

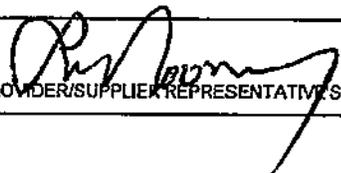
FORM APPROVED

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: TN7105	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 02/12/2013
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 000	Initial Comments A licensure survey was conducted February 4 - 12, 2013, at Bethesda Health Care Center and no deficiencies were cited as a result of the survey.	N 000		

Division of Health Care Facilities

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



TITLE
ADMINISTRATOR

(X6) DATE
2/25/13

STATE FORM

6899

DNOM11

If continuation sheet 1 of 1