

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0401</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>09/07/2010</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BLED SOE COUNTY NURSING HOME</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367</b>
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(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  No deficiencies were cited under 1200-8-6 Licensure Standards for Long Term Care for complaint #26623.	N 001		

Division of Health Care Facilities

*Stephanie Burt*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Administrator*

(X6) DATE  
*9/21/10*

SEP 23 2010