

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7502</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>05/16/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BOULEVARD TERRACE REHABILITATION AND</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>1530 MIDDLE TENNESSEE BLVD MURFREESBORO, TN 37130</b>
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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	<p>Initial Comments</p> <p>Complaint investigation #38325, #38701, and #38793 were completed on 5/09/16 - 5/16/16, at Boulevard Terrace Rehabilitation and Nursing Home. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		
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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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