Division of Health Care Facilities

PRINTED: 04/04/2016
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TN4716		03/23/2016

NAME OF PROVIDER OR SUPPLIER: SENATOR BEN ATCHLEY STATE VETERANS' H

STREET ADDRESS, CITY, STATE, ZIP CODE: ONE VETERANS WAY KNOXVILLE, TN 37931

(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 001	1200-8-6 Initial Comments During the annual Licensure survey conducted on 3/21/16 through 3/23/16 at Senator Ben Atchley State Verterans Home , no deficiencies were cited in relation to the complaint # 36199 under 1200-8-6, Standards for Nursing Homes.	N 001		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: [signature]

TITLE: Administrator

(X6) DATE: 4/14/16

STATE FORM 6TT311

If continuation sheet 1 of 1