Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED
	TN1908		C 07/02/2015

NAME OF PROVIDER OR SUPPLIER: CUMBERLAND HEALTH CARE AND REHABILI

STREET ADDRESS, CITY, STATE, ZIP CODE: 4343 ASHLAND CITY HWY 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 000	Initial Comments During complaint investigation of #35640, 35735, 36126, and 36447. conducted on June 29 - July 2, 2015, at Cumberland Health Care and Rehabilitation, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Jennifer Jackson | TITLE: Administrator | (X6) DATE: 7/17/15