

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN4705</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/24/2016</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BEVERLY PARK PLACE HEALTH AND REHAB</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918</b>
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(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	<p>1200-8-6 No Deficiencies</p> <p>A licensure survey was conducted from 8/22/16, through 8/24/16 at Beverly Park Place Health and Rehab. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 002		

Division of Health Care Facilities REGULATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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