Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4708	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 04/07/2011
NAME OF PROVIDER OR SUPPLIER HOLSTON HEALTH & REHABILITATION CENT	STREET ADDRESS, CITY, STATE, ZIP CODE 3916 BOYDS BRIDGE PIKE KNOXVILLE, TN 37914		

(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 During complaint investigation number TN00027655, conducted on April 7, 25011, at Holston Health& Rehabilitation Center no deficiencies were cited in relation to the complaint under chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities

KJ McCool
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE: Administrator

(X6) DATE: April 14, 2011

APR 15 2011