Division of Health Care Facilities

PRINTED: 10/15/2015
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN3401	A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	10/11/2015

NAME OF PROVIDER OR SUPPLIER: HANCOCK MANOR NURSING HOME

STREET ADDRESS, CITY, STATE, ZIP CODE: 1423 MAIN STREET, SNEEDVILLE, TN 37869

(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 10/11/2015, 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: [signature]

TITLE: Administrator

(X6) DATE: 11/05/2015

STATE FORM

XI1Q21

If continuation sheet 1 of 1