Division of Health Care Facilities

PRINTED: 09/16/2013
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN0106	A. BUILDING: _____ B. WING _____	09/11/2013

NAME OF PROVIDER OR SUPPLIER: GOLDEN LIVINGCENTER - WINDWOOD

STREET ADDRESS, CITY, STATE, ZIP CODE: 220 LONGMIRE RD CLINTON, TN 37716

(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 An onsite annual Licensure survey and complaint investigtions of #'s 29770, 29816, 30169, 31121, and 31729 were completed on September 11, 2013, at Golden Living Center. No deficiencies were cited related to the complaint investigations under Chapter 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nancy Clarkwood
TITLE: Executive Director
(X6) DATE: 9/25/13

STATE FORM 6899 CNW811 If continuation sheet 1 of 1