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Division of Health Care Facilities

PRINTED: 07/14/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING: B. WING	(X3) DATE SURVEY COMPLETED
	TN4705		C 07/11/2014

NAME OF PROVIDER OR SUPPLIER: BEVERLY PARK PLACE HEALTH AND REHAB

STREET ADDRESS, CITY, STATE, ZIP CODE: 5321 BEVERLY PARK CIRCLE KNOXVILLE, TN 37918

(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	Initial Comments Complaint investigation #33683was completed on June 11-July 11, 2014, at Beverly Park Place Health and Rehab. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.	N 000		

Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Diesette Williamson

TITLE: Administrator

(X6) DATE: 7-17-14

STATE FORM 6899 CMVT11

If continuation sheet 1 of 1