8/13/12 at 1:15 PM, revealed that metal containers with self-closing cover devices into which ashtrays can be emptied were not readily available.</p> <p>During an interview in the smoking area on</p>	K 066	<p>K 66 SS=D</p> <p>A. Metal Smoking Containers with self-closing cover devices in which ashtrays emptied will be purchased and installed by 9/12/12</p> <p>B. All residents could be affected by this practice. No residents were harmed</p> <p>C. The Facilities Management staff will monitor during their monthly fire extinguisher checks.</p> <p>D. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor.</p>	9/14/12	

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K 066	Continued From page 3 8/13/12 at 1:15 PM, the Director of Facilities Management confirmed there were no metal containers with self-closing cover devices into which ashtrays can be emptied into. This finding was acknowledged by the Director of Facilities Management, the Assistant Administrator, and the Interim Administrator during the exit conference on 8/13/12.	K 066			

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K 062 SS=D	<p>NFPA 101 LIFE SAFETY CODE STANDARD</p> <p>Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5</p> <p>This STANDARD is not met as evidenced by: Birmingham building</p> <p>Based on observations, it was determined the facility failed to maintain the automatic sprinkler system.</p> <p>The finding included:</p> <ol style="list-style-type: none"> Observations of room 219, room 225 and the kitchen on 8/13/12 beginning at 11:25 AM, revealed debris on the sprinklers. Observations of room 225 and the beauty shop on on 8/13/12 beginning at 11:31 AM, revealed the escutcheon plates on the sprinklers were not secured properly. <p>These findings were acknowledged the Director of Facilities Management, the Assistant Administrator, and the Interim Administrator during the exit conference on 8/13/12.</p>	K 062	<p>K 62 SS=D - 1</p> <ol style="list-style-type: none"> Debris found on Sprinkler heads in 219, 215, and Kitchen was cleaned on 8/27/12 All residents could be affected by this practice. No residents were harmed The Facilities Management staff will monitor during their monthly preventive maintenance checks. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. <p>K 62 SS=D - 2</p> <ol style="list-style-type: none"> Sprinkler escutcheon ring in 225 and the Beauty Shop will be replaced by 9/12/12 All residents could be affected by this practice. No residents were harmed The Facilities Management staff will monitor during their monthly preventive maintenance checks. Documentation will be kept on file in the Facilities Management Department and reviewed by the Facilities Management Director or Supervisor. 	9/14/12 9/14/12

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

Kmishv

TITLE

Administrator

(X6) DATE

8/30/12

A 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 program participation.