

Division of Health Care Facilities

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| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7501 | (X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____ | (X3) DATE SURVEY COMPLETED 02/02/2015 |
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| NAME OF PROVIDER OR SUPPLIER ADAMSPLACE, LLC | STREET ADDRESS, CITY, STATE, ZIP CODE 1927 MEMORIAL BOULEVARD MURFREESBORO, TN 37129 |
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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 |
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| N 002 | 1200-8-6 No Deficiencies Based on observations, testing, and records review it was determined the facility had no life safety deficiencies | N 002 | | |

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| Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
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