PRINTED: 11/28/2017
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TN8501		11/15/2017

NAME OF PROVIDER OR SUPPLIER: HARTSVILLE CONVALESCENT CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 649 MCMURRY BLVD, HARTSVILLE, TN 37074

(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 #42720 was completed on 11/13/17/ - 11/15/17 at Hartsville Convalescent Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Deborah Beasley
TITLE: NHA
(X6) DATE: 12-6-17

STATE FORM 6899 4ZDI11 If continuation sheet 1 of 1

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