### Statement of Deficiencies and Plan of Correction

**Provider/Supplier/CLIA Identification Number:**

**State:**

**City:**

**State:**

**ZIP Code:**

**Complete Date:** 04/03/2009

<table>
<thead>
<tr>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Summary Statement of Deficiencies</th>
<th>ID</th>
<th>Prefix</th>
<th>Tag</th>
<th>Provider's Plan of Correction</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>1200-8-6</td>
<td>No Deficiencies</td>
<td>During the self report investigation on 4-3-09, this facility was found to be in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board for Licensing Health Care Facilities, Chapter 1200-8-6, Standards for Nursing Homes.</td>
<td>N 002</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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**Division of Health Care Facilities**

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

**State Form**

**Form Approved**

**Printed:** 02/03/2012