

Division of Health Care Facilities

PRINTED: 01/16/2014
FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7105	(X2) MULTIPLE CONSTRUCTION A. BUILDING: 01 - MAIN BUILDING 01 B. WING _____	(X3) DATE SURVEY COMPLETED C 01/13/2014
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NAME OF PROVIDER OR SUPPLIER BETHESDA HEALTH CARE CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 444 ONE ELEVEN PLACE COOKEVILLE, TN 38501
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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 002	<p>1200-8-6 No Deficiencies</p> <p>This Rule is not met as evidenced by: No deficiencies were cited as a result of Complaint Investigation TN00033093 completed on 1/13/14.</p>	N 002		

Division of Health Care Facilities LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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