

Division of Health Care Facilities

PRINTED: 05/07/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN5302	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____ B. WING _____	(X3) DATE SURVEY COMPLETED 04/23/2014
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NAME OF PROVIDER OR SUPPLIER BAPTIST HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 700 WILLIAMS FERRY RD LENOIR CITY, TN 37771
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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
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N 000	<p>Initial Comments</p> <p>A Licensure survey and complaint investigation #32426, #32641, and #33500, were completed on April 21 - 23, 2014, at Baptist Healthcare Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		
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Division of Health Care Facilities
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE
Christa C. Smith
STATE FORM 6099 TITLE Administrator (X6) DATE 5/16/14
B1M711 If continuation sheet 1 of 1