**Division of Health Care Facilities**

<table>
<thead>
<tr>
<th>Statement of Deficiencies and Plan of Correction</th>
<th>Provider/Supplier/CLIA Identification Number: TN9507</th>
<th>(X2) Multiple Construction A. Building</th>
<th>(X3) Date Survey Completed 02/17/2012</th>
</tr>
</thead>
</table>

**Name of Provider or Supplier:** PAVILION, THE CPC  
**Street Address, City, State, Zip Code:** 1406 MEDICAL CENTER DRIVE LEHANON, TN 37067

<table>
<thead>
<tr>
<th>(X4) 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>(X5) Complete Date</th>
</tr>
</thead>
</table>
| N 000              | Initial Comments  
During the annual survey conducted on February 13-15, 2012, the facility had no deficiencies cited with Chapter 1200-8-6 Standards for Nursing Homes. | N 000       |                                                                                                  |                   |

**Division of Health Care Facilities**

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

**Title:** Administrator

**State Form:** 6500

**MAR 02 2012**