PRINTED: 07/25/2016
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN8001	A. BUILDING: _____ B. WING _____	07/21/2016

NAME OF PROVIDER OR SUPPLIER: KINDRED NURSING AND REHABILITATION-SM

STREET ADDRESS, CITY, STATE, ZIP CODE: 112 HEALTH CARE DR CARTHAGE, TN 37030

(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. A licensure survey and complaint investigation #39177 were completed on 7/18-21/16, at Kindred Nursing and Rehabilitation-Smith County. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

sion of Health Care Facilities
ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Michael J. Mauch
TITLE: Executive Director
(X6) DATE: 8/5/16

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