Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN4702	(X2) MULTIPLE CONSTRUCTION A. BUILDING ____ B. WING ____	(X3) DATE SURVEY COMPLETED C 05/16/2012
NAME OF PROVIDER OR SUPPLIER BRAKEBILL NURSING HOME INC.	STREET ADDRESS, CITY, STATE, ZIP CODE 5837 LYONS VIEW PIKE KNOXVILLE, TN 37919		

(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 000	Initial Comments Complaint investigation #29700 was completed on May 16, 2012, at Brakebill Nursing Home, INC. No deficiencies were cited related to the complaint investigation under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE Thorma E Lindsey RN TITLE Administrator (X6) DATE 5/25/12

STATE FORM 6899 2IO911 If continuation sheet 1 of 1

MAY 25 2012