Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION<br>A. BUILDING: **01 - MAIN BUILDING 01**<br>B. WING _____ | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | **TN7105** | | **02/02/2017** |

NAME OF PROVIDER OR SUPPLIER

**BETHESDA HEALTH CARE CENTER**

STREET ADDRESS, CITY, STATE, ZIP CODE

**444 ONE ELEVEN PLACE**
**COOKEVILLE, TN 38501**

| (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<br><br>During the complaint investigation of TN #00040531, it was determined no deficiencies were cited under 1200-08-06, Standards for Nursing Homes. | N 002 | | |

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE