Division of Health Care Facilities

PRINTED: 02/14/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0103	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 02/11/2014

NAME OF PROVIDER OR SUPPLIER: NORRIS HEALTH AND REHABILITATION CENT

STREET ADDRESS, CITY, STATE, ZIP CODE: 3302 ANDERSONVILLE HIGHWAY, ANDERSONVILLE, TN 37706

(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) COMPLETE DATE
N 002	1200-8-6 No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on February 10 2014, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature] TITLE: HSA Administrator (X6) DATE: 3-5-14

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