

State Form: Revisit Report

(Y1) Provider / Supplier / CLIA / Identification Number TN1701	(Y2) Multiple Construction A. Building B. Wing	(Y3) Date of Revisit 9/15/2014
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Name of Facility BELLS NURSING AND REHABILITATION CENTER	Street Address, City, State, Zip Code 213 HERNDON DRIVE BELLS, TN 38006
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This report is completed by a State surveyor to show those deficiencies previously reported that have been corrected and the date such corrective action was accomplished. Each deficiency should be fully identified using either the regulation or LSC provision number and the identification prefix code previously shown on the State Survey Report (prefix codes shown to the left of each requirement on the survey report form).

(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date	(Y4) Item	(Y5) Date
ID Prefix <u>N0765</u> Reg. # <u>1200-8-6-.06(9)(I)</u> LSC _____	Correction Completed <u>09/08/2014</u>	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed
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ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed	ID Prefix _____ Reg. # _____ LSC _____	Correction Completed

Reviewed By <input checked="" type="checkbox"/>	Reviewed By <u>JP</u>	Date: <u>9/15/14</u>	Signature of Surveyor: <u>JP PHAN 2/2/14</u>	Date: <u>9/15/14</u>
Reviewed By _____	Reviewed By _____	Date: _____	Signature of Surveyor: _____	Date: _____

Followup to Survey Completed on: <u>8/26/2014</u>	Check for any Uncorrected Deficiencies. Was a Summary of Uncorrected Deficiencies (CMS-2567) Sent to the Facility? <table style="float: right;"> <tr> <td>YES</td> <td>NO</td> </tr> </table>	YES	NO
YES	NO		