STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:  445409
(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________
(X3) DATE SURVEY COMPLETED
C 02/24/2011

NAME OF PROVIDER OR SUPPLIER
CRESTVIEW HEALTH AND REHABILITATION
STREET ADDRESS, CITY, STATE, ZIP CODE
2030 25TH AVE N
NASHVILLE, TN 37208

(X4) ID PREFIX TAG SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)
(F9999 ID PREFIX TAG PROVIDER'S PLAN OF CORRECTION
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)
(X5) COMPLETION DATE

F9999 FINAL OBSERVATIONS

Intakes: TN00025184, TN00027247
A complaint investigation was conducted on 2/22/11 through 2/23/11. The facility was in compliance with federal and state regulations.

L laboratorY directOr's Or provider/supplieR repRsentative's signatuRe

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.