PRINTED: 06/20/2016
FORM APPROVED

Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN1302 | | 06/08/2016 |

NAME OF PROVIDER OR SUPPLIER: LAUREL MANOR HEALTH CARE

STREET ADDRESS, CITY, STATE, ZIP CODE: 902 BUCHANAN RD, NEW TAZEWELL, TN 37825

| (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<br><br>During the Licensure survey and investigation of complaints #36977 and #37634 conducted on 6/6/16 through 6/8/16, no deficiencies were cited under Chapter 1200-8-6 Standards for Nursing Homes. | N 000 | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Robert G Polsher | TITLE: Admin | (X6) DATE: 7/1/2016