Division of Health Care Facilities

PRINTED: 05/11/2017
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING	(X3) DATE SURVEY COMPLETED
	TN9002		05/09/2017

NAME OF PROVIDER OR SUPPLIER: CORNERSTONE VILLAGE

STREET ADDRESS, CITY, STATE, ZIP CODE: 2012 SHERWOOD DRIVE, JOHNSON CITY, TN 37601

(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 survey conducted on 5/9/17, no deficiencies were cited under 1200-8-6 standards for nursing homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Cathy P. O'Neal | TITLE: Administrator | (X6) DATE: 6/15/17

STATE FORM 6899 LW9W21 If continuation sheet 1 of 1