STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

A. BUILDING PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445433

B. WING _____________________________

MULTIPLE CONSTRUCTION

C. WING _____________________________

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445433

(2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________

B. WING _____________________________

(3) DATE SURVEY COMPLETED

03/14/2011

NAME OF PROVIDER OR SUPPLIER

GRACE HEALTHCARE OF CLARKSVILLE

STREET ADDRESS, CITY, STATE, ZIP CODE

111 USSEY ROAD

CLARKSVILLE, TN 37043

SUMMARY STATEMENT OF DEFICIENCIES

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

F9999 FINAL OBSERVATIONS

Intakes: TN00027704

No deficiencies cited during this complaint investigation.

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

F9999

TITLE

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.