DIVISION OF HEALTH CARE FACILITIES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION

(X1) PROVIDER/SUPPLIER/CLA IDENTIFICATION NUMBER:  
TN8205

(X2) MULTIPLE CONSTRUCTION

A. BUILDING
   ————

B. WING
   ————

(X3) DATE SURVEY COMPLETED

07/28/2011

NAME OF PROVIDER OR SUPPLIER

INDIAN PATH MEDICAL CENTER TRANSITION

STREET ADDRESS, CITY, STATE, ZIP CODE

2000 BROOKSIDE DRIVE
KINGSPORT, TN 37660

(X4) ID PREFIX TAG

SUMMARY STATEMENT OF DEFICIENCIES
(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)

N 002

1200-8-6 No Deficiencies

N 002

During the annual licensure survey conducted on July 28, 2010, there was no deficiencies cited under Chapter 1200-8-6, Standards for Nursing Homes.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE


DIVISION OF HEALTH CARE FACILITIES

TITLE VP/CEO

STATE FORM

If continuation sheet 1 of 1

AUG 10 2011