STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445444

(X2) MULTIPLE CONSTRUCTION
A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED  C  04/02/2012

NAME OF PROVIDER OR SUPPLIER
SAVANNAH HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE
1645 FLORENCE RD
SAVANNAH, TN 38372

(X4) ID PREFIX TAG  (X5) COMPLETION DATE

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

F9999 FINAL OBSERVATIONS

Intakes: TN00029227

This facility is in compliance with 42 CFR Part 483, Subpart B, Requirements for Long Term Care investigated during this complaint survey.

Laboratory Director's or Provider/Supplier Representative's Signature

Title

(X6) DATE

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.