## Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

**TEN0302**

**Multiple Construction**

**A. Building:**

**B. Wing:**

**Date Survey Completed:**

**05/06/2009**

**Name of Provider or Supplier:**

**Camden Healthcare & Rehab Center**

**Street Address, City, State, Zip Code:**

**197 Hospital Dr**

**Camden, TN 38320**

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider’s Plan of Correction</th>
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</thead>
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<tr>
<td>N 000</td>
<td>Initial Comments</td>
<td>N 000</td>
<td>No deficiencies were cited during the Nurses Aide Training survey. Recommend recertification. Mashelle D. Gibson, RN, PHNC1</td>
<td></td>
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**Division of Health Care Facilities**

**Laboratory Director’s or Provider/Supplier Representative’s Signature**

**Title**

**Date**

**State Form**

**If continuation sheet 1 of 1**