**Division of Health Care Facilities**

**STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION**

**(X1) PROVIDER/SUPPLIER/CIA IDENTIFICATION NUMBER:**

TN7105

**(X2) MULTIPLE CONSTRUCTION**

A. BUILDING

B. WINS

**(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 38504

<table>
<thead>
<tr>
<th>(X4) ID TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)</th>
<th>ID TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETE DATE</th>
</tr>
</thead>
<tbody>
<tr>
<td>N 000</td>
<td>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.</td>
<td>N 000</td>
<td></td>
<td></td>
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</tbody>
</table>

**Division of Health Care Facilities**

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

ADMINISTRATOR

STATE FORM

DNOM11