STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445166
(X2) MULTIPLE CONSTRUCTION
A. BUILDING
B. WING

(X3) DATE SURVEY COMPLETED
C 09/15/2010

NAME OF PROVIDER OR SUPPLIER
THE HEALTH CENTER AT RICHLAND PLACE

STREET ADDRESS, CITY, STATE, ZIP CODE
504 ELMINGTON AVENUE
NASHVILLE, TN  37205

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

(X5) COMPLETION DATE

F9999 FINAL OBSERVATIONS

Intake: TN00023252

A complaint investigation was conducted on 9/13/10 through 9/15/10. The investigation consisted of medical record review, observations and interviews. The facility was in compliance with federal and state regulations. No deficiencies were cited.

FORM CMS-2567(02-99) Previous Versions Obsolete
Event ID: 3N9811  Facility ID: TN1910
If continuation sheet Page 1 of 1

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.