

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN0701</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>07/07/2010</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BEECH TREE MANOR</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>240 HOSPITAL LANE, PO BOX 300 JELICO, TN 37762</b>
---	--

(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 001	<p>1200-8-6 Initial Comments</p> <p>This Rule is not met as evidenced by: Entity reported incident investigation # 20106281240 and complaint investigation # TN00026168, was completed on July 7, 2010 . The allegations were substantiated and no deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.</p>	N 001		
-------	---	-------	--	--

Division of Health Care Facilities

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

TITLE

(X6) DATE

STATE FORM

6899

OYOX21

If continuation sheet 1 of 1