A. BUILDING  PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445455  

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION  

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 445455  

(X2) MULTIPLE CONSTRUCTION  

A. BUILDING  

B. WING  

(X3) DATE SURVEY COMPLETED  

C  08/23/2011  

NAME OF PROVIDER OR SUPPLIER  

CLARKSVILLE NURSING AND REHABILITATION CENTER  

STREET ADDRESS, CITY, STATE, ZIP CODE  

900 PROFESSIONAL PARK DRIVE  
CLARKSVILLE, TN  37040  

(X4) ID PREFIX TAG  

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

(X5) ID PREFIX TAG  

PROVIDER'S PLAN OF CORRECTION  
(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)  

(X5) COMPLETION DATE  

F9999  ID PREFIX TAG  

FINAL OBSERVATIONS  
F9999  ID PREFIX TAG  

Intakes: TN00026999  

A complaint investigation was conducted on 8/21/11 through 8/23/11. The facility was in compliance with federal and state regulations.  

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.