

Division of Health Care Facilities

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 C 02/19/2016
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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>Complaint investigation #37149, # 37469, and # 37599, were completed on 2/16-19/16 at Baptist Health Care 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	TITLE	(X6) DATE
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