PRINTED: 05/16/2014
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
	TN7302		05/12/2014

NAME OF PROVIDER OR SUPPLIER: BRIDGE AT ROCKWOOD, THE

STREET ADDRESS, CITY, STATE, ZIP CODE: 6580 ROANE STATE HWY ROCKWOOD, TN 37854

(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 and Complaint survey (#33534 and #33782) on May 5, 2014 through May 12, 2014, at The Bridge at Rockwood, no deficiencies were cited under chapter 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: 5-27-14

STATE FORM 1YHI11 If continuation sheet 1 of 1