

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7502	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 09/29/2015
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NAME OF PROVIDER OR SUPPLIER BOULEVARD TERRACE REHABILITATION AND	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
N 000	Initial Comments Complaint investigation of #35074, 35430, 35545, 35583, 35628, 35933, 35934, 35952, 36216, 36315, 36215, 36324, 36325, 36552, 36636, 36849, 36944, 37106, 37141, 37321 was conducted at Boulevard Terrace 9/15/15 - 9/29/15. No deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes.	N 000	This Plan of Correction affirms our allegation of compliance for the deficiencies cited, however, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction has been respectfully developed and submitted as required for compliance with federal and state regulations	11-13-15

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Anakia Bogwood, RN, Administrator

TITLE

(X6) DATE

10-31-15

STATE FORM 6599 Z31U11 If continuation sheet 1 of 1