**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**NAME OF PROVIDER OR SUPPLIER**
HILLVIEW COMMUNITY LIVING CENTER

**STREET ADDRESS, CITY, STATE, ZIP CODE**
897 EVERGREEN STREET, PO BOX 769
DRESDEN, TN  38225

**DIVISION OF HEALTH CARE FACILITIES**

<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 002</td>
<td>This Rule is not met as evidenced by: During the investigation survey conducted on 9/26/12 this facility was found to be in compliance with the requirements of the National Fire Protection Association (NFPA) 101, Life Safety Code, 2000 edition, Chapter 19, Existing Health Care Occupancies.</td>
<td>N 002</td>
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**LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE**

**STATE FORM**

6899  JN1P21  If continuation sheet  1 of 1