

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN0401	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - STATE BUILDING B. WING _____	(X3) DATE SURVEY COMPLETED 03/22/2011
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NAME OF PROVIDER OR SUPPLIER BLED SOE COUNTY NURSING HOME	STREET ADDRESS, CITY, STATE, ZIP CODE 107 WHEELERTOWN AVENUE PIKEVILLE, TN 37367
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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
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N 002	1200-8-6 No Deficiencies Based on the annual Licensure survey conducted on 3/22/11 there were no fire safety deficiencies cited.	N 002		
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Division of Health Care Facilities <i>Stephanie Buss</i> LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE Administrator 4/17/11 (X6) DATE
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APR 08 2011