

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7942	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/25/2010
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NAME OF PROVIDER OR SUPPLIER BAPTIST REHABILITATION-GERMANTOWN	STREET ADDRESS, CITY, STATE, ZIP CODE 2100 EXETER ROAD GERMANTOWN, TN 38138
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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 This Rule is not met as evidenced by: An initial licensure survey was completed in this facility 10/25/10. The facility was found in compliance with state regulations for long term care facilities.	N 002		

Division of Health Care Facilities . TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
STATE FORM 6899 HZ811 If continuation sheet 1 of 1