

Division of Health Care Facilities

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| 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 C 05/17/2012 |
| 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 002 | 1200-8-6 No Deficiencies During complaint investigation of #29013, #29295, #29264, & #29318, conducted on May 15-17, 2012, at Beverly Park Place Health and Rehab, no deficiencies were cited in relation to the complaints under 1200-8-6, Standards for Nursing Homes. | N 002 | | |

Division of Health Care Facilities

TITLE

(X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6899

VKWQ11

If continuation sheet 1 of 1