Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN9008	A. BUILDING: _____ B. WING _____	10/14/2015

NAME OF PROVIDER OR SUPPLIER: LAKEBRIDGE HEALTH CARE CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 115 WOODLAWN DRIVE, 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	1200-8-6 No Deficiencies During the licensure survey and investigation of complaint #37487 at Lakebridge Health Care Center, no deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Nyla Bays
TITLE: Exec Dir/CO
(X6) DATE: 11/2/15

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