

Post-Certification Revisit Report

Public reporting for this collection of information is estimated to average 10 minutes per response, including time for reviewing instructions, searching existing data sources, gathering and maintaining data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate or any other aspect of this collection of information including suggestions for reducing the burden, to CMS, Office of Financial Management, P.O. Box 26684, Baltimore, MD 21207; and to the Office of Management and Budget, Paperwork Reduction Project (0938-0390), Washington, D.C. 20503.

(Y1) Provider / Supplier / CLIA / Identification Number 445033	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 5/7/2010
Name of Facility BORDEAUX LONG TERM CARE	Street Address, City, State, Zip Code 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218	

This report is completed by a qualified State surveyor for the Medicare, Medicaid and/or Clinical Laboratory Improvement Amendments program, to show those deficiencies previously reported on the CMS-2567, Statement of Deficiencies and Plan of Correction that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the CMS-2567 (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>F0157</u> Reg. # <u>483.10(b)(11)</u> LSC _____	Correction Completed 04/30/2010	ID Prefix <u>F0309</u> Reg. # <u>483.25</u> LSC _____	Correction Completed 04/30/2010	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By _____ State Agency	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____
Reviewed By _____ CMS RO	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: 3/30/2010	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? YES NO
---	--

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

PRINTED: 04/27/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
MAY 07 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	--	--	---

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
--------------------	--	---------------	---	----------------------

F 157 SS=D	<p>483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC)</p> <p>A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a).</p> <p>The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section.</p> <p>The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.</p> <p>This REQUIREMENT is not met as evidenced by: Complaint #TN00025194</p> <p>Based on policy review, medical record review</p>	F 157	<p>The plan of correction is a requirement of federal law, but not necessarily an acknowledgement of any violation of federal laws and regulations.</p> <p>A. Resident #30 is no longer a resident in the facility as of 01/22/2010. The nurse who administered the sliding scale insulin on 1/22/10 has been designated as a "do not use" with the agency and will not be returning to the facility. Nursing staff on the unit were in-serviced on 1/22/10 (See Attachment 1) addressing the proper assessment of a resident's change in condition and subsequent notification of medical staff regarding elder condition changes.</p> <p>B. The DON, ADON, Director of Skilled Services, Patient Care Manager (PCM) Charge Nurse, Nursing Supervisor, Resident Assessment Manager, Unit Assessment Coordinator, Clinical Educators or Director of Quality or Quality Manager will complete an audit of all accucheck and Sliding Scale Insulin (SSI) orders from March 23rd – April 12th and corresponding documentation to assure that medical staff were appropriately notified of all accucheck readings and SSI administration per protocol. (See Attachment 2) Any errors or omissions will be corrected at that time and documented in the medical record. Additionally the PCM will receive a copy of any issues identified regarding notification of changes.</p>	4/30/10
---------------	---	-------	---	---------

acceptable per 5/11/10 JPP/HR

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rodman Morrison</i>	TITLE Administrator	(X6) DATE 4/30/10
---	------------------------	----------------------

Any 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.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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
F 157	<p>Continued From page 1 and interview, it was determined the facility failed to ensure the physician was notified of a low blood sugar (BS) for 1 of 30 (Resident #30) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Protocol: Hypoglycemia" documented, "...Risk for Injury related to insufficient glucose to meet metabolic needs. Blood glucose less than or = [equal] 60 mg/dl [milligrams per deciliter] and are symptomatic. Notify MD [Medical Doctor]... 2. Treatment of blood glucose levels less than or =60 mg/dl (complete a - [through] f below ASAP [as soon as possible] a. Check glucostick b. If less than or equal to 60 mg/dl then treat resident based on level of consciousness and notify medical staff for further instructions. c. If after hours contact house supervisor who will in turn notify medical staff. 1. If responsive, give juice, milk, ensure or Insta Glucose and recheck blood glucose within 15 min. [minutes]. If blood glucose continues to be = or < [less than] 60 mg/dl then give the Glucagon IM [intramuscular] and recheck blood glucose in 15 min. If blood glucose continues to be = or <60 mg/dl repeat IM Glucagon, recheck blood glucose in 15 minutes. If resident continues not to respond to treatment then start process to send resident out for evaluation and treatment..."</p> <p>Medical record review for Resident #30 documented an admission date of 10/7/09 with diagnoses of Diabetes Mellitus with Neuropathy, Diabetic Neuropathy, Hypertension with Chronic Renal Failure. Review of Resident #30's diabetic monitoring flow sheet documented "BS for 1/22/09 - 1600 [4:00 PM] BS= [result] 40 food/juice given." Review of a progress note</p>	F 157	<p>C. All BLTC licensed nursing personnel will be re-educated on the following:</p> <ul style="list-style-type: none"> ▪ Notification of Elder Changes Learning Objectives Include: <ul style="list-style-type: none"> • Changes in resident medical status that require medical staff notification. Time frames and methods for notifying medical staff. • Changes in resident condition that require the responsible party to be notified including timeframes and methods for notification. ▪ Hypo/Hyperglycemia Protocols Learning objectives: <ul style="list-style-type: none"> • Assessment for signs/symptoms of hypoglycemia • Treatment of blood glucose levels ≤ 60 mg/dl • Conditions that warrant notification of the medical staff • Interventions to use to address a hypoglycemic event • Documentation surrounding the event • Follow up monitoring of the resident ▪ Appropriate Nursing Assessment to Identify Changes in Condition Learning Objectives: <ul style="list-style-type: none"> • Assessment by the nurse for signs/symptoms of hypoglycemia such as: Diaphoresis, Shakiness, Dizziness, Decreased Level of Consciousness 	

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	--	--	---

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
F 157	<p>Continued From page 1</p> <p>and interview, it was determined the facility failed to ensure the physician was notified of a low blood sugar (BS) for 1 of 30 (Resident #30) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Protocol: Hypoglycemia" documented, "...Risk for Injury related to insufficient glucose to meet metabolic needs. Blood glucose less than or = [equal] 60 mg/dl [milligrams per deciliter] and are symptomatic. Notify MD [Medical Doctor]... 2. Treatment of blood glucose levels less than or =60 mg/dl (complete a - [through] f below ASAP [as soon as possible] a. Check glucostick b. If less than or equal to 60 mg/dl then treat resident based on level of consciousness and notify medical staff for further instructions. c. If after hours contact house supervisor who will in turn notify medical staff. 1. If responsive, give juice, milk, ensure or Insta Glucose and recheck blood glucose within 15 min. [minutes]. If blood glucose continues to be = or < [less than] 60 mg/dl then give the Glucagon IM [intramuscular] and recheck blood glucose in 15 min. If blood glucose continues to be = or <60 mg/dl repeat IM Glucagon, recheck blood glucose in 15 minutes. If resident continues not to respond to treatment then start process to send resident out for evaluation and treatment..."</p> <p>Medical record review for Resident #30 documented an admission date of 10/7/09 with diagnoses of Diabetes Mellitus with Neuropathy, Diabetic Neuropathy, Hypertension with Chronic Renal Failure. Review of Resident #30's diabetic monitoring flow sheet documented "BS for 1/22/09 - 1600 [4:00 PM] BS= [result] 40 food/juice given." Review of a progress note</p>	F 157	<p>All above training will be approved by the DON. The DON, ADON, Director of Skilled Services, PCM, Clinical Educator, Resident Assessment Manager, Nursing Supervisor, Director of Quality and Quality Manager may conduct this training.</p> <p>All Agency Licensed Nursing staff utilized by BLTC will be notified of process changes that will include the following:</p> <ul style="list-style-type: none"> ▪ Prior to any agency staff being oriented at BLTC, the agency must provide proof of the training and competency checks completed by the agency. ▪ Agency Licensed Nursing personnel will be re-educated on the following: <ul style="list-style-type: none"> • Notification of Elder Changes Learning Objectives Include: <ul style="list-style-type: none"> ▪ Changes in resident medical status that require medical staff notification. Time frames and methods for notifying medical staff. ▪ Changes in resident condition that require the responsible party to be notified including timeframes and methods for notification. 	

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	--	--	---

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
F 157	<p>Continued From page 1</p> <p>and interview, it was determined the facility failed to ensure the physician was notified of a low blood sugar (BS) for 1 of 30 (Resident #30) sampled residents.</p> <p>The findings included:</p> <p>Review of the facility's "Protocol: Hypoglycemia" documented, "...Risk for Injury related to insufficient glucose to meet metabolic needs. Blood glucose less than or = [equal] 60 mg/dl [milligrams per deciliter] and are symptomatic. Notify MD [Medical Doctor]... 2. Treatment of blood glucose levels less than or =60 mg/dl (complete a - [through] f below ASAP [as soon as possible] a. Check glucostick b. If less than or equal to 60 mg/dl then treat resident based on level of consciousness and notify medical staff for further instructions. c. If after hours contact house supervisor who will in turn notify medical staff. 1. If responsive, give juice, milk, ensure or Insta Glucose and recheck blood glucose within 15 min. [minutes]. If blood glucose continues to be = or < [less than] 60 mg/dl then give the Glucagon IM [intramuscular] and recheck blood glucose in 15 min. If blood glucose continues to be = or <60 mg/dl repeat IM Glucagon, recheck blood glucose in 15 minutes. If resident continues not to respond to treatment then start process to send resident out for evaluation and treatment..."</p> <p>Medical record review for Resident #30 documented an admission date of 10/7/09 with diagnoses of Diabetes Mellitus with Neuropathy, Diabetic Neuropathy, Hypertension with Chronic Renal Failure. Review of Resident #30's diabetic monitoring flow sheet documented "BS for 1/22/09 - 1600 [4:00 PM] BS= [result] 40 food/juice given." Review of a progress note</p>	F 157	<ul style="list-style-type: none"> • Hypo/Hyperglycemia Protocols Learning objectives: <ul style="list-style-type: none"> ▪ Assessment for signs/symptoms of hypoglycemia ▪ Treatment of blood glucose levels \leq 60 mg/dl ▪ Conditions that warrant notification of the medical staff ▪ Interventions to use to address a hypoglycemic event ▪ Documentation surrounding the event ▪ Follow up monitoring of the resident • Appropriate Nursing Assessment to identify changes in condition Learning Objectives: <ul style="list-style-type: none"> ▪ Assessment by the nurse for signs/symptoms of hypoglycemia such as: Diaphoresis, Shakiness, Dizziness, Decreased Level of Consciousness <p>All above training will be approved by the DON. The DON, ADON, Director of Skilled Services, PCM, Clinical Educator, Resident Assessment Manager, Nursing Supervisor, Director of Quality and Quality Manager may conduct this training.</p>	

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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
F 157	Continued From page 2 dated "1/22/10-1600- Res [resident] c/o [complained of] not feeling well, asked for feet to be put on bed, BS [checked] earlier was 40. Food and drink given, family present. 1700 [5:00 PM] Res c/o [not] feeling well still... 1740 [5:40 PM] Res called for assistance. Wanted her legs off bed. Still appears tired... Will continue to monitor. 1815 [6:15 PM] Found Res in w/c [wheelchair] in room, unresponsive, attempted to revive c [with] out success. Called for assistance to put in bed. 1822 [6:22 PM] Code Blue called D/T [due to] unresponsiveness..." There was no documentation Resident #30's BS was being checked every 15 minutes after the initial blood sugar of 40. The next documented BS on the diabetic monitoring flow sheet was at 6:30 PM with a BS of 161. There was no documentation the MD was notified of the low BS. During an interview in the conference room on 3/30/10 at 8:20 AM, the Director of Nursing (DON) stated, "Less than 60 MD or medical staff should be notified. Give juice, milk, food or Instant glucose. Recheck BS in 15 minutes, still not up give IM Glucagon recheck in 15 minutes, still not up repeat IM Glucagon. If not responding need to go out." The DON was asked what should have been done for this resident. The DON stated, "Should have been checked [referring to BS] again in 15 minutes and the doctor should have been notified."	F 157	D. The Patient Care Manager, DON, ADON, Director of Skilled Services, Quality Manager or Director of Quality will audit 20% of the charts to insure that Medical Staff were notified according to the sliding scale insulin policy monthly for three months. Once 95% compliance is reached for 3 consecutive months, then one additional quarterly audit will be completed. After that time additional audits may be conducted upon the discretion of the DON or Director of Quality/Risk Management. Audits will be reported in Quality Council Committee by the Department Manager.	
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment	F 309	A. The PCM or Charge Nurse reviewed the medical staff orders and care plans for Resident #1 and Resident #15. Heel protectors were provided to Resident #15. The elevated leg rests had been removed from the wheelchair of Resident #1 as the interdisciplinary team determined the leg rest increased her fall risk. The order for this device was discontinued as of 3/29/10. (See Attachment 6) All other devices currently ordered were provided to the resident or placed on the resident by the PCM or Charge Nurse. This was completed on 4/12/10.	4/30/10

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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
F 309	<p>Continued From page 3 and plan of care.</p> <p>This REQUIREMENT is not met as evidenced by: Amended 2567 on 4/27/10</p> <p>Based on policy review, medical record review, observation and interview, it was determined the facility failed to follow physician's orders for leg extenders and/or heel pads and/or failed to follow the facility's policy for monitoring a blood sugar (BS) every (q) 15 minutes for a BS result of 40 and failed to notify the Medical Doctor of a low BS for 3 of 27 (Residents #1, 15 and 30) sampled residents.</p> <p>The findings included:</p> <p>1. Medical record review for Resident #1 documented an admission date of 2/6/07 with diagnoses of Alzheimer's Dementia, Congestive Heart Failure, Coronary Artery Disease and Parkinson's. A physician's order dated 2/26/10 for Resident #1 documented, "OOB [out of bed] to wheelchair w [with]/elevating leg rest."</p> <p>Observations in the recreation room on 3/29/10 at 11:21 AM, revealed Resident #1 sitting in a wheelchair (w/c) with her feet dangling.</p> <p>Observations in Resident #1's room on 3/29/10 at 11:45 AM, revealed Resident #1 sitting in the w/c eating lunch with her feet dangling.</p> <p>During an interview in the Patient Care Manager's office, on 3/29/10 at 11:34 AM, the Patient Care Manager stated, "[Resident #1's] feet should be</p>	F 309	<p>Resident #30 is no longer a resident in the facility as of 01/22/2010. The nurse who administered the sliding scale insulin on 1/22/10 has been designated as a "do not use" with the agency and will not be returning to the facility. Nursing staff on the unit were in-serviced on 1/22/10 (See Attachment 1) addressing the proper assessment of a resident's change in condition and subsequent notification of medical staff regarding elder condition changes.</p> <p>B. The DON, ADON, Director of Skilled Services, Patient Care Manager (PCM), Charge Nurse, Nursing Supervisor, Resident Assessment Manager, Unit Assessment Coordinator, Clinical Educators, Quality Manager, or Director of Quality will complete an audit of all device orders and proper application within the facility from 3/23 - 4/12/10. Any discrepancies will be corrected at that time. The Patient Care Manager will receive a list of any discrepancies noted for use in future monitoring.</p> <p>The DON, ADON, Director of Skilled Services, Patient Care Manager (PCM) Charge Nurse, Nursing Supervisor, Resident Assessment Manager, Unit Assessment Coordinator, Clinical Educators or Director of Quality or Quality Manager will complete an audit of all accucheck and Sliding Scale Insulin (SSI) orders from</p>	

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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
F 309	<p>Continued From page 4 elevated."</p> <p>2. Medical record review for Resident #15 documented an admission date of 11/19/09 with diagnoses of Status Post Cerebral Vascular Accident with Bilateral Paralysis Syndrome with Cognitive deficit, Dysphagia and Vision Disturbances. A physician's order dated 2/25/10 for Resident #15 documented, "Posey Pillow heel protectors while in bed to Bil [bilateral] feet."</p> <p>Observations in Resident #15's room on 3/29/10 at 12:05 PM and on 3/30/10 at 9:00 AM, revealed Resident #15 lying in bed with no heel protectors in use as ordered.</p> <p>During an interview in Resident #15's room on 3/30/10 at 9:00 AM, Nurse #5 stated, "Oh you [Resident #15] don't have your heel protectors on."</p> <p>3. Review of the facility's "Protocol: Hypoglycemia" documented, "...Risk for Injury related to insufficient glucose to meet metabolic needs. Blood glucose less than or = [equal] 60 mg/dl [milligrams per deciliter] and are symptomatic. Notify MD... 2. Treatment of blood glucose levels less than or =60 mg/dl (complete a - [through] f below ASAP [as soon as possible] a. Check glucostick b. If less than or equal to 60 mg/dl then treat resident based on level of consciousness and notify medical staff for further instructions. c. If after hours contact house supervisor who will in turn notify medical staff. 1. If responsive, give juice, milk, ensure or Insta Glucose and recheck blood glucose within 15 min. [minutes]. If blood glucose continues to be = or < [less than] 60 mg/dl then give the Glucagon IM [intramuscular] and recheck blood glucose in</p>	F 309	<p>March 23rd – April 12th and corresponding documentation to assure that medical staff were appropriately notified of all accucheck readings and SSI administration per protocol. (See Attachment 2) Any errors or omissions will be corrected at that time and documented in the medical record. Additionally the PCM will receive a copy of any issues identified regarding notification of changes.</p> <p>C. All BLTC nursing personnel including CNTs and licensed nurses will be re-educated on Aspects of Device Management. Learning objectives include:</p> <ul style="list-style-type: none"> ▪ Properly following a physician's (medical staff) order ▪ Proper assessment/monitoring of residents with device orders ▪ Proper documentation procedures for refusal to use/wear device ▪ Proper notification of medical staff/RP if refusals occur ▪ Proper amendment of the care plan to reflect refusals <p>The DON, ADON, Director of Skilled Services, Patient Care Managers (PCM), Charge Nurse, Nursing Supervisor, Resident Assessment Manager, Unit Assessment Coordinator, Clinical Educators, Quality Manager or Director of Quality, Risk and Advocacy will complete the staff education.</p>	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
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
F 309	<p>Continued From page 5</p> <p>15 min. If blood glucose continues to be = or <60 mg/dl repeat IM Glucagon, recheck blood glucose in 15 minutes. If resident continues not to respond to treatment then start process to send resident out for evaluation and treatment..."</p> <p>Medical record review for Resident #30 documented an admission date of 10/7/09 with diagnoses of Diabetes Mellitus with Neuropathy, Diabetic Neuropathy, Hypertension with Chronic Renal Failure. Review of Resident #30's diabetic monitoring flow sheet documented "BS for 1/22/09 - 1600 [4:00 PM] BS= [result] 40 food/juice given." Review of a progress note dated "1/22/10-1600- Res [resident] c/o [complained of] not feeling well, asked for feet to be put on bed, BS [checked] earlier was 40. Food and drink given, family present. 1700 [5:00 PM] Res c/o [not] feeling well still... 1740 [5:40 PM] Res called for assistance. Wanted her legs off bed. Still appears tired... Will continue to monitor. 1815 [6:15 PM] Found Res in w/c [wheelchair] in room, unresponsive, attempted to revive c [with] out success. Called for assistance to put in bed. 1822 [6:22 PM] Code Blue called D/T [due to] unresponsiveness..." There was no documentation Resident #30's BS was being checked every 15 minutes after the initial BS of 40. The next documented BS on the diabetic monitoring flow sheet was at 6:30 PM with a BS of 161. There was no documentation the MD was notified of the low BS.</p> <p>During an interview in the conference room on 3/30/10 at 8:20 AM, the Director of Nursing (DON) stated, "Less than 60 MD or medical staff should be notified. Give juice, milk, food or Instant glucose. Recheck BS in 15 minutes, still not up give IM Glucagon recheck in 15 minutes, still not</p>	F 309	<p>All BLTC licensed nursing personnel will be re-educated on the following:</p> <ul style="list-style-type: none"> ▪ Notification of Elder Changes Learning Objectives Include: <ul style="list-style-type: none"> • Changes in resident medical status that require medical staff notification. Time frames and methods for notifying medical staff. • Changes in resident condition that require the responsible party to be notified including timeframes and methods for notification. ▪ Hypo/Hyperglycemia Protocols Learning objectives: <ul style="list-style-type: none"> • Assessment for signs/symptoms of hypoglycemia • Treatment of blood glucose levels \leq 60 mg/dl • Conditions that warrant notification of the medical staff • Interventions to use to address a hypoglycemic event • Documentation surrounding the event • Follow up monitoring of the resident 	

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	---	--	--

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
--------------------	--	---------------	---	----------------------

F 309	Continued From page 6 up repeat IM Glucagon. If not responding need to go out." The DON was asked what should have been done for this resident. The DON stated, "Should have been checked [referring to BS] again in 15 minutes and the doctor should have been notified."	F 309	<ul style="list-style-type: none"> ▪ Appropriate Nursing Assessment to Identify Changes in Condition Learning Objectives: <ul style="list-style-type: none"> • Assessment by the nurse for signs/symptoms of hypoglycemia such as: Diaphoresis, Shakiness, Dizziness, Decreased Level of Consciousness <p>All above training will be approved by the DON. The DON, ADON, Director of Skilled Services, PCM, Clinical Educator, Resident Assessment Manager, Nursing Supervisor, Director of Quality and Quality Manager may conduct this training.</p> <p>All Agency Licensed Nursing staff utilized by BLTC will be notified of process changes that will include the following:</p> <ul style="list-style-type: none"> ▪ Prior to any agency staff being oriented at BLTC, the agency must provide proof of the training and competency checks completed by the agency. ▪ Agency Licensed Nursing personnel will be re-educated on the following: ▪ Notification of Elder Changes Learning Objectives Include: <ul style="list-style-type: none"> ▪ Changes in resident medical status that require medical staff notification. Time frames and methods for notifying medical staff. ▪ Changes in resident condition that require the responsible party to be notified including timeframes and methods for notification. 	
-------	---	-------	--	--

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

PRINTED: 04/27/2010
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 _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	---	--	--

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
F 309	Continued From page 6 up repeat IM Glucagon. If not responding need to go out." The DON was asked what should have been done for this resident. The DON stated, "Should have been checked [referring to BS] again in 15 minutes and the doctor should have been notified."	F 309	<ul style="list-style-type: none"> • Hypo/Hyperglycemia Protocols Learning objectives: <ul style="list-style-type: none"> ▪ Assessment for signs/symptoms of hypoglycemia ▪ Treatment of blood glucose levels \leq 60 mg/dl ▪ Conditions that warrant notification of the medical staff ▪ Interventions to use to address a hypoglycemic event ▪ Documentation surrounding the event ▪ Follow up monitoring of the resident • Appropriate Nursing Assessment to identify changes in condition Learning Objectives: <ul style="list-style-type: none"> ▪ Assessment by the nurse for signs/symptoms of hypoglycemia such as: Diaphoresis, Shakiness, Dizziness, Decreased Level of Consciousness <p>All above training will be approved by the DON. The DON, ADON, Director of Skilled Services, PCM, Clinical Educator, Resident Assessment Manager, Nursing Supervisor, Director of Quality and Quality Manager may conduct this training.</p>	

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

PRINTED: 04/27/2010
FORM APPROVED
OMB NO. 0938-0391

RECEIVED
MAY 07 2010

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445033	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 03/30/2010
--	---	--	--

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
--------------------	--	---------------	---	----------------------

F 309	Continued From page 6 up repeat IM Glucagon. If not responding need to go out." The DON was asked what should have been done for this resident. The DON stated, "Should have been checked [referring to BS] again in 15 minutes and the doctor should have been notified."	F 309	<p>D. The Patient Care Manager, DON, ADON, Director of Skilled Services, Wound Care Nurse, Director of Quality, Quality Manager or Unit Assessment Coordinator will audit 20% of charts, care plans, bedside care guides and resident monthly orders for three months to ensure all ordered devices are applied appropriately. Once 95% compliance is reached for 3 consecutive months, then one additional quarterly audit will be completed. After that time additional audits may be conducted upon the discretion of the DON or Director of Quality/Risk Management. Audits will be reported in Quality Council Committee by the Department Manager.</p> <p>Additionally, the Patient Care Manager, DON, ADON, Director of Skilled Services, Quality Manager or Director of Quality will audit 20% of the charts to insure that Medical Staff were notified according to the sliding scale insulin policy monthly for three months. Once 95% compliance is reached for 3 consecutive months, then one additional quarterly audit will be completed. After that time additional audits may be conducted upon the discretion of the DON or Director of Quality/Risk Management. Audits will be reported in Quality Council Committee by the Department Manager.</p>	
-------	---	-------	---	--