

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0401</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>05/04/2016</b>
--	---	--	---

NAME OF PROVIDER OR SUPPLIER  <b>BLEDSOE COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367</b>
--	--

(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	<p><b>Initial Comments</b></p> <p>A licensure survey was completed at Bledsoe County Nursing Home on 5/4/16. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		
-------	--	-------	--	--

Division of Health Care Facilities  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

*Stephanie Bynum*

TITLE  
*Administrator*

(X6) DATE  
*5/19/16*

STATE FORM

6829 BGJ311

If continuation sheet 1 of 1