

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7942	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 77 - BAPTIST SNF REHABILITATION - GERMANTOWN B. WING _____	(X3) DATE SURVEY COMPLETED 04/08/2014
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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
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N 002 1200-8-6 No Deficiencies	An annual licensure survey was conducted on 4/7/14. This facility is in substantial compliance with the state licensure regulations for life safety code.	N 002		
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MAY 05 2014

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE <i>Rebecca O. Oelhouse</i>	TITLE <i>Administrative</i>	(X8) DATE 5-1-14
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