

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN1920	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  C 06/21/2016
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NAME OF PROVIDER OR SUPPLIER  NASHVILLE COMMUNITY CARE & REHABILIT/	STREET ADDRESS, CITY, STATE, ZIP CODE 1414 COUNTY HOSPITAL RD NASHVILLE, TN 37218
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(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	<p>Initial Comments</p> <p>During the complaint investigation including complaints #38991, 39041, and 39046, conducted on 6/13/16 to 6/21/16, at Nashville Community Care and Rehabilitation, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.</p>	N 000		

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Anthony Mas*

TITLE  
*Administrator*

(X6) DATE  
*7/15/16*