PRINTED:04/27/2016
FORM APPROVED

Divis on of Health Care I=ac|lilies

STATI;MoNT OF DHFICIENCIoS AND PLAN OF CORRECTION	(X1) PROVIDERISUPPLIERICLIA IDENTIFICATION NUMBER:	(X2) MULTIPIE CONSTRUCTION A.BUiIDING: 01-MAIN BUILDING 01 B.WING •.•.	(X3) DATE SURVEY COMPLET D
	TN0610		04/25/2016

NAME OF PROVIDER OR 5UPPLIER
ROAN HIGHLANDS NURSING CENTER

STREET ADDRESS,CITY,STATE,ZIP CODE
146 BUCK CREEK ROAD
ROAN MOUNTAIN, TN 37687

(X4) ID.I PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGUIATORY ORLSC IOENTIr-YING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION $HOUW 85 CROSS-REFERENGEO TO TH APPROPRIATII DEFICIENCY)	(X6) COMPLETE DATe
N 002	1200-8-6 NO Deficiencies During the annualSlate Licensure survey conducted on 4/25/16, no deficiencies were cited under 1200-QS-06, Standards for Nursing Homes.	N002		

vision or Health Care Faoilliea
\BORATORY OIRoCTOR'S OR PROVIDoRISUPPUER REPRESENTATIVE'S SIGNATURE<

TITLE Executive Director

(XII)OATE 5/17/16

TATE FORM

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