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FORM APPROVED

Division of Health Care Facilities

FEB 04 2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN2708	(X2) MULTIPLE CONSTRUCTION A. BUILDING 02 - LTC B. WING	(X3) DATE SURVEY COMPLETED 01/18/2011
NAME OF PROVIDER OR SUPPLIER BAILEY PARK CLC	STREET ADDRESS, CITY, STATE, ZIP CODE 2400 MITCHELL STREET HUMBOLDT, TN 38343		

(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 831	1200-8-6-.08(1) Building Standards (1) The nursing home must be constructed, arranged and maintained to ensure the safety of the resident. This Rule is not met as evidenced by: Based on observation, it was determined the facility failed to secure all gas cylinders. The findings included: Observations in the group room on 1/18/11 at 8:56 AM revealed an unsecured helium cylinder.	N 831	N 831 The helium cylinder has been removed from the facility. No helium will be stored in the facility in the future.	2/2/11

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE — TITLE: Administrator — (X6) DATE: 2/4/11

STATE FORM — 6899 — 4HQ621 — If continuation sheet 1 of 1