## Statement of Deficiencies and Plan of Correction

**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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<th>ID</th>
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<th>Summary Statement of Deficiencies</th>
<th>ID</th>
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<th>Tag</th>
<th>Provider's Plan of Correction</th>
<th>Completion Date</th>
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| F9999 |       |     | **Intakes:** TN00025801, TN00025960, TN00026056, TN00026242, TN00026733, TN00026887, TN00027165, TN00027239, TN00027593, TN00027853  
This facility complies with all requirements for participation for long term care facilities investigated during this complaint survey. | F9999 |       |     |                                 |                  |

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 program participation.