FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN0202 | | C 04/01/2020 |

NAME OF PROVIDER OR SUPPLIER

GLEN OAKS HEALTH AND REHABILITATION

STREET ADDRESS, CITY, STATE, ZIP CODE

1101 GLEN OAKS ROAD
SHELBYVILLE, TN 37160

| (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<br><br>Complaint investigation for complaint #50384 and #50761 was completed on 4/1/2020 at Glen Oaks Health and Rehabilitation. No deficiencies were cited related to the complaint investigation under Chapter 1200-8-6, Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities

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