

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN7105</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING <b>01 - MAIN BUILDING 01</b> B. WING _____	(X3) DATE SURVEY COMPLETED  <b>C</b> <b>11/19/2012</b>
--	---	---	---

NAME OF PROVIDER OR SUPPLIER  <b>BETHESDA HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>444 ONE ELEVEN PLACE COOKEVILLE, TN 38501</b>
--	---

(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  No deficiencies were cited as a result of Complaint Investigation TN00030813 completed on 11/19/12.	N 002		

Division of Health Care Facilities TITLE (X6) DATE

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