PRINTED: 08/15/2012
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7509	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED 08/14/2012
NAME OF PROVIDER OR SUPPLIER: CHRISTIAN CARE CENTER OF RUTHERFORD	STREET ADDRESS, CITY, STATE, ZIP CODE: 202 ENON SPRINGS ROAD EAST SMYRNA, TN 37167		

(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 000	Initial Comments The State Licensure Survey, and Complaint Investigations numbers TN29824, TN29253, TN29990, TN28885, TN29748, TN29597, and TN29291, were conducted August 12 to 14, 2012. No deficiencies were cited related to the State Licensure Survey, or the complaints, under 1200-8-6 Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 8/31/12

STATE FORM 6899 DTQZ11 If continuation sheet 1 of 1