

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES
AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA
IDENTIFICATION NUMBER:

TN0401

(X2) MULTIPLE CONSTRUCTION

A. BUILDING: 02 - STATE BUILDING

B. WING _____

(X3) DATE SURVEY
COMPLETED

02/24/2014

NAME OF PROVIDER OR SUPPLIER

BLEDSOE 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

N 002

Based on observations, testing, and records review on 2/24/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications.

Division of Health Care Facilities

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

Stephanie Boyd

TITLE

Administrator

(X6) DATE

3/13/14

STATE FORM

5800

P1P521

If continuation sheet 1 of 1