

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN4705	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  04/16/2014
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NAME OF PROVIDER OR SUPPLIER  BEVERLY PARK PLACE HEALTH AND REHAB	STREET ADDRESS, CITY, STATE, ZIP CODE 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918
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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 000	<p>Initial Comments</p> <p>A licensure survey and complaint investigation #33297 and #33399 were completed on April 14-16, 2014, at Beverly Park Place Health and Rehab. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE \_\_\_\_\_ TITLE \_\_\_\_\_ (X6) DATE \_\_\_\_\_