FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN9505	(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED 05/24/2010
NAME OF PROVIDER OR SUPPLIER QUALITY CARE HEALTH CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 932 BADDOUR PARKWAY LEBANON, TN 37087		

(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 Based on observation during the annual life safety survey on 5/24/2010, it was determined, the facility had no fire safety deficiencies.	N 002		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Judy White TITLE Administrator (X6) DATE 6/10/10

STATE FORM 6899 UCE421 If continuation sheet 1 of 1

JUN 11 2010