**NAME OF PROVIDER OR SUPPLIER**

BETHESDA HEALTH CARE CENTER  

**STREET ADDRESS, CITY, STATE, ZIP CODE**

444 ONE ELEVEN PLACE  

COOKEVILLE, TN 38501

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<table>
<thead>
<tr>
<th>(X4) ID PREFIX TAG</th>
<th>SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LGG IDENTIFYING INFORMATION)</th>
<th>ID PREFIX TAG</th>
<th>PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCES TO THE APPROPRIATE DEFICIENCY)</th>
<th>(X5) COMPLETION DATE</th>
</tr>
</thead>
</table>
| K9999             | FINAL OBSERVATIONS  
Based on observation, testing, and interviews, it was determined the facility had no life safety deficiencies as a result of complaint investigation TN00031488 conducted on 4/10/13. |               | K9999                                                                                           |                     |

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Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the data of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

TITLE  

(XX) DATE