## Statement of Deficiencies and Plan of Correction

### Name of Provider or Supplier
CAMDEN HLTHCARE & REHAB CENTER

### Street Address, City, State, Zip Code
197 HOSPITAL DR
CAMDEN, TN 38320

### Summary Statement of Deficiencies

| ID | Prefix | TAG | Provider's Plan of Correction (Each Corrective Action Should Be Cross-Referenced to the Appropriate Deficiency) | Date
|----|--------|-----|--------------------------------------------------------------------------------------------------|------
| F9999 | FINAL OBSERVATIONS | | | |

Intake TN00026017

Complaint #26017 was investigated. The facility was found to be in compliance with state and federal regulations as related to the complaint.

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.