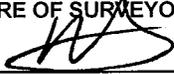


## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / TIFICATION NUMBER 44J033 Y1	MULTIPLE CONSTRUCTION A. Building 03 - BIRMINGHAM B. Wing	DATE OF REVISIT 6/3/2016 Y3
NAME OF FACILITY NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE		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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0021	Correction Completed 05/06/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 05/06/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0062	Correction Completed 05/06/2016
ID Prefix _____ Reg. # NFPA 101 LSC K0077	Correction Completed 05/06/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0130	Correction Completed 05/06/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0147	Correction Completed 05/06/2016
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 <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>CH</i>	DATE <i>6/9/16</i>	SIGNATURE OF SURVEYOR 	DATE <i>6-3-16</i>
REVIEWED BY RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/5/2016

CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY?  YES  NO

## POST-CERTIFICATION REVISIT REPORT

PROVIDER / SUPPLIER / CLIA / IDENTIFICATION NUMBER 440033 <span style="float: right;">Y1</span>	MULTIPLE CONSTRUCTION A. Building 04 - RIBEIRO B. Wing	DATE OF REVISIT 6/3/2016 <span style="float: right;">Y3</span>
NAME OF FACILITY NASHVILLE COMMUNITY CARE & REHABILITATION AT BORDE	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).

ITEM Y4	DATE Y5	ITEM Y4	DATE Y5	ITEM Y4	DATE Y5
ID Prefix _____ Reg. # NFPA 101 LSC K0025	Correction Completed 05/06/2016	ID Prefix _____ Reg. # NFPA 101 LSC K0077	Correction Completed 05/06/2016	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 <input checked="" type="checkbox"/>	REVIEWED BY (INITIALS) <i>ML</i>	DATE <i>6/9/16</i>	SIGNATURE OF SURVEYOR <i>[Signature]</i>	DATE <i>6-9-16</i>
REVIEWED BY RO <input type="checkbox"/>	REVIEWED BY (INITIALS)	DATE	TITLE	DATE

FOLLOWUP TO SURVEY COMPLETED ON 4/5/2016	<input type="checkbox"/> CHECK FOR ANY UNCORRECTED DEFICIENCIES. WAS A SUMMARY OF UNCORRECTED DEFICIENCIES (CMS-2567) SENT TO THE FACILITY? <input type="checkbox"/> YES <input type="checkbox"/> NO
---	--