PRINTED: 06/09/2011
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7504	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 06/06/2011
NAME OF PROVIDER OR SUPPLIER COMMUNITY CARE OF RUTHERFORD	STREET ADDRESS, CITY, STATE, ZIP CODE 901 COUNTY FARM RD MURFREESBORO, TN 37127		

(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 Based on the Fire Safety Survey conducted on 6/6/11 there were no Life Safety deficiencies cited.	N 002		

Division of Health Care Facilities

Charles N. [illegible] Administrator 6/21/11

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

COMMUNITY CARE Fax:6158987989 Jun 23 2011 9:02 P.11