STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

A. BUILDING

B. WING

MULTIPLE CONSTRUCTION

DATE SURVEY COMPLETED

C

04/17/2012

NAME OF PROVIDER OR SUPPLIER

MAPLEWOOD HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

100 CHERRYWOOD PLACE

JACKSON, TN 38305

SUMMARY STATEMENT OF DEFICIENCIES

(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

ID PREFIX TAG

F9999

FINAL OBSERVATIONS

Intakes: TN00029574

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

F9999

PROVIDER'S PLAN OF CORRECTION

(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)

COMPLETION DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

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.