

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0401	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED 05/04/2016
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NAME OF PROVIDER OR SUPPLIER
BLED SOE COUNTY NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE
**107 WHEELERTOWN AVENUE
 PIKEVILLE, TN 37367**

(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 During the Life Safety portion of the annual Licensure survey conducted on 5/4/16, no deficiencies were cited under 1200-08-6, Standards for Nursing Homes.	N 002		

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

Stephanie Bynthe

TITLE

Administrator

(X6) DATE

5/19/16

STATE FORM

5899

BGJ321

If continuation sheet 1 of 1