PRINTED: 09/05/2013
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7602	A. BUILDING: 01 - MAIN BUILDING 01 B. WING	09/03/2013

NAME OF PROVIDER OR SUPPLIER: ONEIDA NURSING AND REHAB CENTER

STREET ADDRESS, CITY, STATE, ZIP CODE: 18806 ALBERTA DR, ONEIDA, TN 37841

(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 002	1200-8-6 No Deficiencies During the Life Safety portion of the survey conducted on September 3, 2013, no deficiencies were cited under 1200-8-6, Standards for Nursing Homes.	N 002		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Angel Chiswood
TITLE: Administrator
(X6) DATE: 9/18/2013

STATE FORM 8V3X21 If continuation sheet 1 of 1