**Division of Health Care Facilities**

**Statement of Deficiencies and Plan of Correction**

**(X1) Provider/Supplier/CLA Identification Number:**

TN0701

**(X2) Multiple Construction**

A. Building
B. Wing

**(X3) Date Survey Completed:**

C
09/19/2012

**Name of Provider or Supplier:**

Beech Tree Manor

**Street Address, City, State, Zip Code:**

240 Hospital Lane, PO Box 300
Jellico, TN 37762

**Summary Statement of Deficiencies**

(Each deficiency must be preceded by full regulatory or LSC identifying information)

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Initial Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 000</td>
<td>During complaint investigation of #30132, conducted on September 19, 2012, at Beech Tree Manor, no deficiencies were cited in relation to the complaint under 1200-8-6, Standards for Nursing Homes.</td>
</tr>
</tbody>
</table>

**Provider's Plan of Correction**

(Each corrective action should be cross-referenced to the appropriate deficiency)

<table>
<thead>
<tr>
<th>ID Tag</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 000</td>
<td></td>
</tr>
</tbody>
</table>

**Director's or Provider/Supplier Representative's Signature:**

**Date**