Division of Health Care Facilities

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | TN7105 | A. BUILDING: 01 - MAIN BUILDING 01<br>B. WING _____ | C<br>03/21/2014 |

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>Based on observations, interview, and records review during complaint investigation TN0003514 conducted on 3/21/14, it was determined the facility was in compliance with the Life Safety Code requirements of the Tennessee Department of Health, Board of Licensing Health Care Facilities and Chapter 1200-08-06 Standards for Nursing Homes and its referenced publications. | N 002 | | |

Division of Health Care Facilities

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