

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0401	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/07/2012
--	---	--	---

NAME OF PROVIDER OR SUPPLIER BLEDSON 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 000	Initial Comments During complaint investigation of #TN29567, completed on August 7, 2012, no deficiencies were cited related to the complaint under 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities	TITLE	(X6) DATE
------------------------------------	-------	-----------

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE