**Division of Health Care Facilities**

**Statement of Deficiencies and Plan of Correction**

<table>
<thead>
<tr>
<th>(K1) Provider/Supplier/CLA Identification Number:</th>
<th>(K2) Multiple Construction</th>
<th>(K3) Date Survey Completed</th>
</tr>
</thead>
<tbody>
<tr>
<td>TN1912</td>
<td></td>
<td>07/13/2012</td>
</tr>
</tbody>
</table>

**Name of Provider or Supplier**

**Imperial Gardens Health and Rehabili**

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

306 W Due West Ave

Madison, TN 37115

<table>
<thead>
<tr>
<th>(K4) ID Prefix Tag</th>
<th>Summary Statement of Deficiencies (Each deficiency must be preceded by full regulatory or LSC identifying information)</th>
<th>ID Prefix Tag</th>
<th>Provider's Plan of Correction (Each corrective action should be cross-referenced to the appropriate deficiency)</th>
<th>(K5) Complete Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 000</td>
<td>Initial Comments: During the Annual Licensure Survey, and Complaint Investigation numbers TN30115 and TN30043, completed July 16 to July 18, 2012, no deficiencies were cited related to 1200-8-6 Standards for Nursing Homes.</td>
<td>N 000</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Division of Health Care Facilities**

**Laboratory Directors or Provider/Supplier Representative's Signature**

**State Form**

4425

**WUHC11**

**Title**

**Administrator**

**Date**

8/6/12