STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445262

MULTIPLE CONSTRUCTION

A. BUILDING ____________________________

B. WING ____________________________

DATE SURVEY COMPLETED

01/23/2011

NAME OF PROVIDER OR SUPPLIER

CUMBERLAND MANOR NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

4343 ASHLAND CITY HWY

NASHVILLE, TN  37218

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

F9999 FINAL OBSERVATIONS

Intakes: TN00027339

This institution complies with all requirements for participation for long term care facilities investigated during this complaint survey.

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

F9999

LAbORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE

LABORATORY DIRECTOR’S OR PROVIDER/SUPPLIER REPRESENTATIVE’S SIGNATURE

TITLe

DATE

DATE

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.