Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN1908	A. BUILDING: **01 - MAIN BUILDING 01** B. WING _____	C **12/29/2021**

NAME OF PROVIDER OR SUPPLIER

AHC CUMBERLAND

STREET ADDRESS, CITY, STATE, ZIP CODE

4343 ASHLAND CITY HIGHWAY
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: A Life Safety Code Complaint Investigation of TN00056091 was conducted by the State of Tennessee Department of Health Division of Health Licensure and Regulation Office of Health Care Facilities on 12/29/2021. During this Life Safety Complaint Investigation, AHC CUmberland was found in substantial compliance with the requirements of the rules of the State of Tennessee Department of Health, Board for Licensing Health Care Facilities Chapter 1200-08-6 Standards for Nursing Homes and the National Fire Protection Association (NFPA) 101 Life Safety (2012 Edition).	N 002		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE