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: 01 - MAIN BUILDING 01	(X3) DATE SURVEY COMPLETED
	TN8003	B. WING	02/10/2016

NAME OF PROVIDER OR SUPPLIER: AGAPE NURSING AND REHABILITATION CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 505 N ROAN STREET, JOHNSON CITY, TN 37604

(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-B.No Deficiencies During the Life Safety portion of the annual Licensure survey conducted on 2/8/16, 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: Mandy Rocker

TITLE: NHA

DATE: 2/17/16

STATE FORM 1111 SX4R21