PRINTED: 08/22/2017
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
	TN9004		08/16/2017

NAME OF PROVIDER OR SUPPLIER: PRINCETON TRANS CARE AT NORTH

STREET ADDRESS, CITY, STATE, ZIP CODE: 400 NORTH STATE OF FRANKLIN ROAD 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 a Licensure health survey and complaint investigation of #39981 conducted on 8/14/17 through 8/16/17, 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: [signature] MBA, RRT, LNHA

TITLE: Administrator

(X6) DATE: 8/30/17

STATE FORM 6699 L4UO11 If continuation sheet 1 of 1