

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2801	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/17/2010
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NAME OF PROVIDER OR SUPPLIER ARDMORE ON MAIN CARE AND REHABILITAT	STREET ADDRESS, CITY, STATE, ZIP CODE 25385 MAIN STREET ARDMORE, TN 38449
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(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 During the annual licensure life safety survey conducted on 5/17/10 the facility was found to be in compliance with state licensure regulations.	N 002		

Division of Health Care Facilities <i>Diana Fisher</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE <i>Administrator</i>	(X6) DATE 6/4/10
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