**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 04/13/2011

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)

ID PREFIX TAG

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

(X5) COMPLETION DATE

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### F9999 FINAL OBSERVATIONS

Intakes: TN00026619

A complaint investigation was conducted on 4/12/11 - 4/13/11. This investigation consisted of medical record review, observations, and interviews. The facility was in compliance with federal and state regulations. No deficiencies were cited.

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

**TITLE**

(X6) DATE

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*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.*