

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 02 - BOULEVARD TERRAACE NURSING HOME B. WING _____	(X3) DATE SURVEY COMPLETED C 02/16/2016
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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION ANE	STREET ADDRESS, CITY, STATE, ZIP CODE 1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130
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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 000	Initial Comments During complaint investigation of #TN00038157 conducted on 2/16/16, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 000		
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Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE _____ TITLE _____ (X6) DATE _____