STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:

445279

(X2) MULTIPLE CONSTRUCTION

A. BUILDING _____________________________
B. WING _____________________________

(X3) DATE SURVEY COMPLETED

C 01/28/2014

NAME OF PROVIDER OR SUPPLIER

LYNCHBURG NURSING CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE

40 NURSING HOME ROAD
LYNCHBURG, TN  37352

(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) COMPLETION DATE

F9999 FINAL OBSERVATIONS

Intakes:  TN00031862

A complaint investigation was conducted on 1/26/14 through 1/28/14. The facility was in compliance with federal and state regulations.