Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING		(X3) DATE SURVEY COMPLETED R 08/01/2018	
		TNPL53526				
	DOCUMENT OF SUCCESS				08/01/20	710
NAME OF PROVIDER OR SUPPLIER STREET ADDRESS, CITY, STATE, ZIP CODE 1547 WEST CLINCH AVENUE						
KNOXVILLE CENTER FOR REPRODUCTIVE HE KNOXVILLE, TN 37916						
(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 (X5) (EACH CORRECTIVE ACTION SHOULD BE COMPLETI CROSS-REFERENCED TO THE APPROPRIATE DATE DEFICIENCY)		
{A 001}	1200-8-10 Initial		{A 001}			
	previous deficiencie deficiencies have b compliance was fou	conducted on 8/1/18 for all es cited on 6/19/18. All een corrected and no new und. The facility is in regulations surveyed.				
	solth Care Engilities					

Division of Health Care Facilities

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

TITLE

(X6) DATE